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IMPROVING ACCOUNTABILITY IN MEDICARE MANAGED CARE: THE CONSUMER'S NEED FOR BETTER INFORMATION

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

WASHINGTON, DC

APRIL 10, 1997

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IMPROVING ACCOUNTABILITY IN MEDICARE MANAGED CARE: THE CONSUMER'S NEED FOR BETTER INFORMATION

THURSDAY, APRIL 10, 1997

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

The committee met, pursuant to notice, at 9:05 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Charles Grassley (chairman of the committee) presiding.

Present: Senators Grassley, Jeffords, Burns, Collins, Breaux, Moseley-Braun, Wyden, and Reed.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. Good morning, everybody. As chairman of the Special Committee on Aging and also for my Democratic colleague, the Senator from Louisiana, the ranking Democrat, I want to welcome all of my colleagues and the witnesses who are here today for this morning's hearing.

The focus of the hearing will be on how Congress and the Administration can provide better information to Medicare beneficiaries when they are trying to select the right health plan to meet their health care needs. Behind the screen, you will see on that tall panel there 7 or 8 or maybe 9 or 10 different plans that come out of the Los Angeles area, and these are just summaries of plans. You could have pounds of paperwork that would come to a household about the details of a plan. You will see how complicated these Medicare-approved HMO plans in the Los Angeles area are. A wall of brochures like that obviously demonstrates better than any words I can say or our witnesses can say that seniors have a major problem trying to choose a Medicare plan.

They have to contact each health plan to get a copy of their brochure, and then, they try to decipher the differences between the plans, and they do that without the benefit of standardized terms or formats in these marketing materials. Most of you in this room are probably very knowledgeable about Medicare, but I would like to challenge anyone to work their way through that maze and come out feeling you made a wise decision regarding the Medicare managed care plan you should join.

Thankfully, the choice of health plans in Medicare is increasing at a rapid rate, and as we look at ways to provide more options for

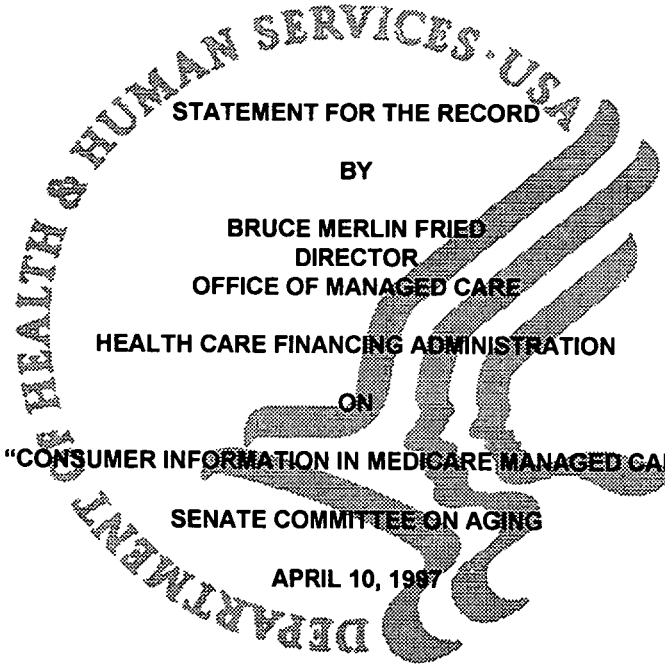
Medicare beneficiaries, we need to make sure that the right information is available so they can make informed decisions. By the end of 1996, approximately 13 percent of the Medicare population or almost 5 million beneficiaries were enrolled in managed care plans, compared to only 5 percent in 1990. The Congressional Budget Office predicts that this figure will approach 25 percent of the total Medicare population by the year 2002. As more beneficiaries decide to enroll in Medicare managed care plans, there is increasing concern among seniors and their advocates that they are not being informed about their health care coverage. Current law requires that Medicare beneficiaries are provided with certain information, but according to testimony we are going to hear this morning, it is not adequate, and it is not provided in a very useful format.

At a recent hearing before the House Ways and Means Subcommittee, Stan Jones, chairman of the Institute of Medicine, testified that the information provided to Medicare beneficiaries about the differences in health plans appears primitive—and those are his words—compared with what is available to private purchasers. He said: "many elderly are making these new choices about managed care without enough information to judge which option is best for them, what the plan they choose will actually cover and how the plan will operate."

This morning, we are going to hear a real life experience of someone who recently became eligible for Medicare and is trying to decide what plan to select but cannot seem to get the information to do so. We will hear from experts in the field and from the General Accounting Office about ways we can improve what and how much information is being provided by Medicare. I would just like to note that we invited the HealthCare Financing Administration (HCFA) to testify about it's plans to improve what information is provided to Medicare beneficiaries, but beyond submitting testimony, they declined to appear.

So, I would like the record to show that HCFA decided not to testify before this committee because they did not like the order of witnesses that I, as the chairman of this committee, requested. So, I say shame on HCFA. There is a certain snobbery, it seems to me, in the bureaucracy of our democracy when these administrators think they are too good to sit at the same table with the average citizen.

[The statements from the Health Care Financing Administration follow:]



STATEMENT FOR THE RECORD

BY

BRUCE MERLIN FRIED
DIRECTOR
OFFICE OF MANAGED CARE

HEALTH CARE FINANCING ADMINISTRATION

ON

"CONSUMER INFORMATION IN MEDICARE MANAGED CARE"

SENATE COMMITTEE ON AGING

APRIL 10, 1997

HCFA
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Health Care Financing Administration

INTRODUCTION

Mr. Chairman and members of the Special Committee on Aging, I am pleased to submit testimony for the record which describes the Health Care Financing Administration's (HCFA) strategy to disseminate Medicare information to beneficiaries, particularly information involving managed care. One of our highest priorities is making sure that beneficiaries receive timely, accurate, and useful information about their health plan options. We certainly agree with the old saying, "knowledge is power." Beneficiaries who possess information about health care options have the ability to make wise decisions about their well being. Making wise choices about health care options can help beneficiaries receive preventive care, possibly avoid illnesses and costly treatments, and for many, recover from sickness. Expanding beneficiaries' knowledge, so that they can choose a health plan to best meet their needs, is cost-effective and the right approach.

Currently, HCFA is undergoing an internal reorganization designed to enhance our beneficiary-centered focus. The reorganization will be complete by this summer and will enable HCFA to respond more efficiently to rapid changes occurring in health care so that we can better serve our beneficiaries. Three separate HCFA divisions are being established to focus on our three primary audiences, which include our beneficiaries, the health care plans and providers who care for beneficiaries, and the states who partner with us in serving our Medicaid beneficiaries. This customer model is similar to markets in the private sector. It recognizes that driving forces behind current changes in the nation's health care system are not internal to the agency, but external. Just as in the commercial health care system, managed care is emerging as an integral and rapidly growing part of our operations. Therefore, it makes sense to integrate managed care and fee-for-service operations throughout the agency, rather than to maintain a separate Office of Managed Care, for example. Similarly, we are combining the Medicaid Bureau, survey and certification operations, insurance regulation, clinical laboratory regulation, and intergovernmental affairs into the Center for State Operations.

HCFA's new organizational structure focuses on the beneficiary as HCFA's ultimate customer by establishing, for the first time, a component dedicated explicitly to understanding and meeting the needs of beneficiaries. The Center for Beneficiary Services (CBS) will exist to protect, serve, and to be an advocate for beneficiaries. It is designed as the focal point for all of the agency's interactions with beneficiaries, their families, care-givers, and other representatives of beneficiaries. The CBS will provide information to help beneficiaries and concerned parties make informed decisions about their health care and program benefits administered by HCFA. It will assess beneficiary and consumer needs, design and implement beneficiary services' initiatives, and develop performance and evaluation programs for beneficiary services activities. The CBS will develop national Medicare policies and procedures for eligibility, enrollment, entitlement, coordination of benefits, managed care enrollment and disenrollment, and appeals. New methods to improve health care delivery systems from the perspective of our beneficiaries will be developed and tested through demonstrations and interventions. Contracts and grants involving customer service will be handled by the Center, and it will coordinate the activities of Medicare's contractors.

Our restructuring is moving HCFA in the right direction. As the Medicare and Medicaid programs evolved over the years, new programs and projects were layered onto existing structures. Over time, this became cumbersome and often confusing. Successfully implementing a more beneficiary responsive agency will facilitate our ability to effectively respond to the needs of beneficiaries. This is an important structural development as we build the bridge to the 21st Century.

This Administration is serious about promoting beneficiary and consumer information through ensuring a more beneficiary-centered agency. We have been working hard on strategic measures to strengthen this goal. Our overall strategy involves numerous initiatives such as making available comparative information about plans; strengthening beneficiary education through our Competitive Pricing Demonstration; conducting beneficiary surveys; offering beneficiary counseling and assistance; ensuring unrestricted medical communication; and making available many publications and resource materials. HCFA's initiatives are designed to ensure that our beneficiaries and consumers receive information necessary to compare fee-for-service or managed care options and enable them to choose the right plan for their needs. Under this Administration, HCFA's efforts are firmly focused on helping beneficiaries and consumers obtain information about their health care plan options. By furthering this goal, our beneficiaries will receive the best value for their investment.

GAO's REPORT ON MANAGED CARE DATA

Late, last year, the Senate's Special Committee on Aging released recommendations submitted by the General Accounting Office in a report entitled, "Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance." The Department of Health and Human Services and HCFA agree with the GAO that Medicare beneficiaries need more information and that informed beneficiaries can hold plans accountable for the quality of care. HCFA's beneficiary and consumer initiatives, which I will soon describe, have directly responded to GAO's suggestions and comments. We are confident that our current strategy is the right one in resolving GAO's concerns.

We believe that our numerous initiatives, programs, and publications are contributing to a stronger Medicare beneficiary-centered program and agency. Our efforts have already begun to make a significant difference in the way in which beneficiaries and consumers choose their health care plans. As we continue to develop and implement our strategies, beneficiary and consumer information about Medicare choices will be enhanced.

One of the GAO's recommendations was that we make disenrollment data available to our beneficiaries. Currently, we use plan specific disenrollment data generated by our systems to assist us in determining which plans need more focused reviews or monitoring. There are a number of reasons that beneficiaries disenroll. A careful analysis in the context of a particular plan's activities and its market of operation needs to be conducted before any meaningful

conclusions can be drawn from disenrollment data. We are currently evaluating the different ways in which disenrollment rates, across plans, can best be expressed and presented, so that beneficiaries can use this data, in conjunction with other plan-specific information, to make good choices among plans. Ultimately, we plan to provide appropriate disenrollment data in HCFA's comparability charts. At this time, I would like to describe some of our initiatives.

HCFA's BENEFICIARY AND CONSUMER INITIATIVES

Comparative Information

We wish to make comparative information available to all Medicare beneficiaries to assist them in making appropriate health care choices. Currently, some of HCFA's regional offices sponsor and disseminate comparative information for beneficiaries. For instance, HCFA's San Francisco, Seattle, Philadelphia, and Denver regional offices are in the process of distributing comparative information. Charts compare benefits offered by area plans, including payments for hospital coverage, physicians and specialists, home health care, emergency care, preventive services, pharmacy benefits, dental, and mental health coverage. In the near future, we plan to provide information regarding Medicare's managed care beneficiary satisfaction surveys and the Health Plan Employer Data and Information Set (HEDIS). HEDIS is designed to provide quantitative and qualitative data on the performance of health plans. This data source is helpful because it includes information about the effectiveness of care, access and availability of care, health plan stability, use and cost of services, and a description of health plans.

Building on these pilots, HCFA plans to make current, comparative data on cost and benefits, and other information available for all plans nationwide. We are working on making comparative information available on the Internet and to beneficiary insurance counseling centers, HCFA Regional Offices, and others with Internet access. Phase I of this project will be available by June 1997, and will provide comparative market data about HMO benefits, premiums, and cost-sharing requirements. Individuals will be able to use HCFA's Internet Web site to retrieve data which will be helpful in making informed decisions about plan options. Currently, the majority of beneficiaries do not have a direct link to Internet. However, beneficiary and consumer advocates, insurance counselors, and public entities who are the most frequent sources of beneficiary advice and counseling do possess this technology, and it will become an even better source for helping to disseminate this data. Our beneficiaries will greatly benefit through this widely accessible and user-friendly data source.

Under the President's 1998 Budget Plan, we seek to further empower beneficiaries by ensuring wider and more consistent dissemination of health plan information in a format that is easier to understand. The President's budget proposes that beneficiaries receive comparative materials on all of their coverage options -- both managed care and Medigap. To help beneficiaries compare various plans, standardized packages for additional benefits offered by managed care plans would be developed. Adjustments would then be made to the current standard Medigap packages to

make comparison easier for beneficiaries. Medigap plans would be required to operate under the same rules followed by Medicare managed care plans. Plans would be required to offer community rated policies and to participate in coordinated open enrollment periods. In addition, plans would be precluded from imposing preexisting condition exclusions.

Competitive Pricing Demonstration

HCFA is currently working to implement a Competitive Pricing Demonstration located in Denver, Colorado, which includes three major components: 1.) Beneficiary education; 2.) Enrollment by a neutral third-party; and 3.) Bidding process for rates. The first and second components relate to beneficiary information. This demonstration is designed to enable Medicare to make the transition to operating like other large payers.

Medicare's beneficiaries in this demonstration will have a guaranteed open enrollment period, slated for the Fall of 1997, during which they will be able to enroll in any of the local Medicare managed care plans. This managed care demonstration will use competitive bidding to set payment rates and will help beneficiaries to be more informed consumers, which will foster competition among plans. A main feature of the project is an expanded, intensified information and education effort. It is designed to test a range of new educational and informational resources for beneficiaries --- including new formats of printed materials, in-person seminars, and a 1-800 hotline. We plan to provide area-specific health insurance option comparison charts, including detailed comparisons of the Medicare managed care plans available in the area. There will also be opportunities for beneficiaries to view brief educational video tapes and taped presentations of the seminars. A special contractor, BENOVA, Inc. of Portland, Oregon, not affiliated with any of the plans, will be available to counsel beneficiaries and will handle the enrollment functions. Beneficiaries wishing to remain in Medicare's fee-for-service or who are already enrolled in a Medicare managed care plan and want to remain in that plan will not need to take any action to retain their existing arrangement. The goal of these resources is to help beneficiaries understand their options under Medicare and to help them make the best choices for their circumstances --- whether it is choosing between fee-for-service and managed care or choosing among various managed care and Medigap options.

We believe that the Denver project will provide beneficiaries with everything they need to be informed consumers, which is essential for this competition to work. In addition, beginning in 1999, payments to managed care plans will be adjusted for risk based on health status measures. Plans will be paid more for enrolling people with disabilities, certain chronic health conditions, or expensive care needs. We expect to learn the fairest way to pay HMOs and to build upon the traditional American reliance on the free-market. It is anticipated that in 1999, we will implement similar competitive pricing demonstrations in two other sites, yet to be determined.

We are encouraged by the strong support of health care experts who believe that there is a right way to implement market-oriented concepts. We are disappointed that some health plans, despite their stated support for a market-oriented approach, oppose these demonstrations. We have been

and will continue to work with these health plans with the hope that plans will end up agreeing with us in this important area of intense study.

Survey of Managed Care Plan Enrollees

In cooperation with HCFA, the Agency for Health Care Policy and Research (AHCPR) initiated the Consumer Assessment of Health Plans Study (CAHPS) to design a Medicare managed care beneficiary satisfaction survey. This survey provides information from Medicare enrollee responses about satisfaction with plan providers, access to services and providers, availability of services, and quality of care. Beginning January 1, of this year, HCFA is requiring all health plans to use CAHPS. We plan to include the results of the beneficiary survey in HCFA's comparability charts so that beneficiaries have important information about particular plans.

Health Insurance Advisory Program

The Health Insurance Advisory Program (HIA) is designed to develop and strengthen the capability of states to provide Medicare beneficiaries with information, counseling, and assistance on adequate and appropriate health insurance coverage. Funding for this program supports information, counseling, and assistance relating to Medicare and Medicaid matters, as well as Medigap, long-term care insurance, and other health insurance benefit information. The President's Fiscal 1998 Budget Proposal continues to provide funding for these health advisory services.

Over half of the states had attempted to deliver counseling and assistance services to Medicare beneficiaries before the HIA grant program began. The significant interest in this effort, shown by states, attests to the perceived need for such services. Currently, all 50 states, as well as the District of Columbia, Puerto Rico, and the Virgin Islands participate in the HIA grant program. Two-thirds of the HIA programs are administered by states' Department on Aging, and one-third of the programs are based in the states' Department of Insurance.

The primary modes of delivering HIA services to Medicare beneficiaries and their representatives are face-to-face counseling, telephone hotlines, and outreach activities. The majority of programs have incorporated a combination of these methods into their programs. In counseling sessions, beneficiaries usually come to a central meeting place, such as a senior center or library, to meet with an HIA volunteer. Counseling sessions focus on general information, education, enrollment, claims forms, and the appeals process. The HIA's volunteers often answer questions about what Medicare pays and assist in solving claims and billing problems.

We are pleased to report that the HIA program is helping to improve the lives of beneficiaries in this country. In Iowa, through the state's Iowa Department of Elder Affairs, the HIA program provides funds to the state's Insurance Division, Senior Health Insurance Information Program (SHIIP). Through this project, Iowa's senior volunteer counselors perform valuable services to beneficiaries.

Let me share with you an example of an HIA-related beneficiary experience. The caretakers of a beneficiary, which we refer to as Sarah, received advice from a SHIIP volunteer. Sarah had three long-term care policies, two Medicare supplemental policies, and five other health insurance policies of limited coverage. As a result of a volunteer's counsel, the caregivers canceled duplicative policies and saved Sarah more than $4,400 in insurance premiums annually. The HIA program successfully serves beneficiaries in other states, such as in Louisiana where the state grantee is the Louisiana Department of Insurance, and the state counseling program is also known as SHIIP. Louisiana's program has 35 counseling sites located throughout the state, which provide counseling services to thousands of beneficiaries each year. It is estimated that during 1994 and 1995, this program saved clients in Louisiana over half a million dollars involving health insurance related concerns.

HCFA's regional offices have been instrumental in building partnerships with the HIA programs and other organizations directly affected by the HIA. For instance, HCFA's New York office sponsored a conference which brought together representatives from HIAs, peer review organizations, carriers and intermediaries, the Social Security Administration, and state and local Agencies on Aging. This event created a forum for the exchange of information and customer service techniques. The majority of beneficiary concerns, as reported by the HIA programs, continue to focus on Medicare supplemental insurance issues, including an explanation of the ten standardized plans and the process to determine which plan best fits a beneficiary's needs. Other issues that rank high among beneficiary concerns include what is covered under Medicare, obtaining prescription coverage, obtaining insurance for the disabled, and dealing with primary and secondary insurance issues. The HIA programs provide an invaluable service to HCFA, supplying much-needed information and assistance, as well as a vital link for HCFA, to the Medicare beneficiary.

Unrestricted Medical Communication

The Medicare statute requires that contracting health plans must make all covered services available and accessible to each beneficiary as determined by the individual's medical condition. In fee-for-service, physicians who participate in the Medicare program are required to make beneficiaries aware of the full range of treatment options. Managed care enrollees are entitled to the same advice and consultation. This is a basic right of the patient.

This past November, we communicated the prohibition of gag clauses contained in managed care HMO contracts through an agency policy instruction to health plans. All of Medicare's risk contractors were sent HCFA's operational policy letter prohibiting the use of gag clauses. Last month, HCFA sent an administrative notification to all 50 State Medicaid Directors reminding them that gag clauses are prohibited. President Clinton has made it clear that he supports legislation to ensure that physicians who participate in managed care plans are free to discuss the full range of treatment options.

National Marketing Guidelines

For the past year and a half, HCFA has been working with representatives of the managed care industry, such as the American Association of Health Plans, and senior advocacy organizations to clarify and to simplify the regulation of managed health care marketing activities to Medicare beneficiaries. This collaborative effort has produced the "National Marketing Guidelines for Medicare Managed Health Care Plans." These guidelines provide a uniform code of acceptable marketing practices which can be applied on a national basis to managed care entities participating in the Medicare program. As a result of this initiative, Medicare beneficiaries will receive marketing material that is consistent, accurate, and timely. In addition, the guidelines will clarify HCFA's policies regarding promotional materials, value added services, and marketing through health care providers.

We anticipate having this new national marketing initiative available on the Internet as early as this month. Medicare managed care health plans that are members of the American Association of Health Plans (AAHP) will be notified by that organization of this added service. Contracting health plans that are not AAHP members will be notified by HCFA. Interested parties may request a hard copy of the document to be mailed. Once the guidelines are available, there will be a 45-day interim period prior to implementation. During this interim period, HCFA and the contracting health plans will communicate directly to ensure that sales and marketing practices are consistent with the standards. Open communications will ensure that health plans properly understand the guidelines' criteria and instructions

Beneficiary Information Dissemination

HCFA's Consumer Information Program (CIP) is a highly visible public education campaign directed toward improving the health of Medicare and Medicaid beneficiaries. It is a nationwide effort led by HCFA in partnership with the Public Health Service. The program conducts public health campaigns, provides customer-friendly health education messages, and encourages greater use of HCFA's preventive health care benefits, such as flu and pneumonia immunizations and screening mammograms.

In addition, HCFA and its Department of Health and Human Services (DHHS) partner agencies have developed several publications to inform Medicare beneficiaries of their rights and options. These beneficiary advisory publications answer frequently-asked questions about HMO enrollment and disenrollment, potential fraud and abuse, and the appeals process. Also, the latest edition of the Medicare Handbook was sent to all 37 million Medicare beneficiaries and it is our goal that all beneficiaries receive an updated handbook every year.

The Medicare Handbook includes useful beneficiary information regarding the Medicare program, supplemental Medigap insurance, and managed care plans. It describes who is eligible for Medicare, how to enroll for Medicare, and what hospital and medical expenses are covered by Medicare, including how much of the bill beneficiaries are responsible for paying. The handbook

provides a detailed description of the different services covered under Medicare Part A and Part B, including a listing of requirements which beneficiaries must meet. It is user-friendly, because the handbook includes numerous examples of services, benefits, deductibles, and copayments. An added feature of the handbook is a state-by-state telephone listing of insurance counseling centers, Medicare carriers, peer review organizations, and durable medical equipment regional carriers available for further information.

Community-based Medicare Information Resource

This past October marked the opening of a pilot project to provide beneficiaries with the latest Medicare information in a convenient, one-stop, personal service facility. The test site for "Your Medicare Center" is a Philadelphia shopping mall, and it is staffed by HCFA employees who explain managed care options, resolve concerns, and correct records. This innovative project will allow the public's concerns about entitlement, managed care choices and enrollment, Medigap insurance, coverage, premiums, and appeals to be answered promptly and efficiently. Additional services including educational seminars on managed care-related issues and health screening will also available, using technology such as interactive video-conferencing and computerized information kiosks.

National Toll-free Hotline

To assure Medicare's beneficiaries with quick and easy assistance or information, we are in the process of piloting a single, national toll-free telephone number for complete and accurate answers to beneficiaries' questions. Currently, beneficiaries must call different toll-free numbers depending on the issue. HCFA maintains or supports more than 150 toll-free numbers nationally, with the total annual volume of calls equaling 34 million. Our market research indicates that beneficiaries are unsure of whom to contact and often must call several toll-free numbers to reach an agent who can address their problem. However, as a result of HCFA's streamlined hotline system, we anticipate reducing beneficiary confusion and increasing the number of calls that are resolved on the first contact.

We are pleased to let you know that as a result of our existing hotlines and in collaboration with the DHHS's Office of Inspector General's hotline, beneficiaries are able to report potential cases involving Medicare and Medicaid fraud and abuse violations. As soon as these fraud cases are reported, prompt action is initiated by either HCFA's intermediaries, carriers, peer review organizations, or the states in the investigation of fraud allegations. The Office of Inspector General with the DHHS also plays a vital role in fraud investigations and corrective action. We believe that our single toll-free line will enhance our ability to combat fraud, because it will be easier for beneficiaries and concerned parties to make calls about potential fraud and abuse.

Information Needs for Consumer Choice

In an effort to assist HCFA in creating information which is easily understandable by our

beneficiaries, we awarded the Research Triangle Institute (RTI) a contract to develop and test prototype materials. HCFA plans to have this prototype language available by midsummer which will be helpful in making our Medicare and Medicaid managed care beneficiary publications more user-friendly. This project determined what consumers find most helpful in selecting their health insurance coverage. The RTI examined different types of information consumers use involving plans, providers, and physicians and practitioners in making their chosen health care plan system work best for them. Information needs vary across insurance groups. In general, Medicare beneficiaries were concerned with their access to current providers and the specialists of their choice, providers' communication skills, technical quality of care, and specific benefits relevant to their circumstances. Medicaid eligibles were most interested in access to after-hours care, provider choice, waiting time, and providers' communication and interpersonal skills.

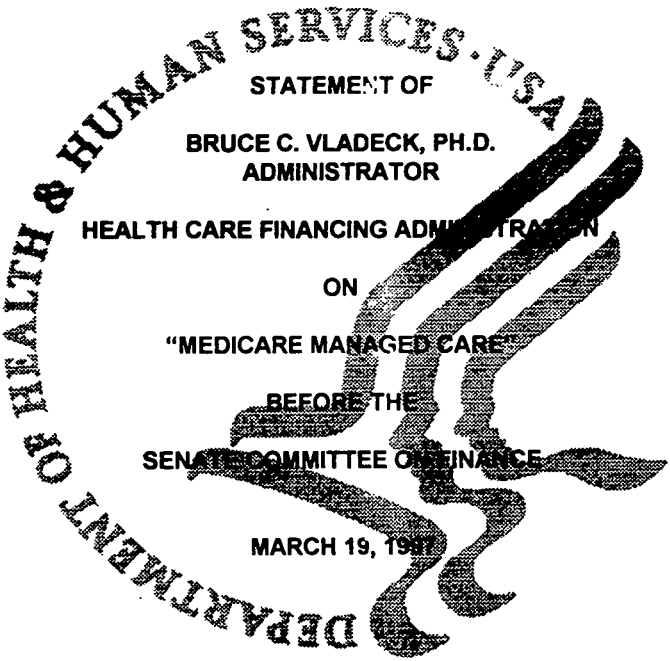
Medicare beneficiaries consistently preferred a combination of individual or group presentations with printed reference material. Medicaid eligibles wanted group counseling sessions, similar to sessions, which they currently receive, but with the addition of detailed information on available plans. All participants indicated that they prefer receiving information from unbiased, consumer-oriented sources. Overall, traditional health plan information, such as premium amounts and benefit coverage, was the most common type of data included in the consumers' materials reviewed.

CONCLUSION

As the largest purchaser of health care, we believe that HCFA has a responsibility to ensure that beneficiaries have the information they need to make the best possible health care decisions. As our many consumer activities demonstrate, we are constantly improving our commitment to being a beneficiary-centered purchaser. Recently, this Administration included beneficiary and consumer information improvements within the President's Fiscal 1998 budget proposal submitted to Congress.

President Clinton is personally committed to ensuring that our beneficiaries, particularly seniors, receive accurate, complete, and timely information regarding their health care options. This Administration's proposals ensure that comparative information, involving fee-for-service, managed care, and Medigap, will be made available to beneficiaries. With the help of Congress, we hope to make a difference in the lives of our beneficiaries through enactment of our legislative proposals. In addition, we are confident that our current initiatives and programs are making it possible for numerous beneficiaries and consumers to be better informed.

We believe that our multiple initiatives, publications, and proposals represent an effective strategy for the dissemination of Medicare information to our beneficiaries and can serve as a model for other purchasers. We look forward to working with this Committee to further strengthen the Medicare program through improved information dissemination.



STATEMENT OF

BRUCE C. VLADECK, PH.D.
ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

ON

"MEDICARE MANAGED CARE"

BEFORE THE

SENATE COMMITTEE ON FINANCE

MARCH 19, 1997

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Health Care Financing Administration

INTRODUCTION

Mr. Chairman, I am very pleased to be here to describe how the Health Care Financing Administration (HCFA) is working to make sure that Medicare beneficiaries receive high quality care under managed care. It is important that we clearly define and support measures to promote quality of care, not only for beneficiaries enrolled in Medicare managed care plans and traditional fee-for-service, but for all Americans in all types of health plans. We also are working to become more adept at being a beneficiary centered purchaser, and as the Nation's largest purchaser of health care, we want to effectively use market forces to obtain best value for our beneficiaries.

Managed care options have been a part of Medicare since the program's inception. With the signing of the first risk contracts authorized under the Tax Equity and Fiscal Responsibility Act in 1985, managed care plans proliferated and today have become an essential part of the Medicare and Medicaid programs. As of January 1, more than 4.9 million beneficiaries have enrolled in 350 Medicare managed care plans, two thirds of which are risk contractors. Risk plan enrollment grew by 33 percent in 1996. This increase is consistent with the rapid rate of program growth in recent years. In 1994, enrollment grew by 25 percent, in 1995, the growth was 36 percent.

In a managed care plan, a network of doctors, hospitals, skilled nursing facilities and other providers offers comprehensive, coordinated medical services to plan members on a prepaid basis. Except in emergencies, services must be obtained from health care providers that are part of the plan. Care may be provided at a central facility or in the private practice offices of the doctors and other professionals affiliated with the plan.

We have found that the managed care option is attractive to many beneficiaries. In many cases, enrollees can receive the same financial protection afforded by Medicare supplemental -- or "Medigap" -- policies without paying a premium. In addition, most plans provide benefits not covered under the Medicare program, such as routine vision care, dental care, and prescription drugs, at little or no additional cost to the beneficiary. I should point out, however, that the ability of managed care plans to provide additional benefits is due in part to the inadequacy of Medicare's payment methodology, which we have proposed to address in this year's budget. Beyond value measured in dollars and cents, managed care plans have the potential to provide value that can be achieved when services are coordinated and when the focus of care is on prevention and "wellness."

Our mission in HCFA is to serve our Medicare and Medicaid beneficiaries. Under this Administration, HCFA's efforts are firmly focused on obtaining the best value for our beneficiaries. We work in partnership with managed care plans in this task, but as I will describe later in my testimony, we have not hesitated to take enforcement actions when warranted.

BENEFICIARY PROTECTIONS

Current law provides beneficiaries enrolling in managed care plans a wide variety of protections, many of which are not received by most commercial enrollees. Let me take this opportunity to outline briefly the protections that beneficiaries enjoy under current law and areas where improvements are warranted.

- **Beneficiaries must receive clear and accurate information about the implications of their choice of a managed care option** -- Current law requires that plans provide certain information to all prospective enrollees including explanations of benefits, premiums and cost-sharing, lock-in requirement, and grievance mechanisms. However, we believe that more needs to be done to educate consumers about their health care alternatives and later in my testimony I will describe our plans for improvement in this area.

- **Beneficiaries cannot be subjected to health screening or preexisting condition limitations** -- Current law is clear in this area. We enforce this requirement through careful monitoring of all marketing materials and activities of contracting plans, and by reviewing beneficiary grievances and appeals.

- **Beneficiaries must have access to medically necessary and appropriate care** -- Before receiving a contract, all plans must meet Federal standards which guarantee beneficiary access to medically necessary services. HCFA is committed to ensuring that HMOs adhere to these Federal standards.

- **Beneficiaries must have access to procedures to resolve grievances and access to a neutral third party for appeals** -- While this is one area where Medicare's protections are significantly beyond those generally available to managed care enrollees in the private sector, we believe that improvements are necessary. Our plans for achieving these improvements will be explained in a subsequent section.

- **Beneficiaries' care is reviewed both internally and externally** -- Plans must have internal quality review mechanisms in order to receive a contract. PROs are responsible for external quality review. We have been working closely with other payers and the industry to make significant improvements in this area and, later in my testimony, I will outline these initiatives.

- **Beneficiaries are protected from the risk of discontinuous or inappropriate care that could result from the financial instability of a plan** -- Under current law, plans must be fiscally sound and must have a plan for protecting beneficiaries in the event of insolvency.

- **Beneficiaries' out-of-pocket expenses are limited** -- Under current law, Medicare managed care plan enrollees are protected by limits on premiums and cost-sharing and by prohibitions against balance billing.

We have also been working toward enhancing beneficiary protections. Some steps can be taken under current law, while other actions would require legislation.

- **Improving the Appeals and Grievance Processes**: The appeals and grievance process serves as a check and balance on contracting plans and helps to ensure that beneficiaries obtain all appropriate and medically necessary services. Improvement activities include an expedited appeals process for certain time-sensitive situations, shortened time frames for all other reviews involving service denials and terminations, and improved health plan accountability on the results of appeals and grievances. However, we cannot afford to be complacent in the face of recently publicized concerns, and streamlining the appeals process is one of our highest priorities.

- **Unrestricted Medical Communication**: The Medicare statute requires that contracting health plans must make all covered services available and accessible to each beneficiary as determined by the individual's medical condition. In fee-for-service, Medicare beneficiaries are made aware of the full range of treatment options by their physicians. Managed care enrollees are entitled to the same advise and consultation. This is a basic right of the patient and we have communicated the prohibition against "gag" provisions in a policy instruction to all health plans.

- **Post-Breast Cancer Surgery Hospitalization**: The national attention given to coverage of mastectomies indicates that there is a need for greater oversight. We are committed to preventing sub-standard care in this area since Medicare pays for one-third of all mastectomies. By law, Medicare beneficiaries who receive mastectomies are entitled to coverage for all medically necessary care. The decisions about what is medically necessary should be made by a woman and her doctor. To emphasize this, on February 12, 1997, we sent a policy letter to all managed care plans, making it clear that they may not set ceilings for inpatient hospital treatment or requirements for outpatient treatment. Similarly, we recently reinforced this message in Medicare's fee-for-service sector.

- **Physician Incentive Plans**: Effective January 1, 1997, the Physician Incentive Plan Final Rule required managed care plans with Medicare or Medicaid contracts to disclose information about their physician incentive plans to HCFA or the State Medicaid agencies, before a new or renewed contract receives final approval. Plans whose compensation arrangements place physicians or physician groups at substantial financial risk must provide adequate stop-loss protection and conduct beneficiary surveys.

- **Prudent Layperson**: The Administration's plan clarifies the obligation of Medicare managed care plans to pay for emergency services rendered to their enrollees. By using HCFA's definition of "emergency services" as those services that a "prudent layperson" would reasonably believe to be needed immediately to prevent serious harm to the patient, States will be better able to determine similar requirements for commercial managed care enrollees.

- **National Marketing Guidelines**: To ensure uniform interpretation and provide beneficiaries with accurate and clear information about managed care plans, we have developed the Medicare Managed Care National Marketing Guidelines. These Guidelines, which will be released next month, were developed in cooperation with the American Association of Health Plans and representatives of the health care industry.

- **Beneficiary Information Publications**: HCFA and its Department of Health and Human Services (DHHS) partner agencies have developed several publications to inform Medicare beneficiaries of their rights and options. These beneficiary advisory publications answer frequently-asked questions about HMO enrollment and disenrollment, potential fraud and abuse, and the appeals process. Also, the latest edition of the Medicare Handbook was sent to all 37 million Medicare beneficiaries and it is our goal that all beneficiaries receive an updated handbook every year.

- **Comparative Information**: We want to provide all Medicare beneficiaries comparative information that would assist them in making choices. In the President's FY 98 Budget Plan, we propose that comprehensive comparative information on all plan options, including Medigap, be provided to Medicare beneficiaries and be funded by the plans. In the interim, we are working on making comparative information available on the Internet and to beneficiary insurance counseling centers. Phase I of this project will be available by June 1997, and will provide comparative market data about HMO benefits, premiums, and cost-sharing requirements. Currently, many of HCFA's regional offices sponsor and disseminate comparative information for local beneficiaries.

  HCFA is currently working to implement a Competitive Pricing Demonstration in Denver to test a range of new education and information resources for beneficiaries — including new formats of printed materials, in-person seminars, and a 1-800 call center, all coordinated by a HCFA-sponsored third party. The goal of these resources is to help beneficiaries understand their options under Medicare and help them make the best choices — whether it is fee-for-service, Medigap, or managed care.

- **Community-based Medicare Information Resource**: This past October marked the opening of a pilot project to provide beneficiaries with the latest Medicare information in a convenient, one-stop, personal service facility. The test site for "Your Medicare Center" is a Philadelphia shopping mall and is staffed by HCFA employees who explain managed care options, resolve concerns, and correct records. This innovative project will allow the public's concerns about entitlement, managed care choices and enrollment, Medigap insurance, coverage, premiums, and appeals to be answered promptly and efficiently. Additional services including educational seminars on managed care-related issues and health screening will also available, using technology such as interactive video-conferencing and computerized information kiosks.

IMPROVED MONITORING AND ENFORCEMENT

All of the beneficiary protections that I have just outlined are only words on paper unless there is an explicit commitment to enforcement. I am proud to say that this Administration has fostered significant improvements in oversight and monitoring of managed care plans. We have initiated a program of special investigations that may target a specific compliance problem, or review all plans in a heavily saturated market area. Protocol-monitoring processes have been revised to improve clarity and establish more consistency in the methods used to evaluate contractor operations. National guidelines for marketing materials have been developed to improve our monitoring of plan compliance with statutory and regulatory requirements.

For the first time in the history of the program, we have begun to impose intermediate sanctions in response to certain plan activities. If we find the same compliance problem in successive monitoring reviews, we are no longer treating the recurrence as an isolated event, but instead are taking enforcement actions. Under these sanctions, we can require a contracting organization to suspend marketing activities or enrollment of new members; in some circumstances we will suspend payments to the plan for new enrollees.

Finally, in regard to monitoring and enforcement, we also have several activities in the planning stages. First, we are evaluating our process for reviewing and approving applications for managed care contracts in order to identify potential problems with a plan's ability to meet contracting requirements before we approve the contracts. Second, we are redesigning our data system to facilitate cross-plan comparison of enrollments, disenrollments, appeals processing, complaints, quality and fiscal soundness in order to identify aberrant patterns that warrant investigation. Lastly, we have begun discussions with State insurance commissioners regarding actions that could be taken to coordinate activities. These include eliminating some duplicative oversight functions, and maximizing the sharing of information, especially with regard to plans experiencing financial difficulties. The importance of consistent and conscientious quality monitoring cannot be overemphasized, and now I would like to describe the progress that we have made in developing quality measurements and in fostering quality improvement.

QUALITY INITIATIVES

The argument for the potential of managed care to improve quality is well known. It starts with a critique of fee-for-service. Fee-for-service care tends to be fragmented with a focus on acute rather than preventive services. Economic incentives are in the direction of over-utilization of health care services. As a result, under fee-for-service, there tends to be an inappropriate and costly allocation of existing health care resources. It is then argued that the capitated prepayment made to managed care allows plans to organize care and re-allocate resources to address, in a coordinated and systematic way, the needs of each patient. In managed care, unlike fee-for-service, the organization is accountable for improving the well-being of the patient. This provides an opportunity, more

elusive in fee-for-service, to improve the quality of care being furnished.

The flip side to the argument is also well known. In managed care, there is the potential for "under-service" and poor quality, if plans try to maximize short-term profits by not delivering appropriate care. The goals of our quality initiatives are to develop mechanisms to measure quality and to hold plans accountable for quality improvement. We have two approaches toward achieving these goals. The first approach is to use utilization data or encounter data to address "inputs" into the delivery of care. Most current performance measures are "process measures." Process measures refer to clinical interventions (tests, medications, procedures, surgery) which are believed to lead to favorable patient outcomes. While this approach has limitations, encounter data and process measures provide significant insight into the quality of care.

The second, and potentially the most efficient strategy for clinical performance measures, is to move toward outcome measures. The problem is that the science of outcomes measures is in its infancy. The movement towards better outcomes measures is critical for HCFA, like-minded purchasers, and beneficiaries in order to hold plans and providers accountable for the care they deliver. HCFA and the Agency for Health Care Policy Research (AHCPR) have been active in promoting research to identify these measures. With such measurements in hand, HCFA and the public will be able to objectively compare managed care to itself and to fee-for-service, and to determine whether managed care is living up to its potential to improve the quality of care. However, more research is needed, especially with regard to the health care needs of the poor, elderly, and other vulnerable populations, and with how to present this information effectively to beneficiaries.

As I indicated earlier in my testimony, a major focus of our efforts in recent years has been in working with our partners in the managed care industry and with other payers to accelerate and standardize the development of outcomes measures.

- **HEDIS 3.0**: The latest iteration of the Health Plan Employer Data and Information Set, HEDIS 3.0, reflects a joint effort of public and private purchasers, consumers, labor unions, health plans, and measurement experts, to develop a comprehensive set of measures for Medicare, Medicaid, and commercial populations enrolled in managed care plans. As of January 1, 1997, HCFA is requiring Medicare managed care plans to use HEDIS. This will facilitate comparison of plan performance measures and permit HCFA to hold plans accountable for the quality of the care they provide. HEDIS measures eight components including: effectiveness of care; access/availability of care; satisfaction with the experience of care; health plan stability; use of services; cost of care; informed health care choices; and health plan descriptive information.

  HCFA, working with the HEDIS Committee on Performance Management, was instrumental in adding functional status for enrollees over age 65 as a measure in the "effectiveness of care" category in HEDIS 3.0. This will be the first outcome measure in HEDIS that will longitudinally track and measure functional status. It addresses both physical and mental status through a self-administered instrument which determines whether the beneficiary

perceives that his or her health status has improved, stayed the same, or deteriorated. In addition, six other measures that impact on Medicare beneficiaries have been added to the "effectiveness of care" category, including: mammography rates, rate of influenza vaccination, use of retinal examinations for diabetics, outpatient follow-up after acute psychiatric hospitalization, and utilization of beta blocker in heart attack patients.

- **Foundation for Accountability**: The Foundation for Accountability (FAcct) is a new non-profit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care. As Federal Liaisons to the FAcct Board of Trustees, HCFA is joined by other public and private sector partners, including the American Association for Retired Persons, the Department of Defense, the Office of Personnel Management, Ameritech, and American Express. The underlying premise of FAcct is that better health care information, assembled from the consumers' point of view, should help steer Americans toward the highest quality care. Specifically, FAcct endorses and promotes a common set of patient-oriented measures of health care quality. Together, HCFA and AHCPR have played major roles in the development of FAcct quality measures for depression, breast cancer and diabetes. HCFA and the ASPE also recently contracted with the RAND Corporation, a non-profit research organization, to refine and test three sets of outcome measures for implementation in 1998.

- **Medicare Beneficiary Survey**: In cooperation with HCFA, AHCPR initiated the Consumer Assessment of Health Plans Study (CAHPS) to design a Medicare beneficiary survey. This survey quantifies Medicare enrollee responses about satisfaction with plan providers, access to services and providers, availability of services, and quality of care. Beginning January 1 of this year, HCFA is requiring all health plans to use CAHPS, which is now available to the public. HCFA plans to administer the survey through an objective single third party vendor in order to ensure comparability.

In addition to our quality measurement initiatives, we are actively involved in promoting quality improvement.

- **Projects to Assess Ambulatory Care in Managed Care Settings**: The Medicare Managed Care Quality Improvement Project (MMCQIP) is designed to enhance HCFA's ability to assess how well the ambulatory care process in managed care is meeting the needs of beneficiaries. At this time, we are evaluating the care received by Medicare managed care plan enrollees diagnosed with diabetes mellitus, and the incidence of screening mammography in a sample of enrolled beneficiaries. The PROs in five states (California, Florida, New York, Pennsylvania and Minnesota) and 23 Medicare-contracting HMOs are collaborating on MMCQIP. In addition, an on-going sister project, utilizing the PROs in Maryland, Iowa and Alabama, will analyze the same measures in the fee-for-service setting. The initial finding is that there is room for improvement in both managed care and fee-for-service in these two areas.

- **Medicare Choices Demonstration** - An important component of this demonstration is improvement in our comprehensive quality monitoring system. Under the Choices project, we will be developing and testing quality/outcomes and risk adjustment measurements systems that use encounter data (health care services received by enrollees); all participating plans will be required to provide 100% encounter data. We have contracted with the RAND Corporation to assist us in designing such a system, which will be refined further using the "Choices" data.

Other important Medicare managed care quality initiatives include the establishment of new requirements for Medicare managed care plans in the areas of quality improvement activity; health information systems; health services management; and member rights and responsibilities. In addition, as part of a project to improve efficiency in monitoring and oversight, teams of HCFA and PRO staff are being formed to target a review of managed care plans' internal quality assessment and improvement programs. We have similar quality improvement initiatives for Medicare fee-for-service plans. Our budget also includes a provision to give us the authority to develop an integrated quality management system, so that we can assess more comprehensively the quality of care provided under fee-for-service.

THE PRESIDENT'S 1998 PROPOSALS

The President's 1998 Budget Plan includes several proposals affecting areas I have already discussed. We believe these changes are important to achieve our stated goals of preserving the solvency of Medicare and enhancing beneficiary protections and choices. Our specific proposals to expand and enhance beneficiaries' choices include:

EXPANDING BENEFICIARY CHOICES

- **Expanded PPO/PSO Options** -- Currently, HCFA can contract with Federally qualified Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to serve as Medicare managed care plans. The Administration believes that Medicare beneficiaries should have more managed care choices, comparable to those available in the private sector. Thus, the President's budget would expand managed care options to include Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs). We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care to rural areas.

- **Comparative Information** -- Everyone agrees that "knowledge is power," and we seek to empower beneficiaries by ensuring wider and more consistent dissemination of health plan information in a format that is easier to understand. The President's budget proposes that beneficiaries receive comparative materials on all of their coverage options -- both managed care and Medigap. To help beneficiaries compare various plans, standardized packages for additional benefits offered by managed care plans would be developed. Adjustments would

then be made to the current standard Medigap packages to make comparison easier for beneficiaries. As described below, Medigap plans would be required to operate under the same rules followed by Medicare managed care plans.

- **Annual Open Enrollment** -- The President's budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans will have to be open for a one month coordinated open enrollment period. Additional open enrollment opportunities will be available under certain circumstances -- such as, when a beneficiary's primary care physician leaves a plan or when a beneficiary moves into a new area. Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare because of a disability or end-stage renal disease beneficiaries have no such choice. If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual's poor health status. As a result, some beneficiaries are reluctant to try managed care or are fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap.

- **Elimination of Pre-existing Condition Exclusions** -- In addition to addressing open enrollment, there are other Medigap reforms included in the President's budget. We would like to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President s budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bi-partisan bill introduced by Senator Chafee and Senator Rockefeller and others and we look forward to working together toward enactment this year.

- **Community Rating for Medigap Plans** -- Our final Medigap reform addresses rating. There are currently no federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice younger beneficiaries to enroll, but as the enrollee ages premiums become unaffordable. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Also, if choice is an important goal, then premium structures such as attained age rating, which in effect make Medigap unaffordable as beneficiaries age, should not be allowed.

QUALITY INITIATIVES

- **Quality Measurement System**: The President's plan would authorize the Secretary to

develop a system for quality measurement which would replace the current requirement that managed care plans maintain a "level of commercial enrollment at least equal to public program enrollment," which is often referred to as the "50/50 rule." In the interim, the Secretary could waive the 50/50 rule for plans in rural areas and for plans with good "track records"or in other instances the Secretary deems appropriate.

PAYMENT REFORMS

Through a series of policy changes, the Administration's plan would address the flaws in Medicare's current payment methodology for managed care. Specifically, the reforms would create a minimum payment to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the minimum payment (generally $350 per member per month), would dramatically reduce geographical variations in current payment rates. **(CHART 1)**

The President's plan would reduce reimbursement to managed care plans by approximately $34 billion over 5 years. An assessment of the impact of the President's Medicare managed care proposals should consider the plan as a whole -- both the merits of the components that have a budget impact as well as other non-budget components, some of which were discussed above. It should also be kept in mind that Medicare per capita costs, upon which managed care payments are based, have grown over the past two years by approximately 16 percent, while growth in payments to plans on the commercial side have been virtually flat.

Proposals With A Budget Impact

- **IME/GME/DSH CARVE-OUT** (Five-year saving ---$10 billion): Payments for indirect medical education (IME), graduate medical education (GME), and disproportionate share payments (DSH) would be carved out of the blended payment rates over a two-year period (50 percent in 1998; 100 percent thereafter) and provided directly to teaching and disproportionate share hospitals for managed care enrollees and to entities with recognized teaching programs. The carve-out of these payments does not represent a reduction in payment for managed care enrollees because these funds would be provided to teaching and disproportionate hospitals directly by HCFA for such enrollees.

  - Managed care plans can consider these funds available to such hospitals when they negotiate their rates.

  - A current law provision that requires non-contracting hospitals to accept the Medicare diagnosis-related groups (DRGs) amount as payment in full would be modified to require non-contracting hospitals to accept the DRG amount, minus the carve-out, as payment in full.

- **INDIRECT IMPACT OF FEE-FOR-SERVICE PROPOSALS** (Five-year saving ---$18 billion). The budget proposes an update mechanism tied to overall Medicare growth. Therefore, policies that would affect fee-for-service providers would also restrain the growth of managed care payments.

- **FAVORABLE SELECTION ADJUSTMENT** (Five-year savings --- $6 billion): Beginning in 2000, an adjustment would be made to payment rates to reduce Medicare's current overpayment, which results from managed care enrollees being, on average, healthier than beneficiaries who remain in fee-for-service. Research studies support basing payments on 90 percent of the AAPCC rather than 95 percent, to take into account this phenomenon referred to as "favorable selection." This adjustment would remain in place until a new health status adjusted payment methodology is implemented.

  - Some have argued that the extent of favorable selection documented by Mathematica Policy Research (MPR) in 1993 no longer exists. This perspective, however, is not supported by a recent HCFA study (HCFA Review, Summer 1996), which would justify payment at 87.6 percent of the AAPCC, or about 83 percent if we continue to pay managed care plans five percentage points less than fee-for-service.

  - In the last three years, the Medicare program has lost, at a minimum, $2.2 billion because of favorable selection into managed care plans, and over $1 billion in the last year alone.

  - HCFA is developing a new payment methodology that incorporates health status adjusters and that moves away from the current policy of ignoring differences in utilization between managed care and fee-for-service in making payment to managed care plans. A proposal could be ready for Congressional action as early as 1999, with phase-in beginning as early as 2001. Payment at the 90 percent level would be consistent with payment levels anticipated under this new payment methodology.

  - Competitive Pricing Demonstration - This demonstration will test a new market-based payment methodology as a possible alternative to the AAPCC method, in addition to offering new education and information resources to local beneficiaries. The Denver site will start in 1997, to be followed by two additional sites.

Proposals Without A Budget Impact

- **BLENDED RATE METHODOLOGY** - The budget would dramatically reduce the current wide geographic variation in payment rates to managed care plans by breaking the link between plan payments and local fee-for-service experience. The blended payment rates, minimum payment and minimum increase would be implemented on a budget-neutral basis.

  - **Impact on Relatively Low Payment Areas** - Managed care plans, now in relatively

low payment counties, would benefit from the proposed blended payment rate. By 2002, 30 percent of their payment rate would be based on a higher national rate. In each year between 1998 and 2002, many of these plans would receive a "double update," with rates increasing due to both the national update and the transition to the 70/30 blend.

- **Impact of Minimum Payment Amounts** - The President's plan would create, for the first time, a minimum payment amount which would significantly increase rates in isolated rural counties and could increase the number of managed care plans serving rural and other low payment areas, especially with the entry of Provider Sponsored Organizations (PSOs) into the Medicare program.

We have a few illustrations of the effects of our managed care payment reforms on rates in counties with various characteristics. As you can see, the impact on a particular county depends both on current teaching costs and on whether the county is currently receiving a relatively low or high payment. **(CHART 2)** The methodology would ensure that no county would receive a decrease during the 5 year budget window except in the year 2000. In 2000, almost two-thirds of counties (64%) would receive increases; the other counties would receive either no increase or a decrease no greater than 3.37%.

The net effect of the President's payment proposals is a balanced approach that achieves savings and significantly reduces current wide geographic variation, while continuing the trend of increased enrollment in managed care. Our actuaries project that the combined effect of the managed care reforms, both the proposals with a budget impact and those without budget impact described earlier, would result in increases in managed care enrollment compared with present law. By fiscal year 2002, under the President's plan, 22.5 % of Medicare beneficiaries would be enrolled in managed care plans, compared to 19.3% under current law. **(CHART 3)**

CONCLUSION

We are aware that there is still much work to do in the area of quality improvement of managed care. As the managed care market further expands and evolves, we expect to reap the benefits of innovative payment, administrative and patient care strategies. Some of these have already been applied to our Medicare modernization efforts and will contribute to Medicare savings. We would like to expand the choices available to beneficiaries; enhance consumer protections; provide comparative information to assist beneficiaries in making health care choices; and reform the payment methodology to plans. These goals are shared by all with a commitment to consumer protection and there is certainly a consensus that quality and availability of health care is our number one priority. In cooperation with Congress, the health care industry, and the research community, we will reach our goals — to extend the solvency of Medicare, and guarantee its existence for future generations of Americans. I look forward to working with you to accomplish these goals.

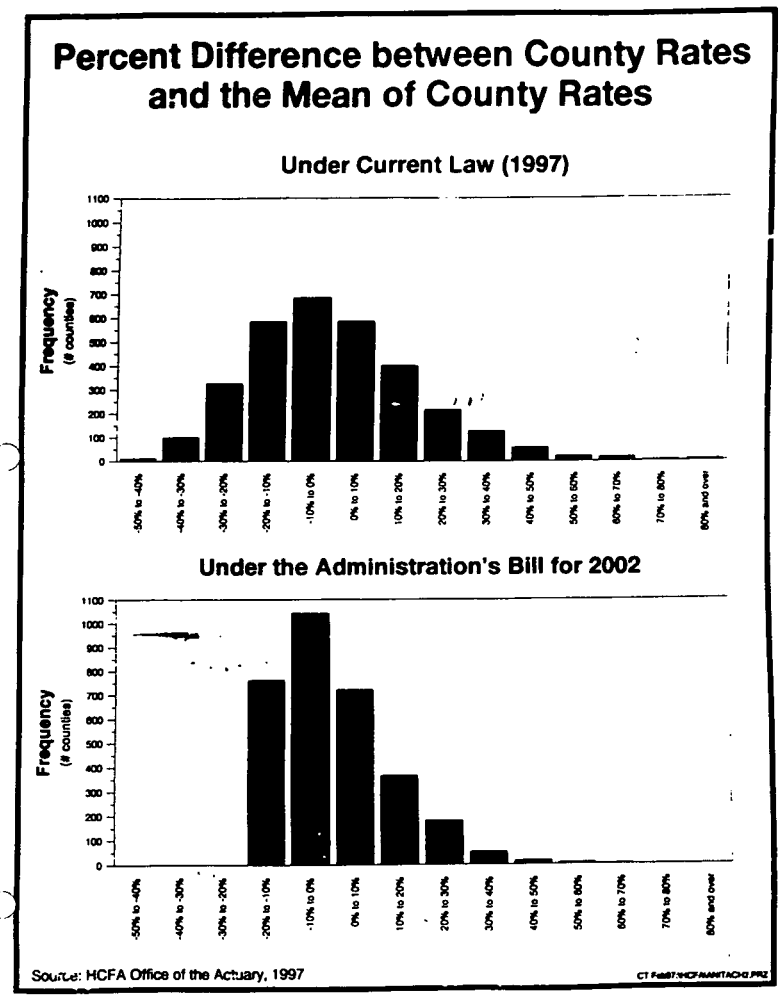

Percent Difference between County Rates and the Mean of County Rates
Under Current Law (1997)
Frequency (# counties)
1100
1000
900
800
700
600
500
400
300
200
100
0
-50% to -40%
-40% to -30%
-30% to -20%
-20% to -10%
-10% to 0%
0% to 10%
10% to 20%
20% to 30%
30% to 40%
40% to 50%
50% to 60%
60% to 70%
70% to 80%
80% and over
Under the Administration's Bill for 2002
Frequency (# counties)
1100
1000
900
800
700
600
500
400
300
200
100
0
-50% to -40%
-40% to -30%
-30% to -20%
-20% to -10%
-10% to 0%
0% to 10%
10% to 20%
20% to 30%
30% to 40%
40% to 50%
50% to 60%
60% to 70%
70% to 80%
80% and over
Source: HCFA Office of the Actuary, 1997

Chart 1

Managed Care Payment Rates Under the President's Proposal

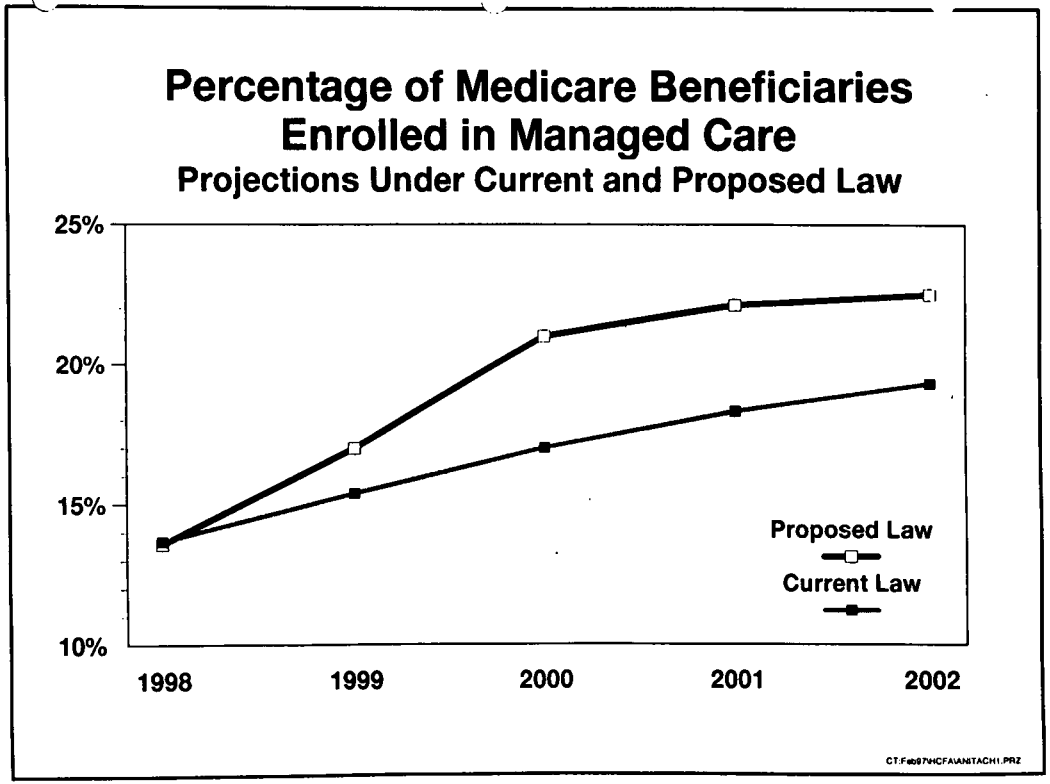
Examples

YEAR (BLEND)	Adams, NE (MedEd/DSH: 1.1%) Medicare pop: 5K		Clackamas, OR (MedEd/DSH: 5.8%) Medicare pop: 33K		Lorain, OH (MedEd/DSH: 3.2%) Medicare pop: 32K		Hillsborough, FL (MedEd/DSH: 5.8%) Medicare pop: 86K		Orange, CA (MedEd/DSH: 6.0%) Medicare pop: 242K		Bronx, NY (MedEd/DSH: 25.6%) Medicare pop: 123K	
	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change
1997	$260.46	n/a	$375.32	n/a	$485.65	n/a	$488.70	n/a	$572.69	n/a	$728.24	n/a
1998 (90/10)	$350.00	+34.4%	$387.37	+3.2%	$489.11	+0.7%	$490.42	+0.4%	$572.98	+0.1%	$728.24	0.0%
1999 (85/15)	$367.55	+5.0%	$398.61	+2.9%	$499.50	+2.1%	$496.40	+1.2%	$578.54	+1.0%	$728.24	0.0%
2000 (80/20) Favorable selection adjustment	$365.42	–0.6%	$409.93	+2.8%	$504.19	+0.9%	$501.40	+1.0%	$584.18	+1.0%	$703.71	–3.4%
2001 (75/25)	$388.70	+6.4%	$445.38	+8.7%	$537.79	+6.7%	$534.95	+6.7%	$623.14	+6.7%	$717.78	+2.0%
2002 (70/30)	$414.66	+6.7%	$483.78	+8.6%	$573.67	+6.7%	$571.22	+6.8%	$665.03	+6.7%	$732.14	+2.0%
Percent change 1997–2002	+59.2%		+28.9%		+18.1%		+17.4%		+16.1%		+0.5%	

NOTE: These rates are estimates, based on estimates of components of the rate setting methodology, such as the Medicare per capita growth rate. No county would receive a decrease in rates during the five-year budget window, except in the year 2000. In 2000, almost two-thirds of counties (64 percent) would receive increases; the other counties would receive either no increase or a decrease no greater than 3.37 percent.

Source: HCFA Office of the Actuary, 1997

Chart 3


Percentage of Medicare Beneficiaries Enrolled in Managed Care
Projections Under Current and Proposed Law
25%
20%
15%
10%
1998
1999
2000
2001
2002
Proposed Law
Current Law
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The CHAIRMAN. I believe this issue of consumer information is so important that I plan to introduce legislation this month to address this and several other important beneficiary protections in managed care Medicare. As we will learn shortly from our witnesses, the information Medicare recipients need is already being collected by Medicare, but it is not reaching the beneficiary. This is a problem we should be able to address right away in a common sense manner. Medicare reform will probably not occur with one, broad comprehensive legislative initiative. We tried that last Congress and failed. Instead, reform will happen through incremental steps.

Improving what and how information in Medicare is provided has bipartisan support. We should act quickly in the areas of consensus to help our older Americans. Medicare beneficiaries cannot afford for us to put these decisions off until some time way into the future. So, I look forward to this testimony. I now turn to Senator Breaux.

[The prepared statement of Chairman Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

As chairman of the Senate Special Committee on Aging, I would like to welcome my colleagues and the witnesses here today to this morning's hearing. The focus of the hearing will be on how Congress and the Administration can provide better information to Medicare beneficiaries when they are trying to select the right health plan to meet their health care needs. As you can see from the display the General Accounting Office (GAO) brought with them, the problem is great. What you are looking at is a wall of brochures from all the Medicare-approved HMO's in the Los Angeles area. This is what Medicare beneficiaries have to contend with when trying to choose a plan. They have to contact each health plan to get a copy of their brochure and then try to decipher the differences between the plans without the benefit of standardized terms or formats in these marketing materials. Most of you in this room are probably very knowledgeable about Medicare. I would like to challenge anyone here to try to choose the best health plan for yourself by going through all the brochures you see displayed.

The choice of health plans in Medicare is increasing at a rapid rate. As we look to ways to provide more options for Medicare beneficiaries, we need to make sure the right information is available so they can make informed decisions.

By the end of 1996, approximately 13 percent of the Medicare population, or 4.9 million beneficiaries were enrolled in managed care plans, compared with only 5 percent in 1990. The Congressional Budget Office predicts that this figure will approach 25 percent of the total Medicare population by the year 2002. As more beneficiaries decide to enroll in Medicare managed care, there is increasing concern among seniors and their advocates that they are not being informed about their health care coverage. Current law requires that Medicare beneficiaries are provided with certain information, but according to testimony we will hear this morning it is not adequate and it is not provided in a useful format.

At a recent hearing before the House Ways and Means Health Subcommittee, Stan Jones, chairman of the Institute of Medicine, testified that the information provided to Medicare beneficiaries about the differences in health plans "appears primitive" compared with what is available to private purchasers. He said, "many elderly are making these new choices (about managed care) without enough information to judge which option is best for them, what the plan they choose will actually cover, or how the plan will operate."

This morning, we will hear a real life example of someone who recently became eligible for Medicare and is trying to decide what plan to select, but can't seem to get the information he needs. We will hear from experts in the field and from the General Accounting Office about ways we can improve what and how information is being provided by Medicare. I would just like to note that we invited the Health Care Financing Administration (HCFA) to testify about HCFA's plans regarding information provided on health plans to Medicare beneficiaries, but they declined to appear. Let the record show that HCFA decided not to testify before this committee because they did not like the order of the witnesses that I, as the chairman of this committee, requested.

I believe this issue of consumer information is so important, I plan to introduce legislation this month to address this and several other important beneficiary protections in Medicare managed care. As we will learn shortly from our witnesses, the information Medicare recipients' need is already being collected by Medicare, but it is not reaching the beneficiary. This is a problem we should be able to address right away in a common sense manner.

Medicare reform will probably not occur with one broad, comprehensive legislative initiative. We tried that last Congress, and it failed. Instead, reform will happen through incremental steps to make the program work better for seniors. Improving what and how information in Medicare is provided has bipartisan support. We should act quickly in areas of consensus to help other Americans. Medicare beneficiaries can't afford for us to put these decisions off until tomorrow.

I look forward to hearing testimony from all the witnesses this morning. I hope we all leave this hearing better informed.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Well, thank you very much, Mr. Chairman. I would like to thank the witnesses who we are going to hear from for being with us and our colleagues for being here as well. This is an important hearing, because it allows us to focus on the major problems with the Medicare system it is a 1965 system that has not truly been updated to 1997 demands. Specifically, one of the principal things I think we are going to see today is the lack of adequate information available to Medicare beneficiaries.

The HMO's and managed care programs are really growing. In my State, there is almost 50 percent growth of HMO's annually, which is very, very high. Yet as people look for other alternatives, the problem is a lack of adequate information. I mean, people have more information about buying a used car than they have about buying health care plans in this country, and that is truly unfortunate. That chart up there looks like the Great Wall of China, and it might as well be written in Chinese as far as most people are concerned, because it is not something that anyone on Medicare would probably ever have the time to read or understand. I know most of us in Congress, who write the laws would not enjoy having to go through that massive amount of information that looks like Egyptian hieroglyphics. To enable people to make reasonable choices, we need to simplify what is out there and what is available.

This has not been an easy struggle. In HCFA's defense, I noted today in a Medicine and Health article, that the American Association of Health Plans is hinting at the possibility of going to court to stop HCFA's planned Medicare HMO competitive bidding demonstration in Denver. So, when they attempt to promote competitive bidding, some of the managed care plans are suing them in hopes of getting them out of their business. Fundamentally, I think ultimately, we are heading toward real reform in this system. The budget plan which we have before the Congress, Mr. Chairman, is really tinkering around the edges. It is the same old way of fixing Medicare by reducing the amount of payments to providers, hospitals, and doctors. That is not reform. That is just reducing the amount of people we pay. Pretty soon, hospitals and doctors are not going to want to take Medicare patients, because we just continue to reduce the amount of reimbursements they get and call that reform.

What we ought to do, and what I am working on, is to try to make the Federal Employees Health Benefit Plan part of Medicare, which would clearly lay out the choices for Medicare patients enabling them to compare price, quality, and substance of competing plans and then assess which is the best plan for them. There is no competition out there right now because of the current rules and regulations. Fundamental reform is necessary. I have always said that if it is good enough for Members of Congress, you can bet it is probably good for a lot of other Americans, and I think we should be moving in that direction.

Thank you for these hearings and thank the witnesses for being with us.

[The prepared statement of Senator Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN B. BREAUX

Thank you, Mr. Chairman.

The issue before us this morning is that many Medicare beneficiaries simply don't know how managed care is different from "standard" fee-for-service Medicare or what the differences between the Medicare Health Maintenance Organizations (HMO's) in their local areas are. In addition, it is generally agreed that in order for HMO's to serve their enrollees well, they must compete on more than just price as they do now. Providing Medicare beneficiaries with more and better information than they now have will help with that goal.

While the vast majority of Medicare beneficiaries—87 percent nationally—remain enrolled in traditional fee-for-service Medicare, this is changing rapidly. The number of beneficiaries nationwide who enroll in HMO's is growing by about 30 percent annually. In Louisiana, the growth rate exceeds 50 percent. The number of health plans with Medicare contracts is also increasing rapidly. In 1993, there were 110 such plans. By the end of last year, the number had more than doubled to 241.

This morning, we will focus specifically on Medicare's role as the supplier of HMO information and ways it should be improved. We will also look at how other large purchasers educate their beneficiaries about managed care options, and the General Accounting Office (GAO) will offer some specific ways beneficiaries can be supplied with better information.

In addition to the GAO, there are other groups which have studied the whole issue of how Medicare beneficiaries receive information on the health plans available to them and the quality of that information. The Prospective Payment Assessment Commission, for example, stated its most recent report that "cost and benefit definitions should be standardized so that beneficiaries can better compare plans."

The Institute of Medicine last year reported that "current information available to Medicare beneficiaries lags far behind the kinds of assistance provided by progressive private employers to their employees."

Mr. Chairman, while we are focused this morning on a very specific consumer issue, I want to strongly reiterate the strong need for comprehensive, bipartisan Medicare reform. It is important that we not lose sight of that goal. I am strongly supportive of using the Federal Employee Health Benefits Program (FEHBP) as a model for broad Medicare reform. As I stated at our Finance Committee hearing on March 19, "nip-and-tuck" methods of Medicare reform only postpone the real reforms that are necessary to save the program from bankruptcy. I called for a fundamental shift by possibly infusing a significant portion of the FEHBP into Medicare. While such a shift is not really our focus this morning, I think FEHBP's plan-selection process, combined with better beneficiary information, could provide Medicare beneficiaries with the tools they need to make informed choices based on cost and quality of care.

One logical answer to certain structural questions posed by Medicare reform appears to lie in providing more and better information so that beneficiaries can make informed choices. It's really a fairly simple concept, but one that government often loses sight of: people make wiser and less costly decisions for themselves and their families if they have the right kind and right amount of information.

I am particularly pleased with the impressive group of witnesses and experts we have with us here today. I trust they will shed some valuable light on how we are doing with regard to providing Medicare recipients the information they need to make informed choices; how we can improve on our efforts; and how we can provide the best quality information possible.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Burns, then Senator Wyden, and then Senator Reed.

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you very much, Mr. Chairman, and thank you for holding these hearings, and I think you have struck upon a real problem we have. I am disappointed that HCFA is not here today either, and I understand it was probably the order in which the witnesses will appear today, and I think that is a little bit of arrogance on their part, and they should be here, and I would just like to parrot what Mr. Breaux has said this morning as far as the information is concerned.

I think with HCFA not being here, it really lends to the argument that I have never seen a compassionate bureaucracy yet, and in this town of 13 square miles, a logic-free environment, they cannot come and listen to the real world. I find that very, very disappointing. I think that HCFA should be supplying information to consumers. All of the information is out there. They should lay it out there in simple language that everybody can understand and compare it side-by-side. We have the same opportunity to pick our plans here in the Congress. It is a very simple deal. This one costs so much; here are the benefits, and this one over here cost so much; here are the benefits. We see that every day. So, I am sorry they are not here.

We have also got to look at the reimbursement. Those reimbursements in Montana are not the same as the reimbursements in New York City or the State of New York. We pay the same; why are our reimbursements not the same? So, I think there has to be a little equity here. Of course, there is legislation that has been introduced to address that particular problem.

So, I appreciate these hearings. I would like to just ask unanimous consent that my complete statement be made part of the record. But, there again, I am sorry HCFA is not here. It lends to the old argument: they love mankind, but they do not love people. I do not understand that kind of thinking, and that is who we have to deal with is real people in real life settings.

I want to thank the witnesses for coming. I am not going to get to stay very long, either. I have only four hearings this morning. I do not know who schedules these things but——

The CHAIRMAN. I started this early so you could get to this one.

Senator BURNS. I know you did, and I appreciate that, and I want to thank you.

[The prepared statement of Senator Burns follows:]

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Thank you, Chairman Grassley, for holding this important hearing this morning and thanks to our witnesses for coming in to share your insights. It's unfortunate that no one from HCFA could be here.

Hardly a day goes by when we don't see a story in the newspaper or on TV about the changing health care market and consumer apprehensions about choice and quality of care. Employers are moving away from traditional indemnity plans toward managed care in vast numbers, and enrollment in Medicare HMO's is increasingly rapidly. Given the choice of health plans, many consumers choose the added benefits and lower costs of managed care. It seems to me that most of the fears consumers have are due to a lack of information on health plans. When that informa-

tion is available, consumers can make an educated decision and avoid being surprised by any provisions in the plan they choose.

Unfortunately, seniors do not have easy access to consumer information. As the General Accounting Office (GAO) has reported, Medicare does not provide comparative information on HMO's to seniors. But this is not because Medicare doesn't have the information—in fact, it collects a large amount of data on the HMO's with which it contracts. As our witnesses will discuss in greater detail, seniors should have this information and Medicare should be providing it. I am pleased that Medicare is working to put some consumer information on the Internet; however, they need to cast a much wider net to ensure that the information gets out.

For as vital as consumer information is, Montana and some other rural States face a more basic problem: we have no Medicare HMO's. This is largely because the payment rate, or adjusted average per capita cost, is too small in low utilization areas such as Montana to attract HMO's to sign up with Medicare. As a result, seniors in rural areas, who have paid the same Medicare tax as their urban counterparts, do not have the same choice of health plans. I joined Senator Thomas and Chairman Grassley in introducing the Medicare Payment Equity Act of 1997, which will narrow the wide gap between rural and urban payments levels. So when we talk about Medicare information for seniors, let's not forget that seniors in rural areas do not have the same choices.

Thank you.

The CHAIRMAN. Senator Wyden.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman. I want to congratulate you, Mr. Chairman, and our ranking member, Mr. Breaux for your work. It was a pleasure to join both of you in our effort to get the GAO report last year, and I would like to make a couple of remarks.

Mr. Chairman, I share your view that it is not going to be possible in this session of the Congress to solve every Medicare problem. But I will tell you that I do think it is possible to lay the foundation in this session for comprehensive, bipartisan Medicare reform. I also think it is possible to get beyond some of the acrimony and bitterness that has accompanied this debate in the past.

The fact of the matter is that this program, which is a lifeline for millions of Americans in much of the United States, is a bureaucratic tin lizzy. It is essentially light-years behind what the private sector is doing, and the reason that this hearing is so important is that the Federal Government needs to set out a new set of policies that empower Medicare patients to have exactly the same rights that other consumers who are working with large purchasers have in the private sector. That is what this is about. If you are a consumer working with a large purchaser, you have, as Senator Breaux mentioned, the ability to compare essentially all of the key policies in a comprehensible, understandable kind of fashion.

So, in my view, this is one of the three key elements for a bipartisan Medicare reform proposal. I introduced S. 386 earlier this year, the Medicare Modernization and Patient Protection Act. It includes these proposals. I am very pleased that my friend Diane Archer is here. She has done yeoman work for years in this regard, and we have essentially put in S. 386 all of the suggestions she makes with respect to comparisons, appeal rights, grievance procedures, among other things.

Two other points that I would mention very quickly, Mr. Chairman, because you and I share many rural areas, as Senator Burns does as well. We now have a situation with Medicare where you ei-

ther have few choices, which is true in lots of rural Oregon, and rural Iowa, and rural Montana, or, as you have correctly pointed out, you have a blizzard of choices that nobody can navigate their way through.

So, in the name of bipartisan reform, I would hope that we would correct this sleep-inducing concept known as the average adjusted per capita cost. Correcting this concept will mean that in rural Iowa, and rural Oregon, and rural Montana, we will have more choices, and we will allow people to start comparing policies.

Finally, what Senator Breaux said about the Federal employee plan is absolutely right. In our bill, S. 386, we basically say why not do something that we know works in terms of competition and competition that allows people to compare their policies. To this end, we look at the Federal employee plan as a model. So, I share your view, Mr. Chairman, that it is overdue for the Federal Government to address this issue. I hope, with the bipartisan good will that you are generating in this committee that empowering the consumer can be one of the three pieces of Medicare reform in this way: that the use of the Federal employee health plan and having defined, secure benefits for seniors, that there could be a bipartisan Medicare reform enacted this year. In closing, as always, I look forward to working with you.

[The prepared statement of Senator Wyden follows:]

PREPARED STATEMENT OF SENATOR RON WYDEN

Mr. Chairman, I'd like to congratulate you and our Ranking Minority Member, Mr. Breaux, for holding this hearing on a most important issue.

Indeed, it is my opinion that improving the quality, reliability and utility of information on health plans received by Medicare beneficiaries is absolutely central in the reform of the Medicare program. So it is very important, I think, that the Aging Committee takes up this question, today.

To guarantee Medicare for the children and grandchildren of today's seniors, Congress needs the fortitude and the foresight to modernize Medicare now, allowing seniors access to the full range of managed care options already available to the privately-insured. Managing the care of Medicare beneficiaries promises beneficiaries high-quality health options care while decelerating spiraling Medicare cost increases. Most privately-insured Americans now see their doctor in some kind of managed care setting. Indeed, the Federal Employees Health Benefits Plan (FEHBP)—relied upon by many members of Congress, their staffs, and Federal employees, as well as their families—presents Congress with a shining example to consider as we modernize Medicare for the twenty-first century. The FEHBP demonstrates, with features such as coordinated open enrollment, how consumers can become well-informed about their managed care options.

Medicare beneficiaries will have to become equally savvy consumers and to do that, they need information. Without up-to-date, accurate, and concise information on health plan options, costs, and performance, seniors cannot ensure that the plans they choose will provide them with the highest standards of care. Health plans also have an incentive to provide top-notch care when they know consumers are able to sit at their kitchen table with plan report cards on which to make their decisions. Health plan awareness of this "closes the loop" and ensures quality.

For these reasons, my recently-proposed Medicare Modernization and Patient Protection Act includes rigorous pro-consumer mandates such as health plan report cards, coordinated open enrollment fairs for Medicare managed care and Medigap plans, and a strengthened grievance and appeals processes for beneficiaries when a health plan wrongly denies coverage. Medicare beneficiaries will be better protected from potential health plan abusers.

In today's testimony, we see that the Health Care Financing Administration (HCFA) is behind the curve when considering the report cards and comparative data disseminated by other large purchasers of health care. In part, this is because the task facing HCFA is more daunting: it has to collect data at the county-level for the entire country—3049 counties; HCFA's plans have greater variation in features

than those offered by other large purchasers; and this represents a substantial undertaking for HCFA, most of whose beneficiaries currently remain outside of managed care.

HCFA has noted that it intends to expand its consumer outreach in the near future, by providing comparative materials that may be accessed on the Internet and distributed by associations, independent benefits counselors, and other interested parties. While a move in the right direction, it does not put directly into the beneficiary's hands critical information on options, costs, and quality. Medicare beneficiaries need this information now, to supplement the information already available in their *Medicare Handbook*. Pilot programs in regional offices have demonstrated that it is possible for HCFA to collect and distribute comparative plan data. As Medicare increasingly looks toward a managed care solution, as proposed in the Medicare Modernization and Patient Protection Act, HCFA needs to quickly become a better educator of its beneficiaries, using tools such as these.

The CHAIRMAN. Thank you, Senator.

Senator Reed.

STATEMENT OF SENATOR JACK REED

Senator REED. Thank you, Mr. Chairman. I, too, want to commend you for holding this hearing; the ranking member for his comments and also indicate that this, I believe, is the first step and probably the most important step in bringing some needed reform to the Medicare system. The idea that consumers should have choice and informed choice seems to be something we not only should take for granted but should expect, and frankly, that is not the case. I think that these hearings are beginning to focus on that issue, and it will provide not only better individual access for seniors, but systemically, I think it will improve the quality of care throughout the system and those two points: improved quality of care, better use of resources and a more understandable and accessible system, should be the foundations of needed Medicare reforms throughout this country.

I am encouraged that we are beginning this process and particularly encouraged that we are beginning on a point which I think has common agreement across every spectrum and every position in the Senate: that is, that at a minimum, seniors should have an informed choice about health care plans. From that, I think we can build a much more formidable structural reform.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Reed.

Now, we will introduce the first panel.

I did not see you come. Senator Collins, would you please give your opening statement

STATEMENT OF SENATOR SUSAN COLLINS

Senator COLLINS. Thank you, Mr. Chairman. I want to briefly thank you for holding this hearing this morning and to associate myself with the remarks of the distinguished Senator from Rhode Island. It is essential that as we talk about giving consumers more choice among health plans for Medicare we also make sure they can easily access the information that they need to evaluate the quality and the services provided by those plans.

Too often, the information provided just focuses on cost. It does not tell consumers enough about the services, how to access the plan and the other kinds of essential information, particularly in the area of consumer satisfaction and quality. So, I look forward to

learning from the experiences of our witnesses today and helping you, Mr. Chairman, as you seek to address this important issue. Thank you.

The CHAIRMAN. Thank you.

Without objection, the statement of Senator Reid will be included in the record.

[The prepared statement of Senator Reid follows along with prepared statements of Senator Jeffords, Craig, and Warner:]

PREPARED STATEMENT OF SENATOR HARRY REID

Good morning Mr. Chairman, fellow members of the Aging Committee, and distinguished panelists. I am pleased that we are once again addressing the issue of managed care on our Committee. With the rapid growth of Medicare managed care options nationally, it is imperative that we provide the necessary oversight to ensure that our seniors, and this Nation's taxpayers, are getting the most bang for their buck.

Nearly 5 million Medicare beneficiaries are enrolled in a total of 358 managed care plans accounting for 13 percent of the Medicare population. In parts of my own State of Nevada the number is much higher. In Clark County which includes the city of Las Vegas, 39 percent of Medicare beneficiaries are enrolled in a managed care plan. Put another way, more than 1 in 3 seniors in Clark County belongs to a Medicare managed care plan. With the growing number of beneficiaries choosing managed care as an option, nearly 85,000 monthly, it is imperative that we make certain the health care decision facing seniors at 65 is facilitated by the provision of the most relevant and complete information possible.

Today's hearing will focus on the need for better information for consumers to allow them to make informed decisions about whether managed care is the right type of health care for them. I am pleased that you Mr. Chairman have chosen this topic so early in our legislative session. It is an important issue for Nevadans, and with more than 15 million beneficiaries predicted to be in HMO's by 2007, it is a very important issue for seniors across this country.

Sky rocketing health care costs have pushed the envelope for funding of the regular Medicare fee-for-service plan. Fee for service plans allow Medicare recipients to see any doctor they wish while paying a portion of the costs. In recent years more and more HMO's have contracted with HCFA to provide health care to Medicare recipients for a fixed, per beneficiary rate. These HMO's compared with the fee-for-service plan, often cover additional benefits, result in less out of pocket costs in that supplemental insurance plans are not necessary, and offer freedom from reams and reams of paper and complicated billing statements.

There are many HMO's operating across the country, which provide health care to Medicare recipients. In fact, over 50 percent of all Medicare recipients have at least two HMO plans from which to choose. In spite of this tremendous availability, and the growing number of Medicare eligibles who are choosing managed care as an option, a recent report published by GAO found that the Health Care Financing Administration does not provide sufficient detailed information about HMO plans to allow Medicare recipients to make informed decisions about their health care options. Because HMO's can differ markedly between services offered, and copayments or premiums required, such information is essential for Medicare recipients to be able to make a wise and informed health care decision. Of particular importance in the search for a health care option at 65 is information on complaint rates, information on appeals, enrollment and disenrollment data. Such information, which addresses the quality of the service provided to current and past enrollees by an HMO, would be very valuable information for review and should be made available to beneficiaries.

Information already collected by HCFA, if provided to prospective managed care enrollees, would reveal to consumers that while some HMO's are very proficient in satisfying Medicare recipient's health care needs, others lag behind. Comparative consumer guides, which are common place for Federal employees and many large employer-based health insurance programs, are simply not universally available for Medicare recipients through HCFA. In that the United States Government is the largest purchase of health care, costing taxpaying citizens nearly $200 billion last year, this lack of information allowing seniors to make the best, and most cost effective decision, is simply not acceptable. Our seniors deserve better and our government is capable of providing better. We must insist that HCFA provide full disclosure of information they have available. We should enact policies and procedures

that promote market competition in health care and give us the best shot at purchasing the best plans with our limited resources. If large systems like CalPERS is able to place primary focus on the customer and their ultimate satisfaction, then we should learn from their model, see what has been done and how, and replicate it immediately. Especially Mr. Chairman, when the customers I'm speaking of are this Nation's senior citizens.

The lack of sufficient information for Medicare recipients makes informed health care decisions very difficult, if not impossible. Further, in order for the HMO market economy to provide the best services for the best price, the information must be available in a comprehensive and understandable format. The plans seniors choose, and remain a part of, will be the best indicator of what makes a successful plan. Others in the HMO industry will surely follow suit. Failure to make such comparative guides public and accessible to seniors ignores market economic forces which could force prices down and place the appropriate emphasis on quality service and customer satisfaction.

Seniors are often lured into joining an HMO without fully understanding how the HMO operates. Such confusion can lead to unfortunate and costly health care experiences causing disenrollment and a subsequent negative impression of managed care as a viable option. We should support policy that permits seniors to make an educated decision on whether to join an HMO or stay with the regular Medicare fee-for-service plan. Many seniors are unsure or scared of HMO's because of the numerous misconceptions which surround them. The fact is Mr. Chairman, HMO's in my view are here to stay and our committee can do much to ensure that emphasis on the customer, quality service and cost containment, work in tandem as this health care option matures and becomes more readily available. For some, fee-for-service is the proper choice, for others it will be an HMO. We must not exclude either option. We owe it to our seniors to provide them with information about HMO's so that they can make the best decision about their health care coverage, thus servicing their own personal needs and situations.

Thank you Mr. Chairman. I look forward to the testimony of our distinguished panel of witnesses.

PREPARED STATEMENT OF SENATOR JAMES M. JEFFORDS

Mr. Chairman, Senator Breaux, thank you for holding this very important hearing. I would like to welcome Mr. Irvin Stewart and his wife Emelda, here today, as well as Ms. Archer and Dr. Scanlon. Thank you all for coming.

As Chairman of the Committee on Labor and Human Resources, I believe that health care quality must be a top legislative priority. Over the past several years, we have witnessed tremendous growth in managed care. As this transition has not been problem-free by anyone's analysis, the subject of today's hearing speaks to a fundamental result of this growth—the lack of uniform, understandable information on HMO's for the Medicare-eligible elderly.

It is critical to inform future beneficiaries of the quality of managed care plans so that consumers will have a sense of whether their health plan will be there when they need it. Based on the GAO's report, many consumer concerns and previous hearings I've attended this year, both as Chairman of the Labor and Human Resources Committee and as a Member of the Finance Committee, there is a pressing need for HCFA to provide to Medicare beneficiaries comprehensive and uniform information on quality. This information should be compiled from disenrollment rates, beneficiary complaints, financial data and HMO monitoring reports and be widely accessible.

Last year, the passage of the Kassebaum-Kennedy legislation demonstrated that significant bipartisan health care reform can take place. This year, we need to address the quality of our health care. As a Member of the Senate Finance Committee, I will soon be introducing legislation to enhance the Federal government's role as purchaser and regulator through the establishment of uniform performance indicators that allows consumers to compare health plans and make informed choices based on cost, satisfaction, benefits, and quality.

I will also be working to resolve the inequity imposed on rural areas by the current Adjusted Average Per Capita (AAPCC) methodology for reimbursing Medicare HMO's. While Administration plans to cut payments for Medicare HMO's may generate easy savings, it will make it even harder to build managed care plans in rural areas where few, if any, are available. Case in point—in my own State of Vermont there is no managed care option for Medicare beneficiaries. I intend to work with my colleagues here in Congress and with the Administration to develop a payment system for Medicare HMO's which creates a level playing field across geographic

areas and give Medicare patients in rural areas the same options enjoyed by others around the country.

Mr. Chairman, I appreciate having the opportunity to listen to testimony on this serious issue and I ask that my statement and questions be made part of the record.

PREPARED STATEMENT OF SENATOR LARRY E. CRAIG

Mr. Chairman, I would like to thank you for holding this hearing today to address some of the concerns that affect Medicare managed care plans. Today, Medicare beneficiaries face a dilemma when choosing a plan that satisfies their health care needs. It is important that these concerns are addressed, and I believe these hearings today will help us find workable solutions to the problem.

It is imperative that Medicare beneficiaries have timely and reliable access to information on their health maintenance organizations (HMO's) in order to make the right choice among available programs. As the American population continues to age, and a greater number of people will depend on Medicare, we should make it a priority to see to it that these problems are solved.

Currently, 4 million Medicare beneficiaries are enrolled in HMO's, Medicare's predominant managed care alternative. In many instances, beneficiaries under the Medicare Program are able to select from as many as 14 competing HMO's for services. This wide selection makes it a difficult and time consuming task to gain the necessary materials and information. A major concern is that this information is not presented in a universal format or language, which complicates the critical comparative cost and benefit analysis.

Presently, the Health Care Financing Administration (HCFA) collects a great deal of data on programs such as premium requirements, benefit services and disenrollment rates. Much of this data indicates whether or not the beneficiary is happy with a particular HMO. By compiling and distributing this information, consumers could have easy access to the necessary information and data that would enable them to make important decisions concerning health care programs.

As the American population continues to age, our obligation will be to supply the ever increasing number of Medicare beneficiaries with clear and concise information on available managed care programs. Again, I am glad to see that the Special Committee on Aging is holding this hearing today to begin the process of exploring and formulating a solution to simplify the way we choose our health plans.

PREPARED STATEMENT OF SENATOR JOHN WARNER

Mr. Chairman, thank you for holding this important hearing today on improving accountability in Medicare managed care. Medicare beneficiaries need improved consumer information so that they are better able to make important decisions regarding which health plans meet their individual health needs.

The Commonwealth of Virginia has a large and growing senior population. By the year 2000, we are projected to have more than one million citizens over the age of sixty-five, representing 15 percent of our total population.

We have heard about "Managed Care" in the last few years as millions of American workers have been enrolled in various HMO's, PPO's, and the like. Businesses have achieved significant savings in their health costs through Managed Care contracts, but not without a reduction in choice for patients, and reports of regulatory straight jacket for physicians, dentists, and other health providers. With ongoing discussions and proposals to extend managed care options to greater numbers of Medicare and Medicaid beneficiaries, we need to explore how Managed Care affects the quality of long term care services for the chronically ill.

I have supported in Congress a mandatory "Point of Service Rule" for Medicare Managed Care. In the Federal health programs where we are experimenting with Managed Care—Medicare Medicaid, and the Military Health System "TRICARE", I want to assure that patients always will have the right to go to providers of their choice. If a certain dentist or doctor is not a part of your managed care plan, you should still be able to utilize their services, even if it requires a higher copayment.

Improved consumer information is critical. In its October 1996 General Accounting Office (GAO) report to Congress, the GAO put forth several proposals that directed the Health Care Financing Administration (HCFA) to provide beneficiaries with comparative data on different health maintenance organizations (HMO's). Ensuring the availability of comparative data would enable Medicare beneficiaries to choose which plan is best for them by having all the information available in order to make an informed decision.

This committee provides an outstanding forum for addressing accountability in Medicare managed care. I look forward to participating in the discussion to improve access beneficiaries have to information in order to ensure quality health service while lowering the cost of health care.

The CHAIRMAN. The first panel will define the problem. They are going to identify problems Medicare beneficiaries face in getting the information they need to make informed decisions about choosing the right health plan. Mr. Irvin Stuart, who is a retired chemical researcher from Bronx, NY, will talk about his experiences in trying to select a Medicare managed care plan and what he believes the Government could do to provide better, more user-friendly information. I think you will agree with me that this person has gone above and beyond what should be expected and still was not able to find useful information. Mr. Stuart is accompanied by his wife, Emelda, and she, as well, is facing the same decisions in a few years.

Next will be Diane Archer, who is executive director of the Medicare Rights Center, a national, not-for-profit organization that provides assistance to Medicare beneficiaries through telephone counseling and public education. Ms. Archer will discuss the type of information beneficiaries need to make informed decisions and common problems beneficiaries face in getting what they need.

Our third witness is Dr. Scanlon, who is director of health financing and systems issues at the General Accounting Office. Dr. Scanlon will discuss the findings of the recent GAO report on consumer information and the Medicare program and recommendations to the Congress and HCFA on how to improve what is currently provided to Medicare recipients.

We will have you go in that order: the Stuarts, Ms. Archer, and Dr. Scanlon. Would you start, Mr. Stuart?

STATEMENT OF IRVIN STUART, MEDICARE BENEFICIARY, BRONX, NY; ACCOMPANIED BY: EMELDA STUART, BRONX, NY

Mr. STUART. Good morning. Can you hear me? Thank you. Good morning. I would like to thank the Senate Special Committee on Aging for inviting me to talk about the experiences—

Senator BURNS. Sir, you might want to pull that microphone a little closer to you, if you can.

Mr. STUART. OK.

The CHAIRMAN. Pull it down just a little bit. Thank you.

Senator BURNS. You need a lot of coaching in the way things are done here.

Mr. STUART. I am telling you.

I would like to thank the Senate Special Committee on Aging for inviting me to talk about the experiences many Medicare beneficiaries face when trying to get information on the various health plan options offered under the Medicare program.

My name is Irvin Stuart, and I am a 65-year-old Medicare beneficiary from the Bronx in New York City. I retired in 1992, and until I turned 65, I purchased my health insurance through Group Health Incorporated, a fee-for-service plan. When I became Medicare eligible, I realized two things: I could not afford to keep my GHI policy, and I would have to pay a lot of money out-of-pocket for Medicare premiums, deductibles and coinsurance. So, I began to

look for an affordable insurance policy that I could use to supplement my Medicare coverage. I knew about supplemental plans that you could buy in addition to standard Medicare fee-for-service from the newsletters and newspapers I had been reading and I had been receiving through AARP. Through friends, I also heard I could join certain other plans at no extra cost. I later found out that these plans were referred to as Medicare HMO's.

I called several of the plans I knew offered Medicare coverage in the New York City area looking for some more information on their plans. The customer service representatives at these plans were just dispatchers. They told me that my questions would be answered by brochures which they would send me. If I had additional questions, I could attend seminars offered by the health plan or ask my primary care physician after I had joined. I would also be sent more information on the plan after I had joined.

I had additional questions. From reading the materials I received and talking to friends about their experiences in Medicare HMO's, I knew that I had to see a primary care physician before I could see a specialist, and he had to authorize all treatments and services received from the plan. But I know people, and I watch a lot of talk shows, and I realized that a lot of people who assumed that they were covered found out when the crunch came that they were not fully covered. So, I wanted to find out under what circumstances treatments and services would be covered before I joined the plan.

I knew that Medicare HMO's offered additional benefits like prescription drug coverage and hearing aids and dental, but I wanted to know if these additional benefits could be taken away from me at any time. I did not want my benefits or my provider to change after I joined the plan. I also knew that I would save money by not paying additional monthly premiums, but I wanted to know if the plan could increase the office copayments or begin charging premiums if they became financially unstable. Nobody, including the Medicare HMO representatives at the seminars, could answer my additional questions.

I continued to shop around, but after reading all of the packets of information I received in my investigation about the Medicare HMO options, I could not find one clear, comprehensive comparison of what traditional Medicare covers and what Medicare HMO's cover; any information that correlated and compiled the benefits of different Medicare HMO's; any information specifying the circumstances under which Medicare HMO's would or would not cover services.

In addition, I found the language of these materials confusing and ambiguous and noticed that they consistently omitted information on what they did not cover. The Medicare HMO recruiting seminars were informative, but they only talked about the merits of their plans, and they did not deal with the issues I had been hearing and talking about from newspapers and television. They did not talk about the times when they denied coverage. I found that I had to constantly flip back and forth between brochures in order to make any comparison between the various plans.

Unfortunately, after 3 months of investigation, I am no closer to making a decision that I can rest easy with. My questions remain

unanswered and look as if they will remain unanswered unless: standardized comparative information on Medicare fee-for-service and Medicare HMO benefits are made available to Medicare beneficiaries; marketing materials indicate the circumstances when these services may or may not be covered; and Medicare HMO's offer consistent benefits or marketing materials that indicate that additional benefits, copayments and providers are subject to change.

After investigating the Medicare HMO options, I found that these plans are ambiguous or misleading about the conditions under which they authorize coverage. I feel that I still have a lot of questions that remain unanswered. My investigation has made me very cautious about enrolling in a Medicare HMO. I do not want to make a decision until I can be sure that I will continue to receive the proper care that I need.

The CHAIRMAN. Thank you, Mr. Stuart.

Mr. STUART. Thank you.

The CHAIRMAN. Mrs. Stuart.

Mrs. STUART. Well, my problem is that I was trying to figure out solutions, and I thought that possibly keeping members informed when the benefits were reduced or added might help and also to clearly define the procedures for emergency room visits, length of stays or circumstances. Are benefits the same in all States and foreign countries? Because senior citizens do travel. Who pays for what tests? Who and what determines your length of stay in a hospital? Are corrective procedures paid for and how much do they cover? When entering a plan, how should you select a primary doctor or the visits to the primary doctor, or should you wait until you are sick?

I think about that mainly because after a woman stops going to a pediatrician, her primary doctor is a gyn, and if you have to go to a primary care doctor to tell you to go to a gyn, when you have a problem—and you should know your own body—it seems to be a waste of money going to that primary care doctor if that gyn doctor is on the list of doctors that they give you.

When should you call an insurance company? Because from going to seminars, we were told that you had to call the insurance company to let them know when there is an emergency. Some companies say they give you 36 hours; some companies say they give you 24 hours, and when you go into a hospital, I understand, under an emergency situation, some insurance companies do not pay unless you see a specialist. Now, these are things that you do not know until you go into a hospital for an emergency at night, and the doctor decides you just have a bad cold; you need aspirin, and he sends you home. Then, the insurance company says, well, you have not seen a specialist; we cannot pay for this procedure.

If you get an HMO, and you are not satisfied with the HMO, are there any problems changing from one HMO to another? What are my options when an insurance company refuses to pay for a procedure? Do they indicate dental plans clearly, and what is the percentage they pay for dental or prescription plans? That was very vague. Some say they pay 10 percent, and you pay 10 percent. Others say they pay a certain amount. It is never clear.

That is pretty much my statement.

[The prepared statement of Mr. Stuart follows:]

Statement of

Irvin Stuart,

Medicare Beneficiary

Before the United States Senate

Senate Special Committee on Aging

Improving Consumer Decision-Making:

The Need for Better Information

April 10th, 1997

I would like to thank the Senate Special Committee on Aging for inviting me to talk about the experiences many Medicare beneficiaries face when trying to get information on the various health plan options offered under the Medicare program.

My name is Irvin Stuart and I am a 65 year old Medicare beneficiary from the Bronx in New York City. I retired in 1992 and until I turned 65, I purchased my health insurance through Group Health Incorporated (GHI), a fee-for-service plan. When I became Medicare eligible, I realized two things: 1) I could not afford to keep my GHI policy; and 2) I would have to pay a lot of money out-of-pocket for Medicare's premiums, deductibles and co-insurance. So, I began to look for an affordable insurance policy that I could use to supplement my Medicare coverage. I knew about supplemental plans that you could buy in addition to standard Medicare fee-for-service from the newsletters I had been receiving from AARP. Through friends, I also heard that you could join certain plans at no extra cost. I later found out that these plans were referred to as "Medicare HMOs".

I called several of the plans I knew offered Medicare coverage in the New York City area, looking for some more information on their plans. The customer service representatives at these plans were just dispatchers. They told me that my questions would be answered by brochures which they would send to me. If I had any additional questions, I could attend the seminars offered by the health plan or ask my primary care physician *after* I had joined. I would also be sent more information on the plan *after* I had joined.

And I had additional questions. From reading the materials I received and talking to my friends about their experiences in Medicare HMOs, I knew that you had to see a primary care physician before you could see a specialist and he had to authorize all treatment and services that you received from the plan. But I know people and I watch a lot of talk shows, and I realized that a lot of people who assumed that they were covered found out, when the crunch came, that they were not fully covered. So, I wanted to find out under what circumstances treatments and services would be covered before I joined the plan.

I knew that Medicare HMOs offered additional benefits like prescription drug coverage and hearing aids. But, I wanted to know if these additional benefits could be taken away from me at any time. I didn't want my benefits or providers to change *after* I had joined the plan. I also knew that I would save money by not paying additional monthly premiums. But, I wanted to know if the plans could increase the office co-payments or begin charging premiums if they became financially unstable. Nobody, including Medicare HMO representatives at the seminars, could answer my additional questions.

I continued to shop around. But, after reading all the packets of information I received in my investigation about the Medicare HMO option, I could not find:

- A clear, comprehensive comparison of what traditional Medicare covers and what Medicare HMOs cover.

- Any information that correlated and compiled the benefits of different Medicare HMOs.

- Any information specifying the circumstances under which Medicare HMOs would or would not cover services.

In addition, I found:

- The language of these materials confusing and ambiguous and noticed that they consistently omitted information on what they did not cover.

- The Medicare HMO recruiting seminars informative, but they only talked about the merits of their plan and didn't deal with the issues I had been hearing about from newspapers and television. They did not talk about the times when they denied coverage.

- I found that I had to constantly flip back and forth between brochures in order to make any comparison between plans.

Unfortunately, after three months of investigation, I am no closer to making a decision that I can rest easy with. My questions remain unanswered and it looks like they will remain unanswered unless: 1) standardized comparative information on Medicare fee-for-service and Medicare HMO benefits be made available to Medicare beneficiaries; 2) marketing materials indicate the circumstances when these services may or may not be covered; and 3) Medicare HMOs offer consistent benefits or marketing materials indicate that additional benefits, co-payments and providers are subject to change.

After investigating the Medicare HMO option, I have found that these plans are ambiguous or misleading about the conditions under which they authorize coverage. I feel that I still have a lot of questions that remain unanswered. My investigation has made me very cautious about enrolling in a Medicare HMO. I do not want to make a decision until I can be sure that I will continue to receive the care that I need.

Thank you very much for your time.

The CHAIRMAN. Thank you, Mrs. Stuart. I appreciate it very much. We will have questions from members after we finish hearing from the other witnesses on the panel.

I would now like to go to Ms. Archer.

STATEMENT OF DIANE ARCHER, EXECUTIVE DIRECTOR, MEDICARE RIGHTS CENTER, NEW YORK, NY

Ms. ARCHER. Thank you very much, Chairman Grassley and Senator Breaux, members of the committee for inviting me to testify today. I am the executive director of the Medicare Rights Center, a national, not-for-profit organization based in New York. MRC operates an insurance counseling and assistance telephone hotline with partial support from the New York State Office for the Aging under contract with the Health Care Financing Administration.

One in five of our hotline callers now have questions about Medicare health maintenance organizations. Clients call us with all sorts of questions that we are unable to answer: Which HMO is best? Can I go to St. Vincent's Hospital with this HMO? Is this the Cadillac of HMO's or the Ford Pinto?

While we provide a general overview of Medicare HMO's, we advise callers to research specifics by requesting information directly from the HMO's. To help our clients with the leg work of shopping for HMO's, we performed our own survey of the HMO's in downstate New York. We found that our survey took far more time and effort than most people on Medicare can devote. It took us about 8½ months to get some information. We made over 100 telephone calls and sent over 50 faxes and mailings to get answers from 11 Medicare HMO's. Even though we were able to bypass the customer service department, it took us 8½ months to get some responses. A person on Medicare slogging through customer service voice mail would have had even more difficulty getting responses from the HMO's.

We also found that HMO answers were often not useful for making comparisons. Data related to quality of care, such as the rate of member disenrollment, were not comparable because they were collected in different ways by different HMO's, and benefits such as eyeglasses and prescription drugs were hard to compare because of different terms of coverage and highly technical restrictions. How are people to compare Elderplan's eyeglass benefit with a $10 copay against Physician Health Service's eyeglass benefit with a $100 maximum?

We found there were many questions that HMO's refused to answer, important questions. HMO's would not reveal information about treatment restrictions that could give people an idea of what care they would get if they became ill, and most would not reveal the drugs that their prescription drugs would cover or the conditions under which they would be covered.

The answers changed constantly. Throughout the project, we repeatedly had to update our chart to incorporate changes in HMO benefits, costs, rules, and restrictions. Doctors in the HMO networks and drugs in the HMO formularies also changed regularly. On the overhead, you can see that the answers we got to one question on whether or not we could get a list of the HMO doctors was

first no and then yes and then no and then yes. We could not get a straight answer.

So, even with the survey results, our counselors are hard-pressed to distinguish among HMO's. In order to help consumers to make meaningful choices among competing HMO's, they need: (1) comparison charts that are based on audited HMO data; (2) up-to-date information on HMO network providers, formularies and rules and restrictions on care which enable them to assess plan quality; (3) standardization of additional HMO benefits; (4) easy availability of HMO data and comparison charts and public education to help them use the comparative information.

Shopping for Medicare HMO's today is unnecessarily complicated. In order to make informed choices among HMO's, consumers need comparison charts of accurate, audited and up-to-date information on costs, benefits and data related to plan quality. They also need standardization of additional HMO benefits so that they can compare one eyeglass benefit against another, and they can easily distinguish whether one prescription drug benefit is more valuable than another. However, comparison charts will be of limited use to consumers who are interested in HMO quality, because good methods of measuring quality for health care have not yet been developed.

Without meaningful quality data, consumers must guess at the quality of care they will receive based on the doctors and hospitals in the HMO, their availability to HMO members and their referral privileges. But this information can be difficult to obtain. They need to know information about the care they will receive, such as the HMO's treatment and financial constraints on doctors and the drugs covered in the HMO's formulary. But currently, HMO's do not make this information available.

Without access to up-to-date descriptions of what HMO's cover and their conditions for coverage, consumers are vulnerable to a bait-and-switch game. For example, our client, Mr. K., of Bridgeport, joined KeyCare 65, a Pennsylvania Medicare HMO, after the HMO told him that his doctor would deliver exactly the same care in the HMO for his cardiac arrhythmia as he did in traditional Medicare. After he joined, his doctor told him that he could no longer obtain the test that he needed for his heart condition twice a year, as he did under traditional Medicare, because the HMO would only authorize them once a year unless he became significantly ill. Mr. K. returned to traditional Medicare to get his tests he needed.

HCFA should collect and verify the necessary data to compile comparison charts and make the charts and information on providers, formularies and treatment restrictions available on the Internet, in publications and through the media. HMO information for consumers should also include notification that benefits and provider networks may be subject to change. People on Medicare should be able to find information on HMO benefits, costs and restrictions as easily as parents are able to find test scores for school districts in the newspaper. Public education efforts must accompany the comparison charts as well. Most people on Medicare have little experience with managed care and do not understand how HMO's work or the relevance of many HMO quality measures to

their own health care. Information must be disseminated in a way that is meaningful to consumers, and appropriate resources for insurance counseling programs across the U.S. should be secured.

Thank you for your time and interest. I would be happy to answer your questions.

[The prepared statement of Ms. Archer follows:]

Medicare Rights Center

Statement of

Diane Archer, Esq.

Executive Director

Medicare Rights Center

Before the

United States Senate

Special Committee on Aging

Improving Accountability in Medicare Managed Care:

The Consumer's Need for Better Information

April 10, 1997

1460 Broadway New York, New York 10036 Telephone: 212 869-3850 Facsimile: 212 869-3532

Thank you very much for the opportunity to testify today. I am the Executive Director of the Medicare Rights Center, a national not-for-profit organization based in New York. MRC assists seniors and people with disabilities on Medicare through counseling and public education. MRC operates an Insurance Counseling and Assistance telephone hotline with partial support from the New York State Office for the Aging.[1] Last year, we fielded more than 42,000 calls to our Medicare counseling hotline. (Appendix A)

The proportion of hotline callers with questions about Medicare Health Maintenance Organizations has exploded from one in twenty just two years ago to one in five this year. Clients call us with all sorts of questions that we are unable to answer. Which HMO is best? Which ones will take good care of me when I get ill? Can I go to St. Vincent's Hospital with this HMO? Is this HMO the Cadillac of health care or the Ford Pinto? While we provide a general overview of Medicare HMOs, we advise callers to research specifics by requesting information directly from the HMOs.

In an effort to help our clients with the legwork of shopping for HMOs, we performed our own survey of the HMOs in downstate New York. We asked each of them 90 questions on plan benefits, costs, rules, restrictions, structures and measurements of quality. (Appendix B) We found the process of shopping for HMOs to be tremendously time-consuming. Moreover, much of the information provided by the HMOs was not useful for making comparisons. (Appendix C)

- **The survey took far more resources and time than most people on Medicare can devote.** We made over 100 telephone calls and sent over 50 faxes and mailings to get answers from 11 Medicare HMOs. Even though we were able to bypass the customer service department, response times ranged from 2 weeks to 8 1/2 months. A person on Medicare slogging through customer service voicemail would have had even more difficulty.
- **Answers to the survey were often not useful for making comparisons.** Data related to quality of care, such as the rate of appeals for denials of care, the rate at which HMO members left the plan, and member satisfaction were collected in different ways and thus not comparable. And benefits such as prescription drugs and point-of-service coverage for out-of-network care were hard to compare. Confusing terminology and confusing answers also made comparison difficult. (Appendix D)
- **There were many questions that HMOs refused to answer.** HMOs wouldn't reveal clinical guidelines or utilization review guidelines that could give people an idea of what care they would get if they became ill. The majority wouldn't reveal which drugs were covered in their formularies. Of those that did, only HIP volunteered the conditions under which the drugs would be covered. One HMO,

[1] A contract to provide Health Insurance Counseling and Assistance from the New York State Office for the Aging, with funding from the Health Care Financing Administration, covers 15% of the costs for our toll-free hotline. The rest is raised from public and private sources.

CIGNA, even refused to provide a list of doctors in the network, stating it was only available to people on Medicare if a sales representative were allowed to visit them.

- **The answers changed constantly.** Throughout the project we had to constantly update our chart to incorporate changes in HMO benefits, costs, rules and restrictions. Doctors in the HMO networks and drugs in the HMO formularies also changed regularly.

So, even with the survey results, our counselors are hard-pressed to distinguish among HMOs. We still don't have useful information about quality, and the answers on the chart are too misleading to release without an accompanying explanation. Consumers need comparison charts, but comparison charts alone are not enough. In order to help consumers to make meaningful choices among competing HMOs, they need:

1. **Comparison charts that are based on standardized, audited, HMO data.**
2. **Up-to-date information on HMO network providers, formularies, and rules and restrictions on care.**
3. **Standardization of additional HMO benefits.**
4. **Easy availability of HMO data and comparison charts, and public education to help them use the comparative information.**

1. **Comparison charts must be compiled that are based on standardized, audited, HMO data.**

The answers that HMOs gave for our survey questions on rates of appeals, grievances and disenrollment were not useful for comparison. HMOs had different methods of collecting and reporting data, and no outside agencies reviewed the accuracy of their information.[2] Other information that HMOs use to advertise quality, such as consumer satisfaction surveys and National Committee for Quality Assurance data on plan performance, is neither audited nor standardized and thus of limited value for comparing HMOs.

People on Medicare today get the majority of their HMO information from marketing materials and presentations.[3] They have very little objective information about HMOs and aren't educated about what they should look for beyond the glossy brochures. HCFA already collects or should collect much of the information that people on Medicare could use to choose among HMOs, such as disenrollment rates, benefits and costs, and it is

[2] For example, Oxford Health Plans categorized disenrollments as voluntary or involuntary, while other HMOs did not make the distinction. In addition, none of the disenrollment data reported by HMOs agreed with statistics reported by HCFA for the same time period.

[3] Kaiser Family Foundation/Agency for Health Care Policy and Research survey, October 1996.

developing standardized measures of consumer satisfaction.[4,5] HCFA should release comparison charts based on this information as a needed first step towards informed choice for people on Medicare.

2. Up-to-date information on HMO network providers, formularies, and rules and restrictions on care should be made available to the public on a frequent and regular basis.

In order to make smart choices, consumers also need detailed information, such as the drugs covered in HMO formularies, that can't be included in a comparison chart. Much of this information is unavailable and constantly changing. While some consumers may be satisfied to compare copayments and caps on prescription drug benefits, others will need more specific and up-to-date information on which drugs the HMO will cover.[6,7,8] For example:

> Mr. P of West Palm Beach joined Humana, a Florida Medicare HMO, for its prescription drug benefit. However, the drug used to control his prostate enlargement was taken off the HMO formulary, and he was left to pay for his medication out-of-pocket.

Many people pick HMOs based on the doctors or hospitals in the HMO network. They want to know before they enroll which doctors are in an HMO, whether they accept new HMO patients, and whether they have referral privileges to other doctors or hospitals that they want to see. Consumers need this information to make informed choices, just as they need information on how HMOs oversee the care that doctors give their patients. Such information includes clinical guidelines with recommendations on how doctors should care for different illnesses, and utilization review guidelines describing the conditions under which HMOs will approve particular treatments for different conditions. For example:

> Mr. K of Bridgeport joined Keycare 65, a Pennsylvania Medicare HMO, after the HMO told him that his doctor would deliver exactly the same care in the HMO for his cardiac arrhythmia as he did in traditional Medicare. After he joined, his doctor told him that he could no longer obtain the tests that he needed for his heart condition twice a year, as he did under traditional Medicare, because the HMO would only

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[4] General Accounting Office. "HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance." October 1996.
[5] The Consumer Assessment of Health Plan Satisfaction (CAHPS).
[6] O'Malley, Sharon. "Report Cards: How Relevant Are They for Patients?" Quality Letter for Healthcare Leaders, 9:3:12 March 1996.
[7] Hibbard, Judith *et al.* "Evaluating the Approaches for Supporting Informed Consumer Decisions." Unpublished paper presented before the American Public Health Association, October 1996.
[8] Sofaer, Shoshanna *et al.* "Providing Consumers with Information to Support Health Plan Decisions: A Theory of Action." Unpublished paper presented before APHA, October 1996.

authorize them once a year unless he became significantly ill. Mr. K returned to traditional Medicare to get the tests he needed.

Without access to up-to-date descriptions of what HMOs cover and their conditions for coverage, consumers are vulnerable to a bait-and-switch game.

HCFA should regularly make available to consumers current information on providers, formularies, clinical guidelines and treatment restrictions. HMO information for consumers should also include notification that benefits and provider networks may be subject to change.

3. Additional HMO benefits should be standardized to allow consumers to make more meaningful comparisons, just as Medicare supplemental insurance was standardized several years ago.

Our clients tell us that shopping for an HMO today is unnecessarily complicated. Our own experience compiling the comparison chart for New York HMOs confirms their opinions:

- **HMO benefits are difficult for our clients to compare by cost.** How are they to compare Elderplan's eyeglass benefit with a $10 copay against PHS's eyeglass benefit with a $100 maximum?
- **HMO benefits are difficult for our clients to compare by coverage.** How are they to know that the "point-of-service" benefit for out-of-network coverage can mean $100 every three months at NYLCare and 80% of the Medicare-approved amount for an extra $87.50 premium each month at USHealthcare?

The additional benefits of Medicare HMOs should be standardized in simple, easy-to-understand packages which still allow room for HMOs to offer new innovations and benefits. Standardized benefits, along with disclosure of information like drug formularies that is difficult to standardize, are needed in order to help people on Medicare make better comparisons among competing HMOs.

4. **The HMO data and comparison charts should be made widely available, and funding should be committed for public education to help people on Medicare use the information.**

While some comparison charts of Medicare HMOs have been created, the commitment to systematically create and disseminate them has not been made.[9] HCFA should collect and verify the necessary data to compile comparison charts, and make the charts and information on providers, formularies and treatment restrictions available on the Internet, in publications and through the media. People on Medicare should be able to find information on HMO benefits, costs and restrictions as easily as parents are able to find test scores for school districts in the newspaper.

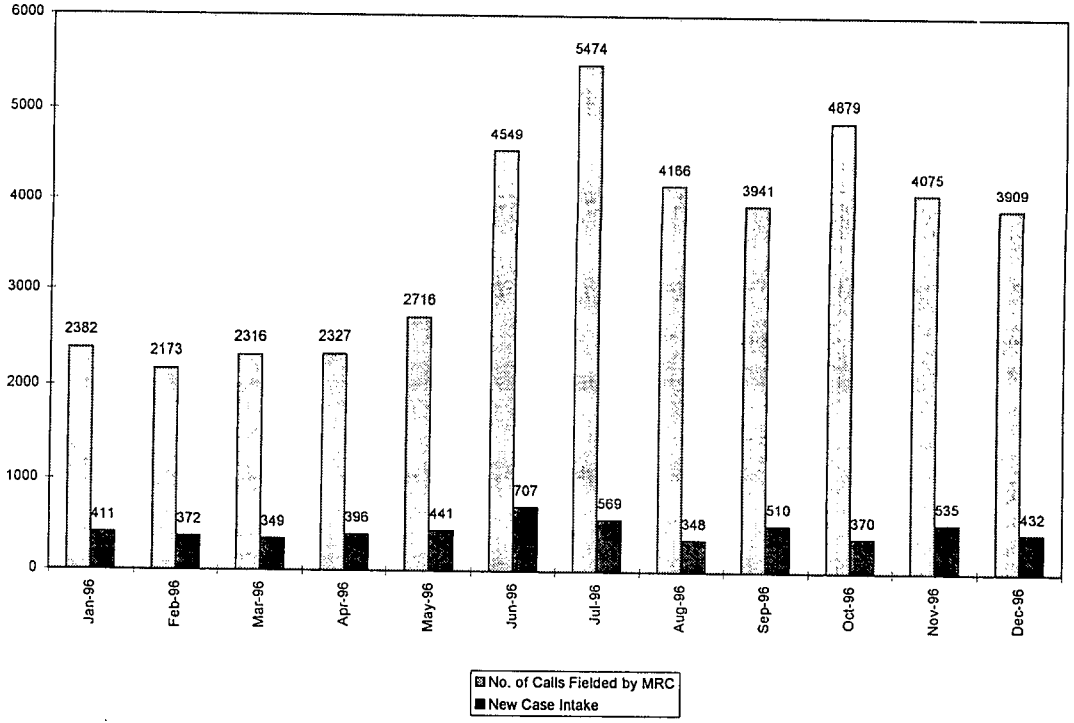
Public education efforts must accompany the comparison charts as well. Most people on Medicare have little experience with managed care and do not understand the relevance of many HMO quality measures to their own health care. Preliminary results from our survey of low-income elderly reveals that most do not even fully understand that HMO members can only see HMO doctors and hospitals for their care. (Appendix E) Many people on Medicare need public education in order to understand what a Medicare HMO is before they can try to choose among HMOs. Information must be disseminated in a way that is meaningful to consumers, and appropriate resources for insurance counseling programs across the U.S. should be secured.

Thank you for your time and interest. I would be happy to answer your questions.

[9] HCFA resources at the present time appear inadequate to compile and disseminate such a chart. While 13% of Medicare beneficiaries are enrolled in managed care organizations, only 5% of HCFA staff are allocated to oversee and administrate Medicare HMOs.

Appendix A

Medicare Rights Center Telephone Counseling Hotline: 1996



APPENDIX B

(Please refer to accompanying charts.)

MEDICARE HMOs IN DOWNSTATE NEW YORK

I. GENERAL INFORMATION

HMO's name	Aetna US Healthcare	CIGNA	Elderplan	Empire BlueCross BlueShield	HIP	Kaiser	Managed Health	NYLCare	Oxford	Physician Health Services	Vytra
HMO's Medicare product name	Golden Medicare Plan, Medicare 5	CIGNA HealthCare for Seniors	Elderplan	Senior Plan	VIP	Senior Advantage	Managed Health 65 Plus	NYLCare 65	Medicare Advantage	SmartChoice	Vytra Medicare
Counties that the HMO serves	1,2,3,4,5,6,7,8,9, 10,11,12	1,3,4,5,8,9,11,12	3	1,3,4,5,8,9,10, 11,12	1,3,4,5,8,9,11,12	12	4,8,11	4,8,11	1,3,4,5,6,7,8, 9,10,11,12	1,2,3,4,5,6,7,8,9, 10,11,12	4,8,11
Type of plan	Risk	Risk	Risk	Risk	Risk	Risk	Risk	Risk	Risk	Risk	Risk
Type of model	IPA	combination of group, IPA, & network	IPA	IPA	Group	Group	Group	IPA	Network	IPA in 5,6,9,11. Network in 1,2,3,4,7,8,10.	IPA
Monthly premium	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*	Medicare Part B + $0 premium*
Started enrolling NY Medicare beneficiaries in	1989	1996	1985	1996	1987	1995	1994	1992	1992	1996	1995
NCQA status	full accreditation	expired	scheduled for review in 1998	scheduled for review in 1997	three year accreditation	one year accreditation	not accredited	scheduled for review in 1997	full, three-year accreditation	full, three-year accreditation	scheduled for review in 1997
Telephone number	1-800-832-2640	1-800-454-2496	718-921-7901	1-800-809-7328	1-888-447-8763	1-800-311-4493	516-683-1010	1-800-231-9555	1-800-303-6720	1-800-244-2691	1-800-330-6418

*Every individual entitled to benefits under Part A and enrolled under Part B or enrolled under Part B only is eligible to enroll in a Medicare HMO. Exceptions include individuals determined to have End Stage Renal Disease and individuals who are receiving hospice benefits.

Counties:
1. Bronx 2. Dutchess 3 Kings 4 Nassau 5. New York 6 Orange 7. Putnam 8 Queens 9 Richmond 10. Rockland 11 Suffolk 12. Westchester

II. MEMBERSHIP TRENDS

	Aetna US Healthcare	CIGNA	Elderplan	Empire BlueCross BlueShield	HIP	Kaiser	Managed Health	NYLCare	Oxford	Physician Health Services	Vytra
Member annual disenrollment rate	3.6%	n/a *	1.3%	n/a *	7.3%	3%	no answer	1.97%	6.5%	n/a *	2.1%
Physician annual disenrollment rate	5%	n/a*	0%	n/a*	9%	4%	no answer	5%	<1%	n/a*	5.7%
# of grievances filed in the last year?	52	n/a*	no answer	n/a*	96	no answer	1	491	no answer	n/a*	0
# of appeals filed in the last year?	43	n/a*	85	n/a*	333	no answer	3	228	no answer	n/a*	3
% of appeals resolved in beneficiary's favor	80%	n/a*	84%	n/a*	no answer	no answer	0%	58%	no answer	n/a*	33%
In addition to customer service representatives, does the HMO have consumer ombudsmen who can help me if I cannot access the care that I think I need?	No	no answer	No	no answer	Yes	Yes	No	No	No	No	No

* This question is not applicable to the plan, because the plan has been operating its Medicare product for less than one year

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MEDICARE HMOs IN DOWNSTATE NEW YORK

III. CAREGIVERS AND RESOURCES

	Aetna US Healthcare	CIGNA	Elderplan	Empire BlueCross BlueShield	HIP	Kaiser	Managed Health	NYLCare	Oxford	Physician Health Services	Vytra
Number of members*	18,772	425	4,986	2,035	53,979	1,465	1,334	11,922	107,220	1,655	7,442
Number of PCPs	1,682	no answer	28	840	627	15	57	365	no answer	no answer	629
Number of PCPs per 200 members	18	no answer	1	83	2	2	9	6	no answer	no answer	17
Percentage of board certified PCPs	85%	no answer	100%	73%	81%	92%	no answer	85%	93%	77.8%	88.1%
Percentage of PCPs currently accepting new patients	95%	no answer	90%	100%	98%	99%	100%	99%	93%	98%	93.8%
Number of specialists	7,700	no answer	237	2,735	1,202	39	200	1,600	no answer	7,000	1,676
Before I enroll in an HMO, can I receive in the mail a book that lists the network providers?	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Can I switch doctors if I am unhappy with my doctor?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there a limit to how many times I can switch doctors?	No	Yes. No more than once a month or three times in a year.	no answer	No	No	No	No	No. But if you change your PCP more than 3 times in a year, the HMO will conduct a review.	No	No	No
Does the HMO offer a Point of Service (POS) option?	Yes Versatel option: For an additional $9.20 per month, the HMO will pay 80% of Medicare allowable charges. Your PCP must belong to the HMO network, but you can see a specialist outside of the HMO network. Golden Choice option: For an additional $87.50 per month, the HMO will pay 80% of Medicare allowable charges. Both your PCP and specialist can be outside of the HMO network	No	No	No	No	No	No	Yes The HMO offers 'opt out coverage'. You can see an out-of-network doctor for consultation purposes only once every 3 months. The HMO will give you a $100 benefit towards that visit.	No	No	No

* Health Care Financing Administration Office of Managed Care. "Disenrollment Rates Report for Risk HMOs in Region 2." December 1996.

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IV. DELIVERY OF CARE

	Aetna US Healthcare	CIGNA	Elderplan	Empire BlueCross BlueShield	HIP	Kaiser	Managed Health	NYLCare	Oxford	Physician Health Services	Vytra
Average wait time for a non-urgent, office visit	3 days	no answer	13 days	3 days	7 days	8 days	18 days	2 to 3 days	5 days	8 days	5 days
If I have a medical condition that requires frequent care, can I choose a specialist as my PCP?	No	Yes, for certain treatments.	Yes, if the specialist is also a PCP. (Some specialists are also PCPs.)	No	No	No	No	No	No	No	No
If I travel outside of the HMO's service area, does the HMO have agreements with other HMOs to provide me with routine healthcare?	No	No	No	Yes	Yes	No	No	No	No	No	No
Does the HMO have a transportation program to help me get to routine, non-urgent office visits?	No	No	No	No	No	Yes	No	No	No	No	No

V. PRACTICE GUIDELINES AND UTILIZATION REVIEWS

	Aetna US Healthcare	CIGNA	Elderplan	Empire BlueCross BlueShield	HIP	Kaiser	Managed Health	NYLCare	Oxford	Physician Health Services	Vytra
Must PCPs consult with the HMO for coverage and medical necessity before referring me to a specialist?	No	No	Yes	No	No	No	No	No	No	No	No
Must PCPs consult with the HMO for coverage and medical necessity before admitting me to a hospital?	Yes	Yes	Yes	Yes	No	No	Yes, for elective admissions only	No	Yes	Yes	Yes
How long are referrals for specialty care valid for?	365 days (First visit must be within 90 days from date of issuance.)	180 days from date of issuance (3 visits maximum per referral)	as directed by the PCP	90 days	referral required only for first visit	depends upon medical condition	30 days	30 days	180 days	180 days	365 days
How does the HMO pay its PCPs?	capitation	capitation and fee-for-service	capitation and fee-for-service	fee-for-service	Medical groups are capitated. Each group then pays its doctors on a salary or profit-sharing basis.	capitation	salary or fee-for-service	capitation	fee-for-service	fee-for-service	fee-for-service

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MEDICARE BENEFITS and YOUR OUT-OF-POCKET COSTS

	Traditional Medicare (under assignment)	Aetna US Healthcare Medicare 5	CIGNA HealthCare for Seniors	Elderplan	Empire BlueCross BlueShield Senior Plan	HIP VIP Option A	Kaiser Senior Advantage	Managed Health	NYLCare 65	Oxford Medicare Advantage	Physician Health Services SmartChoice	VYTRA Medicare
Outpatient												
Physician office visits	$100 annual Part B medical deductible plus 20% of the Medicare approved amount	$5 copayment	$10 copayment	No copayment	$10 copayment	$5 copayment	$5 copayment	$10 copayment	$5 copayment	$10 copayment for 5 boroughs of NYC $15 copayment for surrounding area:	$10 copayment	$5 copayment
Immunizations	Medicare does not cover most vaccines, but it does help to pay for flu, pneumococcal pneumonia, and hepatitis B vaccines.	No copayment for flu and pneumococcal pneumonia vaccines $5 copayment for Hepatitis B vaccines	$10 copayment for Hepatitis B vaccines No copayment for all other vaccines	No copayment	No copayment	No copayment for flu and pneumococcal pneumonia vaccines $5 copayment for all other vaccines	No copayment	Same as traditional Medicare	No copayment	No copayment	$10 copayment	No copayment
Diagnostic tests (X-ray and laboratory services)	No charge *for approved diagnostic tests provided by certified, Medicare-participating laboratories.* $100 annual Part B medical deductible plus 20% of the Medicare approved amount *for tests done in a doctor's office.*	$5 copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Inpatient												
Hospitalization in a general hospital	Days 1-60*: $760 deductible only Days 61-90*: $190 per day Days 91-150*: $380 per day (Medicare only provides for 60 lifetime reserve days.)	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary	No copayment Unlimited days as medically necessary
Home Health	No charge for Medicare approved visits.	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare
Skilled nursing facility	Days 1-20*: No charge following a medically necessary 3 day hospital stay Days 21-100*: $95 per day	No copayment Up to 100 days* 3-day hospital stay is not required.	No copayment Up to 100 days* 3-day hospital stay is not required.	No copayment Up to 100 days* 3-day hospital stay is required	No copayment Up to 100 days* 3-day hospital stay is not required.	No copayment Up to 100 days* 3-day hospital stay is required	No copayment Up to 100 days* 3-day hospital stay is required.	No copayment Up to 100 days* 3-day hospital stay is required.	No copayment Up to 100 days * 3-day hospital stay is required.	No copayment Up to 100 days* 3-day hospital stay is not required.	No copayment Up to 100 days* 3-day hospital stay is not required.	No copayment Up to 100 days* 3-day hospital stay is required
Emergency room	$100 annual Part B medical deductible plus 20% of the Medicare approved amount	$35 copayment This fee is waived if you are admitted into a hospital.	$50 copayment This fee is waived if you are admitted into a hospital.	$50 copayment This fee is waived if you are admitted into a hospital	$50 copayment This fee is waived if you are admitted into a hospital.	$50 copayment This fee is waived if you are admitted into a hospital	$5 copayment at a emergency room at a Kaiser Permanente Health Center $25 copayment at an emergency room outside of the Kaiser Permanent Health Center	$25 copayment This fee is waived if you are admitted into a hospital.	$50 copayment This fee is waived if you are admitted into a hospital.	$50 copayment This fee is waived if you are admitted into a hospital.	$50 copayment This fee is waived if you are admitted into a hospital.	$25 copayment This fee is waived if you are admitted into a hospital
Ambulance services when medically necessary	$100 annual Part B medical deductible plus 20% of the Medicare approved amount	No copayment	No copayment	$2 copayment	No copayment	No copayment	Same as traditional Medicare	No copayment	No copayment	No copayment	No copayment	Same as traditional Medicare

* per benefit period

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MEDICARE BENEFITS and YOUR OUT-OF-POCKET COSTS

	Traditional Medicare (under assignment)	Aetna US Healthcare Medicare 5	CIGNA HealthCare for Seniors	Elderplan	Empire BlueCross BlueShield Senior Plan	HIP VIP Option A	Kaiser Senior Advantage	Managed Health	NYLCare 65	Oxford Medicare Advantage	Physician Health Services SmartChoice	VYTRA Medicare
Mental Health												
Outpatient care	$100 annual Part B medical deductible plus 50% of the Medicare approved amount	$25 copayment	50% of Medicare approved charges	$5 copayment	$25 copayment	$25 copayment	50% of Medicare approved charges	No copayment for first 10 visits $10 copayment for each additional visit	No copayment	50% of Medicare approved charges	$25 copayment	50% of Medicare approved charges
Inpatient care in a psychiatric hospital	Days 1-60*: $760 deductible only Days 61-90*: $190 per day Days 91-150*: $380 per day Medicare covers 190 days per lifetime.	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	Same as traditional Medicare
Substance Abuse												
Outpatient care	$100 annual Part B medical deductible plus 50% of the Medicare approved amount *for mental health services* $100 annual Part B medical deductible plus 20% of the Medicare approved amount *for non-mental health services*	$5 copayment	50% of Medicare approved charges	Same as traditional Medicare	$25 copayment	$25 copayment	50% of the Medicare approved amount for mental health services $5 copayment for non-mental health services	No copayment for first 10 visits $10 copayment for each additional visit	Same as traditional Medicare	50% of Medicare approved charges	$25 copayment	Same as traditional Medicare
Inpatient care	Your out-of-pocket costs depend upon whether you are admitted to a general or psychiatric hospital. Please see *Hospitalization in a general hospital* and *Mental Health Inpatient care* for appropriate information.	No copayment Up to 190 days per lifetime	No copayment Up to 190 days per lifetime	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	No copayment Up to 190 days per lifetime	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare	Same as traditional Medicare

* per benefit period

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	Traditional Medicare (under assignment)	Aetna US Healthcare Medicare 5	CIGNA HealthCare for Seniors	Elderplan	Empire BlueCross BlueShield Senior Plan	HIP VIP Option A	Kaiser Senior Advantage	Managed Health	NYLCare 65	Oxford Medicare Advantage	Physician Health Services SmartChoice	VYTRA Medicare
Miscellaneous												
Outpatient prescription drugs	**Medicare does not cover most outpatient prescription drugs. Medicare does help to pay for the following items: antigens, hemophilia clotting factors, hepatitis B vaccine, immunosuppressive drugs, and oral cancer drugs.**	**$1500 limit per calendar year** No quarterly cap	**$1500 limit per calendar year** No quarterly cap	**No limit when ordered from Elderplan formulary by a physician**	**$1000 limit per calendar year** No quarterly cap	**$1000 limit per calendar year** No quarterly cap	**$1500 limit per calendar year** No quarterly cap	**$1000 limit per calendar year** No quarterly cap	**$1000 limit per calendar year** $250 quarterly cap	**$1000 limit per calendar year** for the 5 boroughs of NYC **$500 limit per calendar year** for surrounding areas No quarterly cap	**$1000 limit per calendar year** No quarterly cap	**$1000 limit per calendar year** No quarterly cap
		$10 copayment per 34-day supply of generic drugs, with up to 5 refills per individual prescription when authorized **$15 copayment** per 34-day supply of brand name drugs, with up to 5 refills per individual prescription when authorized After the initial prescription, most maintenance drugs can be refilled with a 90-day supply (with one $10/$15 copayment per prescription) when authorized	**$5 copayment** per 30-day supply of generic drugs at local pharmacies **$10 copayment** per 30-day supply of brand name drugs at local pharmacies **$10 copayment** per 90-day supply of generic drugs through mail order **$20 copayment** per 90-day supply of a brand name drugs through mail order	**$2 copayment** per 60-day supply through mail order **$5 copayment** per 30-day supply at local pharmacies	**$5 copayment** for drugs on the plan's formulary at local pharmacies **$15 copayment** for drugs not on the plan's formulary at local pharmacies **$10 copayment** per 90-day supply of drugs on the plan's formulary & through mail order **$30 copayment** per 90-day supply of drugs not on the plan's formulary & through mail order	**$10 copayment** per 30-day supply	**$5 copayment** per 30-day supply	**$5 copayment** for generic drugs **$15 copayment** for brand name drugs	**$3 copayment** for generic drugs **$10 copayment** for brand name drugs	**$7 copayment** for generic drugs **$15 copayment** for brand name drugs for residents of the 5 boroughs of NYC **$20 copayment** for brand name drugs for residents of the surrounding area	**$10 copayment** for drugs as prescribed by your doctor (If your doctor specifies a brand name drug on your prescription, then you just pay the $10 copayment. If your doctor does not specify a brand name drug and if you request a brand name drug, you pay the difference.)	**$5 copayment** for generic drugs **$15** for brand name drugs
Routine podiatry care	**Medicare does not cover routine podiatry care, unless the patient has a condition for which non-professional care would pose a hazard (i.e., diabetes).**	**$5 copayment*** You are limited to 4 routine foot care visits per calendar year -- no limit per quarter	**$10 copayment***	**$2 copayment***	**Same as traditional Medicare**	**$5 copayment*** You are limited to 4 routine foot care visits per calendar year -- 1 per quarter	**Same as traditional Medicare**	**Same as traditional Medicare**	**$5 copayment*** You are limited to 4 routine foot care visits per calendar year -- 1 per quarter	**No copayment*** You are limited to 4 routine foot care visits per calendar year -- 1 per quarter	**Same as traditional Medicare**	**Same as traditional Medicare**
Chiropractor	**$100 annual Part B medical deductible plus 20% of the Medicare approved amount. Coverage is limited to manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray.**	**$5 copayment*** Coverage is limited to manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray	**$10 copayment***	**Same as traditional Medicare**	**$10 copayment*** Coverage is limited to manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray	**$5 copayment*** Coverage is limited to manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray	**Same as traditional Medicare**	**Same as traditional Medicare**	**Same as traditional Medicare**	**Same as traditional Medicare**	**$10 copayment*** Coverage is limited to manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray	**Same as traditional Medicare**
Non-urgent Transportation (i.e., to us from a doctor's office)	**Medicare does not cover non-urgent transportation.**	**Same as traditional Medicare**	**Same as traditional Medicare**	**Same as traditional Medicare**	**Same as traditional Medicare**	**Same as traditional Medicare**	**No copayment** Limit to 6 free round-trips per calendar year or 12 one-way trips	**Same as traditional Medicare**	**Same as traditional Medicare**	**Same as traditional Medicare**	**Same as traditional Medicare**	**Same as traditional Medicare**

* You must see a doctor that is approved by the HMO.

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MEDICARE BENEFITS and YOUR OUT-OF-POCKET COSTS

	Traditional Medicare (under assignment)	Aetna US Healthcare Medicare 5	CIGNA HealthCare for Seniors	Elderplan	Empire BlueCross BlueShield Senior Plan	HIP VIP Option A	Kaiser Senior Advantage	Managed Health	NYLCare 65	Oxford Medicare Advantage	Physician Health Services SmartChoice	VYTRA Medicare
Routine eye exams with an optometrist	Medicare does not cover routine eye exams, but it does help to pay for treatments for eye disease or injury.	$5 copayment* Limit 1 routine exam per 12 months	$10 copayment* Limit 1 routine exam per 12 months	No copayment* Limit 1 routine exam per 12 months	$10 copayment* Limit 1 routine exam per 12 months	$5 copayment* Limit 1 routine exam per 12 months	$5 copayment* Limit 1 routine exam per 12 months.	No copayment* Limit 1 routine exam per 12 months.	$10 copayment* Limit 1 routine exam per 24 months	No copayment if you see an Oxford doctor Limit 1 routine exam per 12 months Or you are given a $50 maximum allowance per 12 months if you see a non-Oxford doctor	$10 copayment* Limit 1 routine exam per 12 months	$5 copayment* Limit 1 routine exam per 12 months
Regular eyewear	Medicare does not cover regular eyewear, but it does help to pay for lenses after cataract surgery.	You are given a $70 maximum allowance per 24 months	You are given a $70 maximum allowance per 2 calendar years	You pay a $10 copayment per pair, per 24 months	No charge for single, bi- or tri-focal lenses and standard frames per 24 months	No charge for one pair of eyeglasses per 24 months when prescribed by a HIP-affiliated doctor and chosen from a select group of frames at a participating provider	You are given a $100 maximum allowance per 24 months	You are given a 50% discount for one pair of eyeglasses per 24 months. The discount amount cannot exceed $90	You are given a $100 maximum allowance per 24 months	No copayment if you see an Oxford doctor Limit one pair 24 months Or you are given a $70 maximum allowance per 24 months if you see a non-Oxford supplier	You are given a $100 maximum allowance per 24 months	You are given a $100 maximum allowance per 24 months Eyeglasses can also be bought at a discount
Routine hearing exams	Medicare does not cover routine hearing exams, but it does help to pay for treatments for ear disease or injury.	Same as traditional Medicare $5 copayment for audiograms (evaluations for hearing aids)	$10 copayment*	No copayment*	No copayment*	$5 copayment*	$5 copayment*	Same as traditional Medicare No copayment* for audiograms (evaluations for hearing aids)	Same as traditional Medicare	No copayment if you go to a Hear X facility You need a referral from your PCP $10 copayment† $15 copayment†† if you do not go to a Hear X facility You need a referral from your PCP	$10 copayment*	$5 copayment*
Hearing aid	Medicare does not cover hearing aids.	You are given a $500 maximum allowance per 36 months	You are given a $500 maximum allowance per 3 calendar years	You pay a $40 copayment per hearing aid, per 24 months	You are given a 30% discount on hearing aids.	You are given a $300 maximum allowance per 36 months	You are given a $400 maximum allowance per 36 months	You are given a $500 maximum allowance per 36 months	Months 1-36 you are given a $500 maximum allowance. Months 37-72 you are given a 50% discount off replacements & repairs Months 73-108, you are given a $500 maximum allowance and a 10% discount off supplies	You are given a $500 maximum allowance per 36-months if you go to a Hear X facility You need a referral from your PCP You are given a $300 maximum allowance per 36-months if you do not go to a Hear X facility You need a referral from your PCP	You are given a $500 maximum allowance per 36 months	You are given a $500 maximum allowance per 36 months
Routine, preventive, cleaning dental care services	Medicare does not cover routine, preventive, cleaning dental care services.	$2 copayment* You are limited to 2 visits per year For additional dental services, you pay discounted fees	Same as traditional Medicare	No copayment* You are limited to 2 visits per year For additional dental services, you pay discounted fees	$10 copayment* You are limited to 2 visits per year For additional dental services, you pay discounted fees	$5 copayment* You are limited to 1 cleaning per year $5 copayment* For additional services performed at the same visit Limited to 2 oral exams per year and/or 2 bitewing x-rays per 6 months	No copayment* You are limited to 2 visits per year	No copayment* You are limited to 1 cleaning and exam per year	No copayment* You are limited to 1 visits per year For additional dental services, you pay discounted fees	No copayment* for 5 boroughs of NYC only You are limited to 2 visits per year Same as traditional Medicare for surrounding areas	Same as traditional Medicare	No copayment* You are limited to 2 visits per year For additional dental services, you pay copayments

* You must see a doctor that is approved by the HMO † for 5 boroughs of New York City †† for surrounding areas

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APPENDIX C

MEMORANDUM

To: Diane Archer, Executive Director
From: Ellen Kim, Policy Analyst
Date: January 16, 1997
Re: What HMOs are disclosing and not disclosing

Last year, I examined 22 Medicare HMO programs in New York and Ohio and asked them a 90-question survey that covered the following issues: the HMOs' caregivers and resources; services; practice guidelines and utilization reviews; enrollment and disenrollment rates; finances; and marketing and enrollment procedures.

Most of the HMOs were helpful in providing us answers to inquiries about the following items:

- names of their participating providers
- percentage of board certified doctors
- procedures for informing enrollees when their physician no longer contracts with the HMO
- average wait time to see a physician
- procedures for obtaining second-opinions, specialty care, inpatient care, or out-of-network care
- coverage for out-of-network services
- language translation services
- transportation programs
- emergency and urgent care policies
- benefits

However, please note that I had an extremely difficult time comparing the benefits that the HMOs offered. Why? Because the HMOs are not required to standardize how they define their benefits. For instance, while some HMOs limit their benefits to a calendar year (i.e., January 1996 to December 1996), other HMOs limit their benefits to a 12 month period (i.e., April 1996 to April 1997), with the period beginning on the month that a member enrolls.

Please also note that the HMOs tended to evade questions regarding their medical protocols for treating people with cancer, heart disease, stroke and other complex and costly health care services. They refused to divulge their criteria and procedures for making medical necessity decisions and did not explain the circumstances under which certain benefits are covered.

Moreover, most HMOs did not make their drug formularies available. Therefore, beneficiaries do not know which drugs the HMO's prescription drug benefit covers and does not cover before they enroll in the plan.

Furthermore, many HMOs did not answer our questions about the financial incentives that the HMOs have installed in order to manage their physicians' activities; their members' disenrollment rates; their physician disenrollment rates; and the grievances and appeals filed against the HMO.

Clearly, there is a very large hole in the information released by the HMOs to the public. While there are organizations, such as the National Committee for Quality Assurance, that attempt to review and evaluate the HMOs, these organizations have had access so far only to preliminary HMO information, such as the HMO's administrative structures and delivery of care procedures. Moreover, much of the HMO data that they review is self-reported and unaudited. Meanwhile, the information that strikes at the heart of this quality of care debate -- such as the medical protocols, physician financial incentives, and health outcomes -- remains inaccessible to the public.

APPENDIX D

Medicare Rights Center

April 2, 1997

Paul Frankel
NYLCare Health Plan of New York
75-20 Astoria Boulevard
Jackson Heights, NY 11370

Dear Mr. Frankel:

Thank you for your comments on our comparability charts of Medicare managed care plans. I have reviewed the corrections that you have submitted for NYLCare 65 and have some questions regarding your comments. I have listed my questions below.

- In response to "**Transportation to routine, non-urgent visits**", you changed our original answer of "**Yes**" to "**No.**"
  ⇒ I have a copy of *Comparison of Benefits - NYLCare 65 Health Plan.* According to that guide, NYLCare 65 offers "transportation to and from physician's office... No charge when coordinated by your primary care physician." Is NYLCare 65 no longer offering this benefit?

- In response to "**Routine eye exams**", you forwarded the following correction: "**$0 copay, same as FFS Medicare coverage**". In addition, in response to "Regular eyewear", you forwarded the following correction: "**Once every 2 years, $10 copay for optometrist exam and $100 toward glasses at participating vision provider**".
  ⇒ Your answers are confusing for the following two reasons: (a) You mentioned that for routine eye exams there is $0 copay, same as FFS Medicare coverage. However, FFS Medicare does not cover routine eye exams. The beneficiary therefore must pay for the full cost of a routine eye exam. (b) In response to the first question, you state there is a $0 copay for routine eye exams. In response to the second question, you state that there *is* a $10 copay for optometrist exams. How are routine eye exams distinguished from optometrist exams?

Please forward your answers to the above questions by Friday, April 4, 1997.

Thank you again for your time and help.

Sincerely,

Ellen Kim

Ellen H. Kim
Policy Analyst

1460 Broadway New York, New York 10036 Telephone: 212 869-3850 Facsimile: 212 869-3532

APPENDIX E

UHF Survey--Highlights of Preliminary Findings

The Medicare Rights Center is compiling statistics on consumer awareness about HMOs as part of a project funded by the United Hospital Fund to develop a training module and educational materials about HMOs. From an initial survey of 85 seniors, polled just before they attended an MRC presentation on Medicare HMOs, we have compiled preliminary results which suggest that seniors lack knowledge about basic HMO features and rely on HMO marketing for information. As we did not field-test the questions, we appreciate that some may have been ambiguous and have selected the clearest results below.

Some consumers are confused about their own coverage

- Of those who responded, 26% self-reported being in Medicare HMOs (17 out of 81)
- 2 who reported being in Medicare HMOs in fact had Medigap policies. At least 1 other who reported being in a Medicare HMO had HMO coverage as a retiree benefit, but was not in a Medicare HMO.

Many consumers don't understand basic network restrictions in HMOs

Statemend evaluated by consumers: "If you go outside the HMO network, Medicare will always pay 80% of the Medicare approved amount for your care and the HMO will pay the other 20%"

Answers from consumers: (out of 60) T:18% F: 60% Don't Know: 21%

Q: "If you travel outside of the HMO's service area, the HMO will not cover you but Medicare will cover any health care you may need while traveling."

A: (out of 50) T: 30% F: 36% Don't Know: 34%

Q: "If you travel outside the HMO's service area, the HMO will cover only emergency or urgent care you may need while traveling."

A: (out of 57) T 40% F 26% Don't Know: 33%

Consumers understand benefits and costs better than they do risk and quality.

Q: If you were advising a friend about whether or not to join an HMO, what would you tell that friend are the most important things to ask or to know about before joining?

A: suggestions mentioned: "all info available"
coverage
benefits
primary care physician
premiums
paperwork
"don't join"
"ask around."

Consumers are getting most of their information from HMO marketing

Q: Is the information you would want that friend to have available to you? From what sources is it available?

A: HMO: 6 mentions
No/ Not sure: 3.
Others mentioned: hospital, retiree benefits office, TV/ magazines/government

Q: From which sources have you received information about HMOs?

A: HMO materials--37 mentions
Government--9
Print articles--32
TV ads/commercials--26
Print ads--15
Others mentioned: Meeting sessions/meals, word of mouth, employer, telephone sales.

Q: If you had an objective, neutral organization watching over the HMO and helping you when you had problems, would you feel more comfortable joining the HMO?

A: (out of 42) Y 80%. N 20%

The CHAIRMAN. Thank you.
Dr. Scanlon.

STATEMENT OF WILLIAM SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. SCANLON. Thank you, Mr. Chairman and members of the committee. I am very pleased to be here today to discuss the steps that HCFA could take to better meet Medicare beneficiaries' need for comparative information on HMO's. As you know, Medicare HMO's must cover all the benefits available under traditional fee-for-service Medicare, but they differ from one another in additional benefits provided, required premiums, networks of providers, and ability to satisfy their members. Because of these differences, beneficiaries need information to pick the plan that is right for them.

With their additional benefits and relatively low out-of-pocket costs, HMO's are attracting, as you noted, Mr. Chairman, a growing number of Medicare beneficiaries. About 4.4 million of the current 38 million Medicare beneficiaries are now enrolled in a risk contract HMO, and that number is increasing at a rate of 85,000 members per month.

At the request of the chairman of the committee and the ranking minority member as well as other members of this committee, we reviewed HCFA's performance in providing beneficiaries information about Medicare HMO's. Based on our findings, we recommended several steps that HCFA could take right away in the area of providing consumer information. Let me explain to you what we found.

First, HCFA does not distribute comparative consumer guides to beneficiaries as do other payers for health plans. Therefore, HCFA is lagging considerably behind employer-based health insurance programs and the Federal Employee Health Benefits Program in terms of distributing such guides. A few of HCFA's regional offices have produced HMO comparison charts for selected market areas, but the charts do not go directly to beneficiaries. Instead, they are distributed mainly to federally supported insurance counselors, some news organizations and HMO's. Beneficiaries could ask for the charts, but few would know that the charts exist. Even insurance counselors, most of whom are volunteers, may be unaware that the charts are unavailable.

This leads to a second problem: beneficiaries must rely solely on HMO's' marketing materials to draw their own comparisons, but that is a very difficult job, because the sales brochures use different terms and different layouts. For example, in trying to compare prescription drug benefits across HMO's, a person can encounter the following terms: preferred drugs, covered drugs, formulary drugs, legend drugs and authorized drugs. To illustrate the diversity and quantity of material a beneficiary would have to wade through to make comparisons, let me call your attention to the wall we have put up over here.

These are only the benefit summaries from the marketing packages distributed by 14 Los Angeles HMO's operating in 1995. We had similar difficulty to what Ms. Archer experienced in terms of collecting these marketing materials; and we were able to assemble

this, but looking at them, one understands quickly that without a comparison chart, a beneficiary would have to study this wall of text to assess the costs and benefits of an area's HMO's.

HCFA could help beneficiaries so that they do not have to face this wall alone. HCFA collects volumes of information on Medicare HMO's that could be summarized, packaged and distributed to help beneficiaries choose among competing HMO's. Let us take this enrollment data as just one example. To illustrate its value, we analyzed 1995 disenrollment data for two large managed care markets: Los Angeles and Miami, and the chart over there will show you the results for the Los Angeles market area.

Within each market, we found that Medicare HMO's' ability to retain beneficiaries varied widely. In fact, for some HMO's in our study, disenrollment rates were high enough to raise questions about whether the HMO's emphasis was on providing health care or continuously recruiting new waves of beneficiaries. In Los Angeles, annual disenrollment rates range from as high at 42 percent at one HMO to as low as 4 percent at another. The situation was similar in Miami but not quite as extreme.

What does this tell a beneficiary? Well, by themselves, disenrollment rates do not indicate the reason for beneficiary dissatisfaction. But they do measure an HMO's ability to retain beneficiaries, and for that reason, disenrollment rates can be helpful to beneficiaries trying to distinguish among seemingly identical HMO's.

HCFA has several consumer initiatives underway, but many of them fall short in one way or another. For example, HCFA plans to make a data base of HMO-specific information available on its Web site. But, as you can imagine, HCFA realizes that many beneficiaries do not surf the Web. Instead, it hopes that insurance counselors, beneficiary advocates and others will distribute this information. Such a passive approach to dissemination may not result in information in the hands of interested beneficiaries.

HCFA is also issuing guidelines for HMO marketing materials distributed to beneficiaries, but compliance with these guidelines is voluntary. Thus, there is really no resolution to the problem of diverse formats and nonstandard terminology that you see on the wall. HCFA is also planning an HMO enrollee satisfaction survey. At least initially, the survey will only include HMO members who have been satisfied enough to stay in their plans for 12 months or more. Given the high disenrollment rates at some HMO's, the value of HCFA's satisfaction survey is questionable. We have similar concerns about the agency's planned longitudinal study of HMO enrollees' health status.

In conclusion, we are encouraged to see that HCFA is moving to make more information available, but we believe the agency could do much more with relatively little expenditure of time and effort. Specifically, we believe HCFA should require HMO's to use standard terms and formats in their benefit descriptions. They should produce comparison charts and make sure the beneficiaries know how to get such charts, and they should analyze and publish disenrollment data and other available comparative data.

By following these recommendations, HCFA could greatly enhance the ability of Medicare beneficiaries to be wise consumers of managed care.

Mr. Chairman, that concludes my prepared statement. I would be happy to answer any questions you or members of the committee have.

[The prepared statement of Mr. Scanlon follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging,
U.S. Senate

For Release on Delivery
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MEDICARE MANAGED CARE

HCFA Missing Opportunities to Provide Consumer Information

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

GAO/T-HEHS-97-109

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss Medicare beneficiaries' need for comparative information on health maintenance organizations (HMO) and steps the Health Care Financing Administration (HCFA) could take to meet that need promptly. Such information would be useful not only to the more than 4 million Medicare beneficiaries enrolled in HMOs, but also to the millions of beneficiaries expected to enroll in a managed care plan during the next several years. Although Medicare HMOs must cover all the benefits available under traditional fee-for-service Medicare, they differ from one another in additional benefits provided, required premiums, networks of providers, and ability to satisfy members. Because of these differences, beneficiaries need information to pick the plan that is right for them.

Last October, at the request of the Chairman, the Ranking Minority Member, and other members of the Senate Special Committee on Aging, we reported[1] on the marketing, education, and enrollment practices of Medicare risk HMOs.[2] We also reviewed HCFA's performance in providing beneficiaries information about Medicare HMOs and the usefulness of readily available HCFA data to caution beneficiaries about poorly performing HMOs. To develop this information, we interviewed representatives from HCFA, large health care purchasing organizations, HMOs, and beneficiary advocacy groups; reviewed beneficiary case files; studied HMO marketing materials; and analyzed HMO data available to HCFA. In our report, we recommended several steps that the Secretary of Health and Human Services should take promptly to help Medicare beneficiaries make informed health care decisions. Today, I will discuss both our report's findings and HCFA's plans to provide beneficiaries with more information about HMOs.

In summary, we found that HCFA does not distribute to beneficiaries comparative consumer guides such as those the federal government and many employer-based health insurance programs routinely distribute to their employees and retirees. Without these guides, beneficiaries cannot easily compare HMOs. Marketing materials distributed by HMOs are of little help because HMOs describe their benefits and costs using different terms and formats.

Although beneficiaries lack information on HMOs, HCFA does not. HCFA amasses volumes of information that could be summarized, packaged, and distributed to help beneficiaries choose among competing Medicare HMOs. For example, HCFA compiles information that can be used to construct HMO benefit comparison charts. HCFA also

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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]Risk HMOs assume the financial risk of providing care for the monthly capitated amount Medicare pays.

routinely collects other information–such as disenrollment rates, beneficiary complaints about HMOs, and the results of HCFA's HMO monitoring visits–that could be provided to beneficiaries. Because some plans do a better job of retaining Medicare beneficiaries than others, disenrollment rates–an indicator of beneficiary satisfaction–may be especially useful in helping beneficiaries distinguish among competing HMOs. For example, our analysis of HCFA's data showed that 1995 annual disenrollment rates ranged from 4 to 42 percent among Los Angeles HMOs and from 12 to 37 percent among Miami HMOs.

HCFA has initiatives, planned or under way, that will make some comparative HMO information available to beneficiaries. Although these initiatives are steps in the right direction, they are very small steps. With little additional time or effort, HCFA could do much more to help Medicare beneficiaries make informed selections among available HMOs. Specifically, HCFA should adopt the recommendations in our report by

- requiring standard formats and terminology in HMOs' informational materials;
- producing benefit and cost comparison charts with all Medicare HMO options available for each market area and ensuring that interested beneficiaries are notified of the charts' availability; and
- analyzing and widely distributing data it already collects–such as HMO disenrollment rates, complaint rates, and the results of HMO monitoring visits–that can help beneficiaries distinguish among competing HMOs.

BACKGROUND

Most beneficiaries live in areas where they can choose to receive Medicare benefits either through an HMO or through a traditional fee-for-service arrangement. HMOs are required to cover all Medicare benefits, but many also provide additional services, such as outpatient prescription drugs, routine physical exams, and hearing aids, that are not covered under traditional Medicare. Enrollees' cost varies as well; some HMOs charge a monthly premium but others do not.[3] In return for the advantages offered by HMOs, beneficiaries give up their freedom to choose any provider. If a beneficiary enrolled in an HMO seeks nonemergency care from providers other than those designated by the HMO, or seeks care without following the HMO's referral policy, the beneficiary is liable for the full cost of that care.

Because of the additional benefits offered by HMOs and the relatively low out-of-pocket costs, growing numbers of Medicare beneficiaries are leaving Medicare fee-for-service and joining managed care plans. In fact, Medicare HMO enrollment is growing by

[3]Beneficiaries must continue to pay a monthly premium to Medicare for part B (currently, $43.80 per month).

about 85,000 beneficiaries per month. More than 11 percent, or 4.4 million, of the 38 million Medicare beneficiaries are now enrolled in "risk contract" HMOs. The Congressional Budget Office estimates that nearly 15 million beneficiaries will be enrolled in a risk HMO by the year 2007.

MEDICARE DOES NOT DISTRIBUTE HEALTH PLAN INFORMATION TO BENEFICIARIES

Medicare currently lags behind other large purchasers in helping beneficiaries choose among plans. The Federal Employees Health Benefits Program, the California Public Employees' Retirement System, Xerox Corporation, and Southern California Edison are all large health care purchasers that provide enrollees with comparative information such as premium rates, benefits, out-of-pocket costs, and member satisfaction survey results for available plans. By contrast, HCFA does not routinely provide beneficiaries comparative information about the Medicare HMOs available in their area.

For the last few years, however, HCFA's regional office in San Francisco has produced HMO comparison charts for selected market areas.[4] More recently, HCFA's regional office in Philadelphia has also produced comparison charts. The regional offices distribute these charts, however, mainly to HMOs, some news organizations, and federally supported insurance counselors in the Information, Counseling, and Assistance (ICA) program.[5] Beneficiaries may request the charts from the regional offices, but few beneficiaries know the charts exist. Even the ICA insurance counselors, most of whom are volunteers, may be unaware of the charts. When GAO staff called a Los Angeles ICA insurance counselor and asked specifically about Medicare HMO information, the counselor did not mention that comparison charts were available.

Beneficiaries Face a Nearly Impossible Task to Compare HMOs' Costs and Benefits

For beneficiaries considering Medicare managed care for the first time or switching to a new plan, getting information on area HMOs can be time consuming. Beneficiaries must first find the correct telephone number to request a list of area plans and then call each plan and request information. When our staff called all 14 Medicare HMOs in Los Angeles to request their marketing materials, information from only 10 plans was received

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[4]However, the regional office has not yet issued 1997 comparison charts–even though the capitation rates Medicare pays to HMOs, and thus their premiums and benefits, changed on January 1, 1997.

[5]The ICA program is federally supported but state-managed. ICA counselors can provide beneficiaries with general information about Medicare, Medicaid, managed care plans, and various types of health insurance available to supplement Medicare.

after several weeks and many follow-up phone calls. Some plans were reluctant to mail the information but offered to send it with a sales agent. Declining visits from sales agents, we finally received the missing brochures by calling the HMOs' marketing directors and insisting the materials be mailed.

Using HMOs' marketing materials to compare HMOs' benefits and costs is extremely difficult because each plan uses different formats and terminology. One Los Angeles HMO's "summary of benefits" spanned 14 pages; another had only a 1-page summary. All together, just the benefit summaries from the 14 Los Angeles HMOs operating in 1995 cover a 10-foot-wide wall. Moreover, terminology differs from plan to plan. A beneficiary reading the marketing materials from several HMOs may not be able to tell, for example, which HMO provides better prescription drug coverage. Most HMOs that offer a drug benefit place an annual limit or cap on the dollar amount covered. Two HMOs with seemingly identical $1,000 annual drug limits may not offer equivalent benefits, however. One HMO may count its actual drug costs, including any discounts it receives, in computing its limit, while the other HMO may use generally higher manufacturers' list prices in computing its limit. Furthermore, 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 limits.

HCFA COULD PACKAGE AND DISTRIBUTE AVAILABLE INFORMATION ON HMOS

HCFA has a wealth of data collected for program administration and contract oversight purposes that can indicate beneficiaries' relative satisfaction with individual HMOs. These indicators include statistics on beneficiary disenrollment and complaint rates. In addition, HCFA collects other HMO-specific information, including plans' financial data and reports from monitoring visits to HMOs. However, HCFA does not routinely distribute this potentially useful information.

Publishing Disenrollment Rates Could Help Beneficiaries Compare Competing HMOs

Because Medicare beneficiaries enrolled in HMOs can vote with their feet each month–switching plans or returning to fee-for-service–a comparison of HMOs' disenrollment rates can suggest beneficiaries' relative satisfaction with plans' service, benefits, out-of-pocket costs, and quality. If beneficiaries are about equally satisfied with HMOs in a market, these HMOs' disenrollment rates should be about the same. Despite the potential value of such information, however, HCFA neither routinely nor systematically compares HMO disenrollment rates. Thus, HCFA misses an opportunity to inform beneficiaries of plans with good records of retaining Medicare enrollees.

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To illustrate the value of disenrollment rates as an indicator, we analyzed 1995 HCFA disenrollment data for two large managed care markets: Los Angeles and Miami. We found that Medicare HMOs' ability to retain beneficiaries varied widely among HMOs in the same market.[6] For some HMOs, disenrollment rates were high enough to raise questions about whether the HMO's emphasis was on providing health care to enrollees or recruiting new enrollees to replace the many who disenrolled.

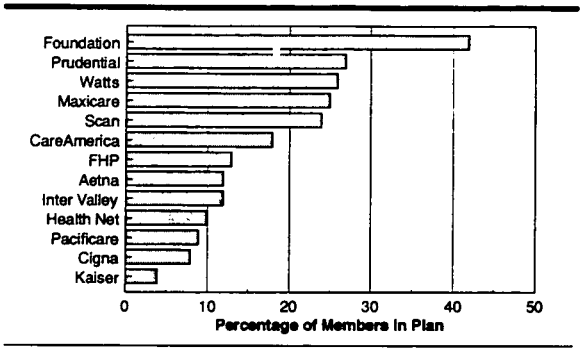
Annual disenrollment rates[7] varied substantially among HMOs operating in the same market. Among the 13 Los Angeles HMOs[8] we analyzed, Foundation Health's 42 percent disenrollment rate was the highest in 1995. (See fig. 1.) Four other plans, however, had disenrollment rates exceeding 20 percent. In contrast, several HMOs had disenrollment rates of 10 percent or less. Kaiser Foundation Health Plan had the lowest rate--4 percent. The seven Miami HMOs active for all of 1995 showed a similar, although slightly less extreme pattern.

[6]We excluded from our analysis disenrollments due to beneficiary death or loss of Medicare part B eligibility.

[7]Annual disenrollment rates represent the percentage of an HMO's average Medicare enrollment lost to disenrollment after excluding disenrollments due to death or loss of Medicare part B eligibility.

[8]One Los Angeles HMO was excluded from our analysis because it had fewer than 100 members.

Figure 1: Los Angeles Medicare HMOs' Annual Disenrollment Rates, 1995



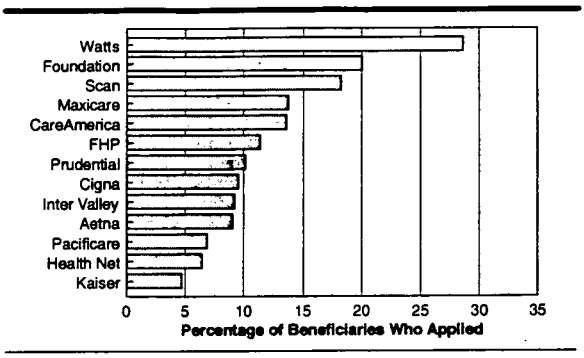
Note: Annual disenrollment rates are the number of beneficiaries who disenrolled--excluding members who died or lost Medicare part B eligibility--in 1995 compared with the average number of enrollees in 1995.

Source: GAO analysis of HCFA disenrollment data.

Beneficiaries who leave an HMO within a short time are more likely to have been poorly informed about managed care in general or about the specific HMO they joined than those who leave after a longer time. Consequently, rates of early disenrollment may indicate beneficiary confusion and marketing problems. In our early disenrollment calculations we included both cancellations--beneficiaries who signed an application but canceled before the effective date--and "rapid disenrollment"--beneficiaries who left within 3 months of enrollment.

Our analysis showed a wide variation in plans' early disenrollment rates. In 1995, Medicare HMOs in Los Angeles had early disenrollment rates ranging from 5 to 29 percent. (See fig. 2.) For Miami HMOs, early disenrollment rates ranged from 9 to 30 percent. That is, nearly one out of three beneficiaries who signed an application with Watts Health Foundation, Inc. (Los Angeles) or CareFlorida (Miami) canceled the application or left the plan shortly after the effective date.

Figure 2: Los Angeles Medicare HMOs' Rates of Early Disenrollment, 1995



Source: GAO analysis of HCFA data.

Disenrollment rates do not indicate the reason for beneficiary dissatisfaction. Out-of-pocket costs, access, or quality issues can all affect beneficiaries' decisions to disenroll. However, we found such large variations within market areas that, even as gross indicators, disenrollment rates can provide valuable information to beneficiaries trying to distinguish among seemingly identical HMOs. Furthermore, if disenrollment rates are published, then health plans may begin to compete on the basis of service and member retention as well as price and drug benefits. In fact, at least one Medicare HMO with low disenrollment advertises its member retention rate. Because beneficiaries do not know about competing plans' member retention (or disenrollment) rates, however, they cannot use this information to compare plans.

HCFA'S CONSUMER INFORMATION INITIATIVES FALL SHORT OF REACHABLE GOALS

HCFA has several initiatives to compile information on Medicare HMOs, make that information available, and increase consistency among HMOs' marketing materials. These initiatives include

- making a database of HMO information available on the Internet;

- issuing National Marketing Guidelines for HMOs to follow when preparing materials distributed to beneficiaries;

- conducting a satisfaction survey of HMO enrollees; and

- compiling selected HMO performance measures from the Health Plan Employer Data and Information Set 3.0 (HEDIS 3.0),[9] including data from a longitudinal study of HMO enrollees' health status.

Although these initiatives are a step in the right direction, many of them fall short in one way or another. For example, HCFA's planned Internet HMO database may have limited value to beneficiaries. Although the information will be available, it may not reach beneficiaries who want it. Many beneficiaries may lack Internet access or the computer sophistication necessary to use the database. HCFA realizes that relatively few Medicare beneficiaries "surf the Web." HCFA expects that HCFA regional offices, the Aging Network, insurance counselors, and beneficiary advocates will be the primary users of the database and will distribute the information to beneficiaries. Such a system can break down, however, as we discovered when we called the Los Angeles ICA office seeking information on HMOs.

HCFA's National Marketing Guidelines initiative may not ensure that beneficiaries can readily compare HMOs using plans' marketing materials. As currently drafted, the guidelines will not require HMOs to use standard formats and terminology in their marketing materials. Because adherence to the model formats in the guidelines is to be voluntary, plans may continue to produce and distribute very dissimilar marketing materials–like we obtained from the Los Angeles HMOs.

The initial HMO enrollee satisfaction survey results may be of limited value because the initial survey excludes beneficiaries who were so dissatisfied with their health plan that they disenrolled.[10] HCFA plans to conduct the survey–known as the Consumer Assessments of Health Plans Study–this summer and release the results in the fall.

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[9]HCFA's selected HEDIS 3.0 measures include: effectiveness of care, access to/availability of care, health plan stability, use of services, cost of care, informed health care choices, and health plan descriptive information. HCFA helped develop and fund the National Committee for Quality Assurance's efforts to develop Medicare-specific clinical effectiveness measures included in HEDIS 3.0.

[10]According to HCFA's recently published regulations on physician incentive plans in managed care settings, HMOs with providers that have been determined to be at substantial financial risk will be required to conduct a survey of current and recently disenrolled members. Plans that are not required to do a survey under the physician incentive regulations are not required to conduct a disenrollment survey.

However, HCFA will survey only beneficiaries who have been continuously enrolled in the same plan for 12 months or more. In the two markets we studied, we found that PCA, CareFlorida, Foundation, Prudential (Los Angeles), and Watts lost more than 25 percent of their members (excluding deaths and loss of eligibility) in 1995. HCFA's survey will miss these Medicare beneficiaries.

We have similar concerns about HCFA's planned longitudinal study of HMO enrollee health status. HCFA plans to gather self-reported health status data from a sample of HMO enrollees and then resurvey those same enrollees 2 years later to determine if their health status has improved, stayed the same, or deteriorated. HCFA intends to compare health outcomes in specific HMOs using the survey results. This survey, however, will miss beneficiaries who become ill and leave because they are dissatisfied with the care they received in their health plan. Moreover, because the study is longitudinal, HCFA does not expect these data to be available until 1999.

CONCLUSIONS

Medicare beneficiaries need more and better information so that they can make informed decisions when choosing a health plan. Though Medicare is the nation's largest purchaser of managed care services, it lags behind other large purchasers in providing comparative information to beneficiaries. The need for this information grows more urgent each month as tens of thousands of beneficiaries join the already 4 million beneficiaries who have opted for the advantages of Medicare managed care. HCFA is moving in the right direction to make information available, but we believe the agency could do much more with relatively little expenditure of time or effort. Requiring that HMOs use standard terminology and formats to describe benefits, producing comparison charts and ensuring that interested beneficiaries know how to get such charts, and analyzing and publishing comparative data already available (such as disenrollment rates) would greatly enhance the ability of Medicare beneficiaries to be wise consumers of managed care.

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

For more information on this testimony, please call James C. Cosgrove, Assistant Director, Health Financing and Systems Issues, on (202) 512-7029. Other major contributors to this statement include Charles A. Walter, Marie E. Cushing, George M. Duncan, and Wayne J. Turowski.

RELATED GAO PRODUCTS

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

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-63, Jan. 18, 1996).

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

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

(101537)

The CHAIRMAN. Well, thank you, and I also want to thank all of the witnesses, because you stayed within your time, and that does not happen very often, and it makes my job a lot easier. I appreciate that.

First of all, I will go rounds of 5 minutes, but as some of you have been so good in coming to the hearing, if any of you have to leave before that time would come, I would give my time to you to do it now. If you want to go first, you can. I always want to offer this at our hearings if there is unanimous consent to do that.

Senator WYDEN. Mr. Chairman, you are very gracious. Given your comments, I would just ask if I could use only one question because I do have a hearing.

I think it is bizarre that the Health Care Financing Administration would drag its feet about giving out information about disenrollment or older people leaving the plans. I want to ask you about it. The foot dragging seems to be based on the idea that the Health Care Financing Administration is concerned about what they call the snowbird phenomenon. It is my understanding that the snowbird phenomenon is the notion that a high disenrollment rate in a northern area does not mean the same thing as a high disenrollment rate in a southern area. But it seems to me that it would be very easy to deal with this phenomenon. All you would do is compare disenrollment rates within a market. In other words, you look at disenrollment rates within the north; then, you look at disenrollment rates within the south. Then you are done. You have an understandable, straightforward way of dealing with it.

Since the chairman was kind enough to give me a question, I would just ask you, Ms. Archer; you, Mr. Scanlon, would that approach not solve this problem, and we would be on our way to dealing with it?

Ms. ARCHER. I think you are right. That would solve that problem. But you are assuming that HCFA is collecting good disenrollment data today, and we actually collected disenrollment data directly from the plans and then compared that data against the HCFA data, and I do not want to assume that the plans were wrong in their reports, but they were so far off from what HCFA was saying that somebody was wrong somewhere. HCFA actually, when we called them, said that we should not rely on their disenrollment data. So, I think the first step is to get HCFA to collect good disenrollment data. Absolutely, within a region, the disenrollment data can be looked at one plan against another. I think while we do not have good quality information, good outcome information, plan performance information, the disenrollment data is about the best we can do to show people what plans people are happy with. I think it is very valuable data, and you are absolutely right: it needs to get disclosed, and it needs to be accurate when it is disclosed.

One other point on that, just to emphasize the accuracy point: we also shared with HCFA our downstate New York chart just recently, and on Monday, we got back a letter from them with a copy of their chart for our region, which we were seeing for the first time, which was much shorter than ours. What was interesting was that they told us that they could not speak to the information that we had that they were not collecting, but with regard to the infor-

mation that both we and they were collecting, they said that some of our information was wrong, and that was probably because we got it from the wrong HMO sources.

So, we, of course, then took direct, immediate action, because we had verified with the HMO's all of our information. I am sorry we do not have the overhead projector up still, but what we found was that HCFA was wrong half the time, and we were wrong half the time. So, that really caused us great concern, because we had already double-checked with the HMO's on the accuracy of our data, and, all of a sudden, now, they were telling us that we were wrong. Yet, HCFA was giving out this data, and they were wrong half the time.

So, this is very problematic, because HCFA needs to be sure to be reporting accurate data, and it has to be up-to-date, because some data is changing not yearly but monthly. So, these are issues that we have to look into, too, and I am not quite sure how to address them.

Mr. SCANLON. I would agree with both Senator Wyden, your premise that by comparing HMO's within a market, one does get an accurate comparison that is not contaminated by the snowbird phenomenon or by other phenomena that may vary across market areas, and that is why, in our report, we chose to look at Los Angeles as one unit and Miami as another unit, and we would think that that would be the appropriate way to approach disenrollment data, that, in fact, plans themselves are using disenrollment data in some of their marketing, because they realize that people put store in terms of the satisfaction levels that are high enough to keep you enrolled, sort of, within their plan. So, we think it is a valuable bit of information for consumers.

With respect to the accuracy of HCFA information on disenrollments, we developed our own disenrollment rates using HCFA's administrative records for payments to HMO's. We think that the data exist within HCFA to be able to calculate an accurate disenrollment rate, to be able to look month-by-month and to fairly identify what the rate is for different HMO's. One of the premises or one of the hypotheses that has existed for a long time in health care is if it is not used for payment, we sometimes do not get the right answers. Since HCFA's disenrollment reports have not been compiled for payment purposes or to serve beneficiaries, it is not surprising perhaps, that the reports are not up-to-date and not always accurate.

Senator WYDEN. Mr. Chairman, thank you for your thoughtfulness.

The CHAIRMAN. Thank you.

As a follow-up on this, would there be any correlation between organizations who do not have understandable information for people to choose to join or not to join and disenrollment? Maybe there have been no studies, but if there are, that is what my question is related to or whether you have any suspicion along that line.

Mr. SCANLON. We do have some suspicion, and I think that there is some confirmation of it in some of the work that the HHS IG has done. In looking at some of the HMO's that have had larger disenrollment rates and surveying people who disenrolled, there was a discovery that more of their beneficiaries did not understand

what they were getting into when they enrolled in that HMO. They did not realize the restrictions on choice of physician and choice of other services. They sometimes thought they were actually signing up for a medigap policy rather than signing up for an HMO.

So, I think it is an issue with both the written information as well as another very important aspect of Medicare enrollment is, that what you hear from the salesperson who is explaining the plan to you. What we found is that the potential for salesmen to not give you complete and accurate information does seem to be correlated with disenrollment.

The CHAIRMAN. Mr. Stuart, my question is a very general question. Do you think that your hesitancy to join a managed care plan is related to your lack of experience with this type of plan or because you have not gotten information that you need to make an informed choice?

Mr. STUART. Well, I think it is a combination of both things. Not having the experience in this area before or not having to have compiled this information before, it makes you a little apprehensive as to which direction you should go in. When you start to compile the information, and you start getting this information, and you hear various other things, you realize that you can enroll in a policy or an HMO or any of these policies, but it is the things that are not told and the things that people, when having medical problems, suddenly find out, well, I am not covered by this particular thing, or we do not cover that, or we do not do that, or we do not do that.

So, I mean, you are at the age that you want to have as much certainty as you can have as to your coverage so that if you are sick, you can at least say that aspect of my life is at least covered; I can get adequate medical attention, not lay in a hospital room and say, now, I wonder if this is going to be paid for; I wonder if that is going to be paid for. You have other things to concern yourself with. That is pretty much my feeling in that area.

The CHAIRMAN. OK; let me ask you about a suggestion that we are hearing that HCFA, the Health Care Financing Administration, plans to start publishing comparative data on premiums and cost-sharing and information on additional benefits under Medicare managed care by the Internet sometime this summer. Now, I suppose that they would readily admit that a lot of people do not have access to the Internet, so, they are hoping that organizations like the AARP or other insurance counseling and assistance programs would access that information for their beneficiaries.

But I want to ask you, as an individual citizen and obviously not a person who relies upon a lot of organizations—you go out and seek your own information—and I am not only asking you what you think but what you think other Medicare beneficiaries think about HCFA's plan to use the Internet. Would it be helpful to people like you?

Mr. STUART. Well, I think it would be helpful, and I think it is necessary. Now, whether putting it on the Internet is the proper solution, I don't know because people of this age group are not always used to using computers and do not always have the patience of scanning the Internet. So, there should be some way of getting the information to people.

The CHAIRMAN. In other words, your statement is that the Internet is not a very useful tool to accomplish that.

Mr. STUART. It is a tool, but I do not think it is the ultimate tool in doing this.

The CHAIRMAN. Diane, you recommended—or, I think your organization is recommending—some standardization of benefits as one way of helping. Because that obviously might be difficult for us to accomplish, I ask this question: is it possible to compare these plans through the use of standard terms for benefits without standardizing the benefits in managed care?

Ms. ARCHER. Chairman Grassley, I think it is, and I think that that is a good way to go, at least initially. I think that what we need to do is to make sure that if one plan is offering a $1,000 drug benefit, and another is offering a $1,000 drug benefit that it is easy for someone to know that they are getting the same benefit from both plans. Right now, two plans may be offering a $1,000 benefit, but one may have a quarterly cap, and another might not. Or, one might have a 30-day supply of drugs with a $5 copay, and another would have a 90-day supply of drugs with a $10 copay. It is still hard to evaluate whether you are getting the same thing from each of the two $1,000 drug packages. So, if we standardize the terms, and people could easily see that they are getting the same benefit, that would be a really great step.

With regard to the Internet, I would just like to add that I think it is important to have it on the Internet, because the data is changing constantly. But probably the most cost-effective way to deal with this issue of getting the information into the hands of seniors quickly—and it just hit me right now—is for HCFA to make the HMO's give out charts for their county that HCFA puts together to people who are shopping in that county for an HMO.

The CHAIRMAN. OK; Dr. Scanlon, my last question before I go to the next colleague is whether HCFA currently collects data for health plans in any sort of standardized format, and also, in your estimation, would it be a costly and time-consuming endeavor for HCFA to require health plans to report data in standardized format and make sure that this information is available in a comparative chart form?

Mr. SCANLON. HCFA does not currently collect the information in a standardized format. HCFA does review the marketing materials that plans are going to share with beneficiaries and approves them. However, the format choices are left to the plans. HCFA has moved to implement some national marketing guidelines, but they are going to be voluntary. In some respects, they are geared towards facilitating the review process as opposed to standardizing the kinds of information that are going to be available to beneficiaries.

It would actually, I think, simplify HCFA's job if there was standardization required, because HCFA is planning on putting together, as we have indicated, the information that will appear on the Internet, and from our conversations with people at HCFA, it is proving to be a difficult task. They are having to take information similar to what is on the wall and boil it down into a comparative chart, and that chore is much more difficult, because they have to struggle with how do they translate the information that is of

varying length and varying complexity there into something that fits into one uniform chart.

The CHAIRMAN. Thank you.

Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. I thank the witnesses for their testimony. Apparently, on March 6, the House Ways and Means Committee must have gotten the lineup of witnesses correct, because HCFA appeared over there. It is not my job to defend them in their absence, but in that hearing, HCFA, according to some of the observations, has begun moving in the right direction by publishing some consumer-friendly Medicare guides. According to the testimony of Bruce Vladeck, who did appear over there. "The Clinton administration has made increasing the information it gives to seniors part of the fiscal year 1998 balanced budget proposal. That plan that is before the Congress calls for dissemination of comparative information on all Medicare health insurance options, including medigap plans to beneficiaries at health plans' expense," their expense. "In the meantime, they also plan to distribute via health insurance counseling centers and the Internet," which we talked about, "data comparing the HMO benefits, the premiums and cost-sharing requirements."

They also include in the budget proposal medigap reforms, which would address the problem of switching from a managed care plan back to Medicare, making the transition easier. Recently medigap rules have come under fire from the White House, some Members of Congress and consumer groups for making it difficult for beneficiaries unhappy with managed care because it can be difficult to get back into the Medicare program. So, apparently, HCFA has some plans out there. I just want to lay that on the table.

But what I want to ask, I guess, Mr. Scanlon, this chart is like, as I said, Egyptian hieroglyphics, and I cannot understand it. The problem is that all of this is complicated. I mean, I am looking at the literature for the CalPERS program's, Managed Care in California, for their retired members, and, you know, it gets pretty complicated. I am holding it upside down, but it is hard to tell for me whether it is upside down or not. [Laughter.]

As an attorney who is supposedly used to reading this type of stuff, I would have an awful difficult job of finding out what is good and what is bad and what is right and what is wrong. Maybe it is impossible to make it simple; I do not know. But it seems like the Federal Employees Health Benefit Plan does a fairly good job of giving Members of Congress, Federal employees and retirees a good bit of information that is fairly understandable. Can you compare what we give out with Medicare with what they give out with the CalPERS information versus the Federal employees' package?

Mr. SCANLON. Right; I think that the biggest difference is this issue of standardization.

Senator BREAUX. Excuse me?

Mr. SCANLON. The biggest difference is the issue of standardization.

Senator BREAUX. Standardization?

Mr. SCANLON. The use of the same language across plans in these different types of brochures, both by the Federal employees

and by CalPERS and by some of the state Medicaid programs as well.

Senator BREAUX. There is nothing standardized now?

Mr. SCANLON. I beg your pardon? Nothing on this chart, on the charts on this wall, have been standardized. You can go over there, and you can see different terms, and the ones that I mentioned in my statement about drugs, the generic drugs, legend drugs, formulary drugs and no definition at times as to what it is that is going to be covered by a particular plan.

That, I think, alone is a big step in terms of making this more understandable, but I share your concern that even the best of these descriptions, the best of these comparative descriptions, is difficult to deal with, because there are many dimensions to a health plan, and there is variation across all of those dimensions across different plans. I think that in addition to the information about benefits and prices, we need information about performance of plans, and we also need assistance for individuals, such as the counseling services that Ms. Archer provides, because individuals cannot all manage to walk through all of this information and make a choice that is going to be effective for them.

Senator BREAUX. Is it fair to say that Medicare beneficiaries get the least amount of information?

Mr. SCANLON. Well, I think that Medicare beneficiaries, generally, for a major payor are getting the least amount of information. Most of our larger employers and the public sector plans such as Medicaid programs that are moving individuals into managed care as well as the Federal employees' plan all do a better job.

Senator BREAUX. Of the information that you have looked at out there, which one would you, as a GAO investigative professional, say provides the most concise, understandable information, if you can make that observation?

Mr. SCANLON. We have not tried to make that assessment. In fact, I have walked away from looking at these materials, the best of them, still shaking my head saying I have been in this field 20 years, and it still would be a tough choice for me every time I would face the selection of a plan. I think that is the kind of problem we are dealing with. We have to make this as easy as possible, but we are never going to make it easy.

Senator BREAUX. Well, Mr. Chairman, I would only observe that if GAO cannot figure it out, we have got some real problems out there. [Laughter.]

Mr. Stuart, what did you ever end up with? Have you got your plan figured out yet?

Mr. STUART. I am sorry?

Senator BREAUX. What did you ever end up with health-wise?

Mr. STUART. Well, I have narrowed down some of the plans, but I have not really committed myself to a supplemental plan for the Medicare plan.

Senator BREAUX. I am going to ask you after this hearing to sit down with Mr. Scanlon. Maybe you can help him. [Laughter.]

Well, we thank all of you very much. You have made some really good, helpful suggestions and pointed out the problems.

The CHAIRMAN. Senator Reed.

Senator REED. Thank you, Mr. Chairman. Ms. Archer or Mr. Scanlon, as a baseline issue, how well does HCFA provide information on traditional fee-for-service plans? Because I would think anyone making a judgment between a managed care plan first has to know what he or she is going to get in the fee-for-service plan.

Ms. ARCHER. I think it is a good point. They provide some information on Medicare fee-for-service, but we get thousands of calls a month from people who do not understand what is covered and is not covered under fee-for-service. The big difference, of course, is that under fee-for-service, you can choose your doctor; you have control over your health care, your course of treatment and all kinds of other health care services. Under an HMO, there are constraints on what kinds of services the doctor can perform, and so, the patient who joins the HMO is at greater risk if he or she joins and is not assured of getting the quality care he or she needs.

Senator REED. Along those lines, it seems to me, stepping back and looking at the overall issue that if a senior is going to make an informed choice, just giving them information about the managed care plans that are available, even if it is standardized, is not sufficient to make the right choice. I guess, the other thing in the back of my mind is that, perhaps, there is a fear at HCFA that if you point out the differences between the traditional fee-for-service plans and managed care plans, people might choose fee-for-service, because they will look at the limits under managed care and say, well, there are no limits here.

Ms. ARCHER. That is a good question. Our chart does, actually, include some fee-for-service data. We do think it is critical that any comparison chart also include what is covered under traditional fee-for-service Medicare. Another thing that is critical, though, is that any one of these charts not go out without stating very clearly on them that this is not all of the information that people need to make an informed choice. As we have talked about throughout the morning, quality information, performance data, is not available. Provider lists are not on these charts. Other information about treatment restrictions is not on these charts. The last thing that we want to do is to imply that a chart that HCFA puts out or that we put out contains all of the information people need to make a good decision, and we need to also note that information is changing.

Mr. SCANLON. I would also note that one of the advantages of joining a managed care plan or an HMO under Medicare is that they typically have been offering additional benefits that are not covered by the regular program, and that is really the nub of the comparisons that you are making in terms of the restrictions that you are facing with respect to choice of providers. You are receiving additional drug benefits, vision care, services like that. The question is: have you evaluated whether that tradeoff is acceptable to you, and do you truly benefit from having chosen that HMO?

Senator REED. Allow me to follow up your comments to my questions. Let us assume we have a standardized terminology; we put in some information with respect to the managed care plans versus fee-for-service, and we have advanced the ball further. But your point, Ms. Archer, if we still have to supply a huge disclosure in bold print at the bottom saying this is not all you need to know,

are we going to have seniors in the same sort of dilemma; where do I go now for the information they have told me I need to have; this is just preliminary information.

Ms. ARCHER. There is still a dilemma. As Mr. Scanlon said earlier, these charts are never going to provide all of the information people need. But, at least, it is a good jump start from there. At least people, once they have this, do not have to start hunting for the cost and benefit data. I want to make one other point here that I think it is critical to make, which is that right now, as you know, the studies are showing that the Government is paying the HMO's about 6 percent more on their HMO enrollees than they would have paid for these patients under traditional fee-for-service Medicare. Our concern is that Medicare HMO enrollees may be subject to a terrific health care bait-and-switch and that as more and more people enroll, what Congress is going to be forced to do is to cut back on the AAPCC's significantly, because right now, you are overpaying, and you have to control Medicare costs. I mean, that should be your primary objective here. What is going to happen is that the additional benefits that drove people into HMO's will not be available. The zero premiums that drove people into HMO's will not be available. Premiums will go up; additional benefits will go down, and we just hope that traditional Medicare is still available to them.

Senator REED. Thank you. Let me ask another question, if I may. Again, this is from, perhaps, the ideal perspective of what a senior needs to know. It seems to me—and I am not as knowledgeable as Mr. and Mrs. Stuart, certainly, because they have been dealing with this every day and you and your expertise—but one's benefits under Medicare also are a function of the type of private insurance a person has. Is that a fair statement?

Ms. ARCHER. Ninety percent of Medicare beneficiaries on traditional Medicare have some supplemental coverage that fills in many of the Medicare gaps. If you are in an HMO, you do not need that, because the HMO generally covers those gaps.

Senator REED. So, in effect, and I think you have alluded to this before, in an ideal world, we would have to have some information about the medigap policies also in this informed decision process.

Ms. ARCHER. That is correct.

Senator REED. Mr. Scanlon.

Mr. SCANLON. That is correct. In fact, I would say that one of the things that is in the HCFA proposals in the President's budget is to provide comparative information on both medigap plans as well as HMO's and as well as to provide more information about the quality of care. I think our illustration of disenrollment data and its usefulness is one step. HCFA is also going to conduct a satisfaction survey of beneficiaries in HMO's, and that information will be available and other markers of quality of care.

We would, I think, not be here today if we knew with certainty that HCFA was going to carry through on all of these promises in a timely fashion. We started inquiring about information and standardized benefit descriptions with HCFA in 1993, and we were told that they would be available in 1995. Subsequently, we have seen that date pushed forward several times. So, all of the things that HCFA is planning are very positive, but the issue is that they

are still in the planning phase. We need them to be implemented because beneficiaries, 85,000 a month, are making a choice.

Senator REED. Thank you.

The CHAIRMAN. Thank you.

Senator Moseley-Braun.

STATEMENT OF SENATOR MOSELEY-BRAUN

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman, and I want to commend you again for holding a timely and informative and important hearing such as this one. What we have here is a Tower of Babel, and the truth is that we have an obligation to provide to seniors clear and concise and comparable data so that they can make informed choices. Instead of a Tower of Babel, I think we have the capacity—we certainly have the information—sufficient to provide seniors with the guidance and the information that they will need to make informed choices, and so, providing them with understandable information is a first step toward empowering seniors to make informed decisions.

As Congress considers changes in Medicare and Medicaid, and as managed care becomes more increasingly common, it is important that the magnitude and the implications of this issue are thoroughly examined, and that is why this hearing is so important. Although the majority of Medicare beneficiaries are still enrolled in traditional fee-for-service Medicare, the number of beneficiaries enrolling in managed care is growing about 30 percent annually, and this trend, of course, is expected to continue in the foreseeable future. HMO's entering into risk contracts to cover Medicare patients are required to cover all Medicare benefits. However, competition, the wide variety in payment rates and other factors gives many HMO's the ability to provide additional benefits.

It is the differences among these various HMO's that creates the problem of the Tower of Babel that we are talking about, because the information, while it is there, there is just no way that you can make sense of it or make your way through it. So, information just piled up is not power but can become the Tower of Babel to which I referred, and that is the problem that we are confronting today: beneficiaries need to receive clear and accurate information on the implications of choosing a particular managed care plan. Currently, trying to compare those plans is difficult, again, due to the lack of easily accessed, standardized information.

The Federal Government and employer-based health insurance programs provide their employees and retirees with comparative consumer guides to aid them in their health plan decisions. Medicare beneficiaries seeking the same information face an exhausting, do-it-yourself process, including phone calls, information requests and plan comparisons. The problem is not that Medicare does not have this information but that Medicare does not share available health plan information with its beneficiaries.

So, the point here is very clear that beneficiaries cannot make informed decisions without comprehensible information, and the information that HCFA already collects needs to be used to help beneficiaries in their decisionmaking, so that they can fight for and protect their own rights and can make decisions tailored to meet their own particular needs.

I want to again congratulate the chairman for holding this hearing, the panel for their discussion of the practical realities of the issue and say that I look forward to working with you in the leadership that you have already demonstrated in this important area.

The CHAIRMAN. Thank you.

Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman, and I thank you for holding these hearings. As you know, I am chairman of the Labor and Human Resources Committee, which is looking at legislation now in this area, and as always, your hearings will be very helpful and pertinent to us in our deliberations. I appreciate your concern that consumers have good information in order to compare plans fairly. I also appreciate that HCFA is already capturing much of the information and needs only to put it in a form which is easily usable by consumers.

However, I am concerned that the regulatory cost to the plans of attaining additional information could outweigh the benefits to consumers in some areas. How burdensome do you think implementing GAO's recommendations would be in managed care plans? We will start with that one.

Mr. SCANLON. Well, some of the information that we have proposed that HCFA make available is information that is being supplied by the plans to HCFA now, but in a nonstandard format. While it is being developed and being reviewed, the process of doing those reviews, because of the nonstandardization, probably takes more time than if it had been standardized in the first place, because you end up having quibbles or arguments over whether or not something is acceptable language, and is it going to be clear to beneficiaries. So, we think in some respects, that would be a savings.

In terms of information on disenrollment, that is information that HCFA already has. It would be internal costs and, we think not very significant costs for them to put that in a fashion that can be used by beneficiaries. We did it with very limited resources for these two markets. You only want to do it for markets in which there is significant competition among the HMO's, and there are not that many of them in the country. It is within HCFA's capacity.

In terms of the other kinds of information that HCFA is collecting, HCFA, I think, is doing exactly what major employers are doing. They are saying to HMO's we need to know something about the quality of services that you are providing and the satisfaction of your beneficiaries, and that has really got to be a cost of doing business. HCFA has coordinated with major employers who are working with the National Committee on Quality Assurance to ensure that they are not creating additional burdens beyond what the employer community believes is valuable as well. So, I think that from that perspective, while there will be costs, they are going to be minimized costs in terms of trying to accomplish a very important objective through the collection of this additional information.

Senator JEFFORDS. Other comments?

Ms. ARCHER. I would agree with everything Mr. Scanlon said. It seems to me that it would be very easy for HCFA to ask each of the Medicare HMO's to submit to them the answers to the questions that they would want to put in the chart and to update those

answers as they changed. The HMO's have these answers, and it would be very low cost for HCFA, then, to put together these charts.

Senator JEFFORDS. Well, thank you.

What is the most efficient source of additional information for HCFA? That is, where is the biggest bang for the buck in capturing additional information?

Mr. SCANLON. We think that the administrative data that HCFA already has probably has the biggest bang for the buck in the sense that it is information—such as disenrollment rates, such as information on complaints and information on the review processes that go on in each annual inspection—that is within HCFA's files but is not currently being compiled and disseminated. That information would put no additional burden on the HMO's.

The other types of information that HCFA is planning will provide a more valuable, more complete picture of HMO quality, but they are going to involve the expenditure of additional resources. Those include the satisfaction survey that is being implemented as well as the information on performance measures that HMO's are going to have to submit. So, I think those are, in some respects, sort of less bang for the buck in the sense that it is going to take more bucks, but they are still very valuable in terms of giving you a better picture of quality in HMO's.

Ms. ARCHER. I would just add one thing here: with regard to consumer satisfaction surveys, many plans promote themselves based on their consumer satisfaction ratings, and I think many consumers look to those ratings. It is very important that data that is captured and revealed to consumers goes to satisfaction, specifically, of people with complex and costly illnesses and also to the satisfaction of people who are leaving the plan. One of the problems with the Consumer Assessment of Health Plans survey that HCFA is developing is that it does not capture satisfaction data of the disenrollees. It would be very informative to know why they left the plan.

Senator JEFFORDS. Thank you, Mr. Chairman.

The CHAIRMAN. Yes; I want to call the second panel, so if anybody has any additional questions, I would ask you to submit them in writing.

Particularly to the Stuarts, I thank you for taking time out of your schedule to come down here and be a real, live example of some of the problems that we have.

Ms. Archer, you have worked with us on a daily basis. You know it as well, and on a professional basis, you, Dr. Scanlon. We thank you all.

I will call the second panel now, and the second panel should give us a perspective of health care purchasers who are currently faced with the challenge of providing quality information to beneficiaries in both the public and the private marketplace. We have Helen Darling, who is a manager of the healthcare strategy and programs for the Xerox Corporation. She served as director of three studies of the Institute of Medicine and is here this morning to discuss findings from the 1996 Institute of Medicine report entitled Improving the Medicare Market: Adding Choices and Protections.

In addition, she will talk about her experiences as a health care purchaser at Xerox Corporation.

Our next witness is Margaret Stanley, who is assistant executive officer for health benefit services at the California Public Employees Retirement System. She is responsible for providing health benefits for nearly 1 million State and public agency employees, and she will discuss the information CalPERS currently provides to their enrollees and the cost and manpower requirements associated with it.

I would ask Ms. Darling and then Ms. Stanley to discuss, in that order.

STATEMENT OF HELEN DARLING, MANAGER, HEALTHCARE STRATEGY AND PROGRAMS, XEROX CORPORATION, REPRESENTING THE INSTITUTE OF MEDICINE, STAMFORD, CT

Ms. DARLING. Thank you very much, Mr. Chairman, Senators. I am testifying, as the chairman noted, on behalf of the Committee of the Institute of Medicine, and I think it is very interesting that this report—and the full report is here; it is also available on the Internet, if you want—talks about adding choice and protections. The committee was interested, among other things, in making sure that traditional Medicare continued as a choice, but we wanted to enhance options and make sure that those options were real options.

As you heard this morning, they are not real options, at least in terms of understanding, and it is fascinating, because we made no comparisons, but the testimony that you heard, especially from the Stuarts, was very much what we discovered in our work for the committee. Our committee found that many elderly are making these choices without enough information, as you heard, to judge which option is best for them, what the plan they choose will actually cover and how the plan will operate. On that, I would note that it is not only just what is covered that needs to be fully understood; it is how that coverage is administered. It could be something as simple as eyeglasses, you get one pair every 2 years. I actually had this yesterday with a retiree at Xerox. Now, is that every 2 years counting from 2 years ago, or is it a rolling 2 years, and different plans do it different ways. So, there are all sorts of ways just to simply make life complicated because they administer it differently.

Our study focused on understanding the needs of the Medicare population—and, among others, we had Ms. Archer testifying—and on identifying ways that the Federal Government and private insurers can help them navigate these uncharted waters. Our recommendations are based on a simple premise: that better-informed beneficiaries will make better choices, and that is good for everybody and ultimately will help create—and several of the Senators this morning mentioned this—the system for everybody will get better if we make it better for Medicare beneficiaries, because Medicare is the largest health care purchasing organization in the world. That is sort of the good news for the beneficiaries and the bad news, perhaps for trying to control the Federal budget, but it is a very powerful lever, and it could be used much more effectively.

Enabling these beneficiaries to make informed choices among competing health plans is a critical first step toward assuring that plans are responsive to beneficiaries' needs, and, as I am sure you will hear from Ms. Stanley from CalPERS and certainly from my own experiences at Xerox, if you are a demanding and reasonably demanding but a demanding purchaser, you will, in fact, improve the plans, and the plans themselves will actually appreciate much of that quality.

That there is not a differential selection is also important among Medicare beneficiaries. Until we have a better way to pay for plans, HMO's in particular, there are serious problems if people choose one plan over another. For example, I had one plan tell me one time—they actually have an excellent program in some very narrow areas. They have some of, really, the best. They were not really wild about my using them as an example in national speeches about what a great program it was, because, in fact, then, everybody with that particular problem would, understandably, flock to it.

So, we have to be certain that we are being balanced and fair and informative so that there is the right distribution of illness and disability across the plans. It is vital that the Medicare program be operated in a way that allows beneficiaries to trust their health program, and I noted this morning that the word trust came up many times; to trust their physicians—and much of the work that the Congress is doing now on disclosure is really related to this—and to trust that the information that they are provided is relevant and of high quality.

Many in today's elderly population have not had experience in making choices, just as Mr. Stuart said, among multiple plans even before they retire. In addition, many in this group are very old, frail, disabled, and have multiple chronic health problems that make their choice of health plans and providers not only very meaningful but, in some cases, heart-wrenching if they make the wrong decision and, of course, terrifying. We found that Medicare beneficiaries do not have the information and experience they need to make the choices demanded of them, and many feel a high level of apprehension, another word that Mr. Stuart used, and mistrust about change. This makes them really paralyzed in terms of making a decision.

Many are confused by the political debate and, frankly, frightened by that as well and by newspaper stories that link the notion of choice and managed care with Federal budget cuts. Further exacerbating the problem is the fact that outside of a few key markets where the AAPCC is very high, most health plans have virtually no experience with marketing and dealing with these populations.

The standards that the committee recommended that ought to be required of all health plans that do business with Medicare include an annual open enrollment season to enable beneficiaries to more easily compare the true value of all options. They also need layers of information, the simple, the easy ones to read, as Senator Breaux was talking about, and in much more detail. It needs to be provided to them simultaneously, and then, they can choose what level of detail they want.

The committee also recommended guaranteed renewal of coverage with no exceptions, no exemptions for people with preexisting health problems. They also recommended provision of information to beneficiaries that is specified by the Federal Government to assure informed choice and finally meeting quality certification requirements comparable to those already developed by national private accreditation organizations. Those should be admission criteria to being allowed to be offered to Medicare beneficiaries.

The new reporting and information set—what is called HEDIS 3.0—it is a new, uniform standard set of information which is required of virtually all health plans in the country, now, by the private sector is partially now being required just as of these last few months by the Health Care Financing Administration. HEDIS 3.0, as it is called, will deal with a lot of the problems that were talked about by our former witnesses, frankly, immediately, and plans already have to provide these, Senator, and so, there should be no additional costs for providing what they are already providing to all of the private sector organizations.

We believe that Medicare beneficiaries should be assured that any plan marketed to them meets all of those benchmark requirements in the same way consumers who purchase a new car assume that basic safety standards are being required. Our study also found that the current information to Medicare beneficiaries lags far behind the kinds of assistance provided by progressive private employers. The committee recommends unprecedented efforts to develop and provide information, including the establishment of a new, private information service to educate the public about Medicare's coverages, costs and purpose and to provide broad and objective information. We call for creation of a national customer service center where one can reach a representative who has access to online information; toll-free telephone service; online communications; town meetings; newsletters; et cetera, and the information center, which is a centralized center, but is not run by the health plans, would also track complaints, grievances and appeals and report this information to beneficiaries annually and to health plan CEO's so that they would know immediately. They would have monthly feedback sessions in which they would be told about the problems that the beneficiaries are having.

We also recommend further experimentation with private choice-facilitating organizations to assist beneficiaries in understanding and choosing among plans, and we call for prohibiting health plans from conducting door-to-door marketing and unrequested phone solicitation. As I said, we recommended preserving traditional Medicare in all circumstances and, clearly, at the very beginning of what will be major changes in the Medicare program.

Making the right choice of a health plan is extremely important. Having the information, education and tools to measure the quality of a health plan is imperative to assisting seniors in this choice. Arming Medicare beneficiaries with safeguards as well as understandable information will help them take advantage of these opportunities that come in an environment of expanded choice. All of these actions will improve the quality and accessibility of health plans for all Americans, not just for Medicare beneficiaries.

Thank you for the opportunity to testify, and I look forward to answering your questions.

[The prepared statement of Ms. Darling follows:]

INSTITUTE OF MEDICINE
NATIONAL ACADEMY OF SCIENCES
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United States Senate
Special Committee on Aging

Medicare Beneficiary Information for HMOs
Thursday, April 10, 1997

WRITTEN STATEMENT

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Assuring Public Accountability and Information for Informed Purchasing
by and on Behalf of Medicare Beneficiaries
Institute of Medicine, National Academy of Sciences

and

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The testimony I am providing is based on the recommendations of the August 1996 Institute of Medicine report, ***Improving the Medicare Market: Adding Choice and Protections.*** I served on the Institute of Medicine Committee that wrote this report.

The Medicare program is being transformed by the same forces that are transforming the entire health care system. Even without the action of Congress, the 31-year-old Medicare program is being restructured.

Chief among the changes is a major movement of Medicare beneficiaries away from the current fee-for-service system, in which the majority of the Medicare population continues to receive care, into a broad range of managed care and other delivery options. An average of 80,000 Medicare beneficiaries each month are switching from the traditional Medicare fee-for-service system to some form of managed care. As of January 1, 1997, a total of 4.9 million Medicare beneficiaries were enrolled in managed care.

Our committee found that many elderly are making these new choices without enough information to judge which option is best for them, what the plan they choose will actually cover, or how the plan will operate. Our study focused on understanding the needs of the Medicare population, and on identifying ways that the federal government and private insurers can help them navigate these uncharted waters.

Our recommendations are based on a simple premise: that better informed beneficiaries will make better choices, and ultimately will help create better health plans. Enabling these beneficiaries to make informed choices among competing health plans is a critical step toward assuring that plans are responsive to beneficiaries' needs and that there is not differential selection that might work against Medicare beneficiaries.

It is vital that the Medicare program be operated in a way that enables beneficiaries to trust their health plan, to trust their physicians, and to trust that the information they are provided is relevant and of high quality. Many in today's elderly population have not had experience in making choices among multiple plans, even before they retired. In addition, many in this group are very old, frail, disabled, or have chronic health problems that make their choice of health plans and providers particularly meaningful.

We found that Medicare beneficiaries don't have the information and experience they need to make the choices demanded of them, and many feel a high level of apprehension and mistrust about change. And many are confused by a political debate that links the notion of choice and managed care with federal budget cuts. Further exacerbating the problem is the fact that outside of a few key markets, most health

plans have little experience marketing and providing comprehensive services to this population.

To help build an atmosphere of trust and greater confidence, our report recommends that all health plans approved for marketing to the Medicare population—including the whole spectrum of new managed care options, as well as Medigap plans and traditional Medicare—should be required to meet a series of benchmark standards that assure quality and service.

These standards include:

- an annual open enrollment season to enable beneficiaries to more easily compare the true value of all options;
- guaranteed renewal of coverage with no exemptions for people with pre-existing health problems;
- provision of information to beneficiariesthat is specified by the federal government to assure informed choice; and
- meeting quality certification requirements comparable to those already developed by national private accreditation organizations. The new HEDIS 3.0 requirements announced by HCFA in October are a significant step in the right direction and a substantial improvement in performance measurement of health plans. In addition, our report says that a requirement that there are health plan guidelines about how to enroll, dis-enroll, and file for appeals or grievances should be made easier to access and use.

We believe that Medicare beneficiaries should be assured that any plan marketed to them meets these benchmarks, in the same way consumers who purchase a new car assume that basic safety standards are being required of automakers. The choices made by beneficiaries in their newer, more active role will then drive plans to exceed the benchmarks.

Our study found that the current information available to Medicare beneficiaries lags far behind the kinds of assistance provided by progressive private employers to their employees. The committee recommends unprecedented efforts to develop and provide information, including the establishment of a new private information service, to educate the public about Medicare's coverages, costs, and purpose, and to provide broad and objective information about new care options. We call for creation of a national customer service center, where one could reach a representative who has access to on-line information. Toll-free telephone service, online communications, town meetings, newsletters, and multimedia techniques should be used not only to provide information, but also to track complaints, grievances, and appeals, and to report this

information to beneficiaries annually and to health plan chief executive officers monthly.

We also recommend further experimentation with private "choice facilitating organizations" whose purpose would be to assist beneficiaries in understanding and choosing among plans. And we call for prohibiting health plans from conducting door-to-door marketing and unrequested phone solicitation.

Preserve Traditional Medicare

Finally, we recommend preserving traditional Medicare as a viable option for the foreseeable future, as an essential step toward ensuring the trust and confidence of Medicare beneficiaries. It is especially critical to preserve this "safe harbor" for beneficiaries whose experience with managed care is far more limited than their younger counterparts.

We are clearly at the very beginning of what will be major changes in the Medicare program. As we say in the report, much of this change represents uncharted waters, especially for those currently enrolled in Medicare. Making the right choice of a health plan is extremely important to older Americans. Having the information, education, and tools to measure the quality of a health plan is imperative to assist seniors in this choice. Arming Medicare beneficiaries with safeguards as well as understandable information will help them take advantage of the opportunities that come in an environment of expanded choice.

Thank you for the opportunity to present our committee's recommendations. I look forward to answering your questions. Following this text is an excerpt from our August 1996 report fully detailing the findings and recommendations of our committee.

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Institute of Medicine, National Academy of Sciences

Choice and Managed Care: Assuring Public Accountability and Information for Informed Purchasing By and on Behalf of Medicare Beneficiaries

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Findings and Recommendations

RECOMMENDATION 1

All Medicare choices[1] that meet the standard conditions of participation and that are available in a local market should be offered to Medicare beneficiaries to increase the likelihood that beneficiaries can find a plan of value. Traditional Medicare should be maintained as an option and as an acceptable "safe harbor" for beneficiaries, especially those who are physically or mentally frail.

Number and Type of Health Plans to Be Offered

Findings

Medicare beneficiaries are currently offered traditional Medicare, Medigap policies, and, in many areas of the country, a growing number of alternative health plans. New initiatives in Medicare and proposed reforms of the Medicare program would broaden the number and range of alternative health plans offered.

For most Medicare beneficiaries the range of options and the responsibility for choosing among those options are likely to be significantly greater than those currently available to a large percentage of the working population. Unlike private employers, which have the power to limit the number and types of plans offered, current Medicare practice and proposed reforms would allow any plan that meets specified conditions of participation to sell coverage to Medicare beneficiaries.

Although the committee was cautioned that a large number of choices may increase the confusion for Medicare beneficiaries, it may also increase the ability of Medicare beneficiaries to find a plan that they like, for example, a plan that includes their chosen doctor, that offers valued additional coverage, or that provides convenient access to services. The fear of not being able to continue to see a chosen caregiver has been shown to be a major reason why elderly individuals are reluctant to move into managed care arrangements. Competition among a larger number of health plans will likely produce more innovation on the part of health plans to find ways to be more responsive to the wants and needs of beneficiaries.

The committee also was concerned that limiting the numbers of plans, beyond requiring them

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[1] For the purpose of this chapter, the term Medicare choices is an umbrella term for traditional Medicare, Medigap insurance, and alternative health plans (including managed care).

to meet benchmark[2] conditions of participation, would raise policy and political issues, given the size of the Medicare program and the proportion of total U.S. health care revenues that it represents. Setting limits would have a vast impact on competitors and the market as a whole.

Subrecommendations

The committee recommends that all *Medicare choices* that meet the benchmark conditions of participation be offered to beneficiaries. Conditions of participation should be carefully constructed to bear the burden of assuring informed choice by beneficiaries and accountability by health plans for access to quality systems of care. All *Medicare choices* should have to meet common conditions of participation.

This policy may result in the marketing of plans with limited appeal and small numbers of Medicare beneficiary enrollees over time. The committee recommends that these kinds of plans be tracked over time and evaluated for their potential impacts on risk selection[3] and administrative costs and the extent to which they cause confusion among beneficiaries.

The Traditional Medicare Program

Findings

Given how little is known about ensuring informed choice and holding health plans accountable for providing quality care to Medicare beneficiaries and given the consequent risks for the beneficiaries, the committee believes that traditional Medicare must remain an option and a safe harbor for beneficiaries.[4] This option should be at least as good as the existing Medicare program in terms of benefits, beneficiary cost-sharing, choice of providers, geographic access, and other factors.

The committee believes that maintaining traditional Medicare as a choice is critical for allowing large numbers and a wide range of plans to be offered to Medicare beneficiaries. Without the ability to retain the traditional Medicare program as an option and safe harbor, particularly for beneficiaries who are physically and mentally frail, the committee would not recommend widening the Medicare marketplace to the extent that is advocated in this report.

The committee is aware that traditional indemnity plans are becoming a relic for the market under age 65; many fee-for-service plans have been discontinued because of their high premiums, their noncompetitive benefits, and adverse risk selection. Within this environment, special challenges exist for the future viability of the traditional Medicare program. Constraints on Medicare spending are adding new urgency to managing the costs of care delivered in the traditional Medicare program. Maintaining traditional Medicare as an option is likely to be difficult and could require additional costs to government.

The committee was not able, within the time frame and scope of its task, to make the difficult estimates of these potential costs to government or their wider social implications. The committee is mindful, however, of efforts by the National Academy of Social Insurance, the Prospective Payment

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[2] Benchmark is defined as a floor, with the expectation that participating plans would exceed this level.

[3] As in other sections of the report, the committee understands the inadequacy and limitations of current risk adjustment methods and recommends that further research be supported in this critical area. In the meantime, however, practical requirements necessitate that available techniques be used to make best-judgment decisions.

[4] The committee defines *safe harbor* as a program that is financially stable and that remains an option for the foreseeable future.

Assessment Commission (ProPAC), PPRC, and others to explore ways in which Medicare's fee-for-service program can be shaped in the future to make it more efficient and to improve its management and delivery of care.

Subrecommendations

In the framework of the findings presented above, the committee recommends that HCFA, under its demonstration authorities, accelerate its efforts to identify private-sector purchasing and management techniques that can be adopted appropriately for use by the traditional Medicare program as an alternative to price reductions and, when possible, to offer additional benefits to maintain the program's value. HCFA's current development of "centers of excellence" for high-technology procedures seems an example of such an adaptation.

As indicated elsewhere, it is also critical that risk selection measurement and adjustment technologies be improved for use by traditional Medicare and health plans. As improved technology for measuring risk selection is developed, HCFA should study the traditional Medicare program's risk pool relative to those of other health plans and assess whether program funding fairly reflects Medicare's risk profile to enable it to offer a product of competitive value to beneficiaries. The federal government should also study and pilot test ways to pay health plans more fairly for chronically ill beneficiaries to encourage health plans to invest in and market to those beneficiaries.

Risk Selection

Findings

It was beyond the scope of the present study to address problems of risk selection among the multiple *Medicare choices* and to recommend steps to correct for those problems. During its deliberations, however, the committee found that mechanisms to prevent or correct for risk selection are critical to the ultimate success of any system offering multiple health plan choices and that the existing Medicare AAPCC cannot be relied on to achieve success in this area.

The number and range of health plan choices being proposed for Medicare beneficiaries and variations in benefits, premiums, and marketing are likely to greatly increase the potential for risk selection among those offering the various *Medicare choices*. Since risk selection can seriously undermine the viabilities of the traditional Medicare program and individual plans, it is important that this problem be addressed and controlled.

Ultimately, the committee is concerned about incentives and the capability of physicians with a direct financial interest in a plan to recruit (or avoid) subscribers on the basis of whether that individual is a high- or low-level user of health services.

RECOMMENDATION 2

> Enrollment and disenrollment guidelines, appeals and grievance procedures, and marketing rules should reflect Medicare beneficiaries' vulnerability and lack of understanding of traditional Medicare and Medigap insurance and their current lack of trust in important aspects of alternative health plans.

Beneficiary Enrollment and Disenrollment

Findings

The committee found that numerous factors make it critical to facilitate the Medicare enrollment and disenrollment process in an environment of market competition and broader choice:

- Medicare beneficiaries are apprehensive about managed care, the concept of risk, the choice

process, and lock-in provisions that would prevent beneficiaries from leaving a plan with which they become dissatisfied after enrollment.

- Many Medicare beneficiaries are poorly informed about traditional health insurance in general and are even more poorly informed about their *Medicare choices* and the choice process. A considerable amount of beneficiary dissatisfaction, especially among those beneficiaries who are new to managed care, appears to be related to misunderstandings of the basic structure, payment and care practices, and the choice process.
- Some beneficiaries unknowingly lose their Medigap insurance coverage or face a premium increase if they join a managed care plan and later return to Medicare.
- Managed care uses practice protocols and definitions of what constitutes medical necessity and appropriate care that vary from those used by the traditional Medicare program. These differences can result in various types and levels of service for specific illnesses and conditions. It is often difficult for beneficiaries to understand these protocols and their implications for the specific services offered by various plans before enrolling in a plan.
- Many Medicare beneficiaries are disadvantaged in the choice process by physical or mental frailty or by poor vision or hearing.
- Some Medicare beneficiaries who receive their care from HMOs now must enroll in and disenroll from plans as they move between summer and winter residences. The portability of a managed care plan may be further hindered by annual open enrollment policies and lock-in provisions.
- Beneficiaries can be negatively affected by health plan changes beyond their control, such as when their provider ceases to contract with the plan.
- Beneficiaries who make misinformed choices can be hurt financially or clinically, or both. The committee is most concerned with minimizing adverse clinical outcomes, but would err on the side of greater leniency in allowing beneficiaries to leave a plan with which they are dissatisfied.

Subrecommendations

Given the findings presented above, the committee recommends a transition period of 2 years from the time that legislation is implemented during which the federal government would continue the current option of permitting monthly changes of enrollment by Medicare beneficiaries. After this transition period, enrollees should be locked into the plan that they have selected for 1 year, with the following exceptions. All enrollees will have 90 days from the time of enrollment in a health plan to disenroll and enroll in traditional Medicare, and newly entitled beneficiaries and beneficiaries who have never before chosen a health plan (i.e., those who have been enrolled in the traditional Medicare program) should have the prerogative of changing plans or rejoining the traditional Medicare program within 90 days. There is a prevailing sentiment among committee members that the federal government should set limits on the number of times that new health plans' members can change plans. Beneficiaries should be allowed to return to their previous Medigap policy with no additional premium costs and with no restrictions placed on preexisting conditions if they disenroll from a health plan within 90 days and return to the traditional Medicare program.

The committee would like to see the federal government encourage plans to offer adequate out-of-area coverage for their enrollees who reside out of the plan's service area for more than 3 months. This can be achieved through interplan reciprocity or point-of-service options.

Grievance and Appeals Procedures

Findings

The current Medicare appeals process has been shown to be slow and not adequately advertised by HCFA or health plans. Furthermore, the current appeals process is tailored more to

reviewing whether a service should be reimbursed by Medicare or a health plan and less on the important issue of whether a needed service was denied.

In a competitive environment, to attain better risk selection, health plans have the incentive to encourage healthier people to enroll in the plan and to discourage from enrollment those who need more services. This could prompt plans to be less responsive to the grievances of sicker Medicare enrollees.

Subrecommendations

The committee recommends that the existing appeals process be strengthened, streamlined, and better publicized.

Furthermore, the committee recommends that the federal government make available an expedited review and resolution process for *Medicare choices* (by an agency independent of the health plan and the traditional Medicare program) to review emergency conditions, such as the following: (1) when a situation is life-threatening, (2) when the time involved to review the appeal under the usual process would result in a loss of function or a significant worsening of a condition or would render the treatment ineffective, or (3) when advanced directives or end-of-life preferences are involved.

The federal government should carry out this expedited review through an independent private nonprofit agency in each area of the country. The agency should review any negative findings with the health plan involved and report to the federal government any recommended changes to improve the plan's performance. The cost of this independent, expedited review process should be covered by the Informed Choice Fund. The federal government should be able to assess the costs of these reviews on the health plans when the number of such reviews and negative findings becomes excessive.

Health Plan, Medigap Insurance, and Traditional Medicare Marketing Practices

Findings

Past experience with Medigap policy sales has demonstrated the potential for widespread abuse. Federal and state regulatory mechanisms have been put into place to deal with these abuses. However, greater incentives for abuse exist with the sale of alternative health plans. The commission on a single sale can be a significant portion of an agent's compensation.

Health insurance is also complex, and it is difficult for beneficiaries to compare the benefits offered by competing health plans. It will likely remain so for most Medicare consumers. Many Medicare beneficiaries are particularly vulnerable in their need and desire for adequate health care coverage and have been found to have low levels of understanding of *Medicare choices*.

All of these factors that make elderly beneficiaries especially susceptible to improper marketing practices are underscored by the fact that elderly people have a preference for and rely on one-to-one interactions as a way of learning about their health plan options.

Subrecommendations

To promote comparable levels of accountability, the committee recommends that serious consideration be given to having a new entity approve in advance the public information and marketing materials used by health plans and by the traditional Medicare program. Additionally, the federal government should work with state governments to oversee the marketing of Medigap policies to individuals in the framework of the new requirement for a single open season and conditions of participation.

The committee recommends that the agents and marketers of health plans and Medigap policies be required to inform Medicare beneficiaries up front of their commission for the sale of the policy. Unsolicited door-to-door marketing and outbound telephone marketing should be prohibited.

Rigorous marketing rules of conduct should be required to protect beneficiaries. For example,

- lock-in requirements should be made more lenient for beneficiaries who enroll via door-to-door or telephone marketing,
- retroactive disenrollment should be permitted if enrollment takes place as a result of misleading marketing, and
- compensation to marketing agents should be tied to retention of the enrollee in the health plan, and
- retention rates should be reported to potential enrollees by the health plan and by agents.

The committee recommends that the federal government define the basic requirements of any marketing presentation by a health plan or Medigap insurance provider, including such items as providing a copy of a brochure or pamphlet that clearly compared standard health plans, a description of the lock-in provision and a discussion of the availability of the beneficiaries' providers under the plan, and marketing materials in the primary language of the buyer. The federal government should also collaborate with states to ensure consistency in these requirements and should be able to effectively sanction health plans and Medigap insurance providers that break the marketing rules.

RECOMMENDATION 3

The committee recommends that special and major efforts be directed to building the needed consumer-oriented information infrastructure for Medicare beneficiaries. This resource should be developed at the national, state, and local levels, with an emphasis on coordination and partnerships. Information and customer service techniques and protocols developed in the private sector should be used to guide this effort, and the best technologies currently available or projected to be available in the near term should be used.

Beneficiary Information Needs for Informed Choice

Findings

Many Medicare beneficiaries do not understand the *Medicare choices*. Many are fearful of any change in Medicare and distrust the new choices of health plans. A wide range of unbiased information about *Medicare choices* may increase the level of trust. The committee has found that Medicare beneficiaries want and need standardized, unbiased, clearly understandable information, including the following:

- how the different *Medicare choices* actually work;
- the out-of-pocket costs of the various plans;
- the experiences of people similar to themselves (e.g., people of the same age, health, sex, ethnicity and cultural background) seeking care under the various *Medicare choices*;
- how patients have access to and are treated by their doctors (both primary care and specialist physicians) under the various options;
- the accessibility of the services that they are likely to need, especially hospital and ancillary services, as well as the accessibility to cutting-edge care and where it is provided;
- an indication that the information is accurate, timely, reliable, and trustworthy (beneficiaries are savvy in discerning the quality and inherent biases of the information); and
- how participating physicians are paid.

Some groups of beneficiaries, especially those with chronic conditions, desire more specific information, such as protocols for treatment or whether a particular prescription drug is provided in

their *Medicare choice.*

Medicare beneficiaries appear to be active users of media of all types, older adults are particularly oriented toward one-to-one communications with another individual. Furthermore, the committee is pleased with the progress being made by private credentialing organizations like NCQA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to develop data sets that can be used to certify plans and inform consumers, such as HEDIS.

Subrecommendations

In efforts to communicate the information in the box "Medicare Choices Information for Beneficiaries" to Medicare beneficiaries, a broad range of mass media and other forms of communication should be used. Emphasis should be placed on providing beneficiaries with easy telephone access to individuals who can guide them on the use of the materials providing comparisons of health plans and who can provide additional clarification and information on plans and providers. To the degree possible, health plans will be asked to submit information in a format that will allow beneficiaries or their families to access the information via the Internet.

To establish trust, a private, nonprofit organization should validate and publish summaries of performance data and make more technical backup data available to beneficiaries and others who have a reasonable right to know. Beneficiary surveys should be standardized across plans, they should be audited, they should include a representative sample of those who are covered (including by ethnicity), and they should oversample beneficiaries with chronic or disabling conditions. Materials should be adapted for use by those with special physical limitations, such as poor vision and hearing.

To keep its information as complete and current as possible, this organization should obtain expert advice from national quality and service accreditation organizations in the continuing development of data needs, comparative reports, and surveys for the purposes described above.

Medicare Customer Service and Enrollment Center

Findings

There exists a critical need to increase understanding of and trust in the restructured Medicare program by the public. Medicare beneficiaries and the general public need to be provided with a broad and objective education about the coverages, costs, and purposes of Medicare and the new health plan choices.

Objective and responsive information on all aspects of *Medicare choices* is also needed to hold the health system and plans accountable. An increase in the amount of this type of information will augment Medicare beneficiaries' trust in the Medicare program and the choice process.

The committee finds that the private sector's information and communication technologies for assembling, cataloging, and making available information on various health plan features to consumers have advanced well beyond those currently being used to serve Medicare beneficiaries. An example cited frequently at the symposium and in the commissioned papers is the notion of customer service centers that allow telephone access to representatives with on-line support. The central availability of the federal government's access to standard data from participating health plans, the traditional Medicare program, and Medigap insurance offers an opportunity to use this technology to better ensure informed choice by beneficiaries and accountability by health plans.

Furthermore, regional and local variations in health plans and health care, coupled with the strong desire among beneficiaries for one-to-one communication, suggest that additional information and service activities be carried out by ombudspersons or agencies at the regional and area levels. Models for such activities exist in information, counseling, and assistance (ICA) programs, which are funded primarily by HCFA.

BOX 3-1
***Medicare Choices:* Information for Beneficiaries**

To provide the necessary information for informed purchasing, the committee recommends that the federal government make available to beneficiaries, directly or through health plans, the following types of information on *Medicare choices*:

1. The enrollment and disenrollment rules, the choice process, and the range of services available from the health plans.
2. How traditional Medicare and Medigap insurance, in comparison with alternative health plans, pay and contract with providers, for example, choice of providers and portability.
3. Comparative benefits, including
- emergency and out-of-plan urgent care;
- hospital services (including access to centers of excellence);
- nursing home, home health, and hospice services;
- prescription benefits;
- physician services, including the availability of specialists;
- foot care, dental care, and mental health care; and
- services of alternative providers such as chiropractors.

4. Comparative costs, including premiums, cost-sharing, and balance billing, with examples of comparative costs for different classes of beneficiaries, for example, the well elderly; disabled, institutionalized, and chronically ill people; and individuals with major illness episodes while on Medicare. Medigap insurance premiums should be shown to be in addition to the Part B premium.
5. Comparative performance on clinical, structural, and satisfaction benchmarks:
- scientifically valid process and outcome measures in a form salient and relevant to beneficiaries, including the
  —percentage of beneficiaries with diabetes who receive an annual eye examination,
  —percentage of female Medicare beneficiaries who receive an annual or biannual mammogram and Pap smear,
  —percentage of males who receive a prostate examination,
  —percentage of beneficiaries who receive preventive services, such as hypertension screening and influenza and pneumococcal vaccinations, and
  —recidivism rate for various diagnoses;
- access measures, including
  —the percentage of referrals denied or unavailable,
  —the average waiting time to obtain a referral,
  —average times to obtain an appointment once a referral has been made,
  —ease of phone access and average waiting times in a physician's office, and
  —physician turnover rates; and
- satisfaction measures (specifying those with chronic conditions or disabilities), including
  —disenrollment information, including the percentage of persons who disenroll within 3 months of enrollment,
  —appeals and grievance information, including the numbers, reasons, and resolutions of grievances and appeals per *Medicare choices* organization,
  —access and quality findings from HCFA monitoring surveys and relevant state regulatory reports, and
  —findings from surveys commissioned by the organization on satisfaction with physicians and hospital care, access to specialists, and other factors found to be important to beneficiaries.

6. A clear description of the details of each plan and the Medigap policy, including
- in- and out-of-network access and costs;
- how referrals are made (e.g., who makes the referral decisions and on what basis);
- appeals and grievance systems;
- up-to-date listings of all providers by type and specialty, credentials, and whether an individual provider is accepting new patients from the plan;
- financial and contractual arrangements between plans and providers that may influence their decisions regarding services in the judgment of the federal government;
- financial and solvency status; and
- use of out-of-area specialty centers.

On request, policies or protocols for covering or providing specific services (such as a prescription drug) or services for specific conditions (such as chronic obstructive pulmonary disease, congestive heart failure, diabetes, and joint replacement) should be provided.

Subrecommendations

To further these objectives, the committee recommends that the federal government contract with and oversee a private, nonprofit agency to develop a state-of-the-art *Medicare Customer Service and Enrollment Center* that would (1) administer a Medicare customer services answer center; (2) develop, collect, and distribute open enrollment materials and enrollment data; (3) reconcile enrollment data and payments to plans, including monthly changes and related transactions; (4) provide an evaluation component for the purpose of continual improvement and plan feedback; and (5) contract for regular customer service satisfaction surveys.

The Center would strive to offer Medicare beneficiaries national and regional or local access to the types of services provided by the benefits departments of the nation's large employers, building on the regional-area work of organizations such as ICA programs.

The Center will provide education, counseling, and legal assistance and will process complaints, grievances, and appeals from plan members through regional and local agents such as ICA programs. It will install a tracking system to report all complaints, grievances, and appeals, and will report this information to beneficiaries annually and to health plan chief executive officers monthly.

In carrying out this effort, the Center will take advantage of the most effective and efficient methods of electronic communication, including toll-free telephone communication, on-line communications, town meetings, newsletters, and multimedia techniques, to provide information about plans and the process of choice that is as detailed as possible.

The Center's national, regional, and area activities would be funded by the federal government through the Informed Choice Fund.

Choice Facilitating Organizations

Findings

The committee finds that many independent private organizations that already exist or that might well develop can assist beneficiaries with making informed choices among the options available through the Medicare program. These facilitating or mediating organizations offer services ranging from providing objective additional information on plans and choices beyond what the Center offers, to evaluating plans by additional objective criteria, to prescreening and selecting plans that the organization's customers or members might choose, to bargaining for better value from the plans. In fact, many employers are offering such services to their Medicare-eligible retirees, making Medicare HMOs or Medigap policies, or both, available to them during their annual open seasons.

These Choice Facilitating Organizations do raise some concerns. Insurance brokers or other parties with financial interests may misuse these opportunities to market products rather than provide objective advice. Also, even well-functioning organizations could divert feedback on the services offered by a plan from the Center and its regional agents and dilute the effectiveness of the Center's national reporting. The committee leans toward limiting the establishment of these organizations to groups that do not have a vested financial interest in the choices that consumers make or, at a minimum, requiring such organizations to adequately disclose their sources of funding and potential biases that might result from these financial interests.

Subrecommendations

The committee recommends that nothing in law or regulation should inhibit the development of private organizations whose major purpose is to facilitate choice for Medicare beneficiaries, including groups that offer preselected panels of health plans. Although the committee believes that such organizations should be limited to groups that do not have a vested financial interest in the choices that are made, at a minimum, these organizations should be required to fully disclose their sources of funding and potential biases that might result from these financial arrangements.

To help make the Choice Facilitating Organizations as useful to beneficiaries as possible, the

federal government should require health plans and the traditional Medicare program to make available appropriate information to such organizations that have a legitimate interest in that information, such as the data behind quality or accreditation scores.

The committee advocates that public and private entities experiment with such organizations, including providing funding from the Informed Choice Fund to those that meet the criteria of independence and objectivity to augment the work of the Medicare Customer Service and Enrollment Center. Choice Facilitating Organizations may be particularly useful during the early phase of Medicare choice development.

The Informed Choice Fund

Findings

The provision of information on *Medicare choices* to Medicare consumers is in its infancy stage. Most of the information about quality and performance that has been developed and collected has been for large purchasers, plan administrators, or clinicians, not as part of an effort to educate and inform individual consumers.

Subrecommendations

The committee recommends that an *Informed Choice Fund* be developed for use by the federal government for the purpose of strengthening the infrastructure used to inform Medicare beneficiaries of their health plan choices. The Informed Choice Fund would be used to fund the operations of the Medicare Customer Service and Enrollment Center. Demonstration grants to Choice Facilitating Organizations could be made from this Fund, as desired by the federal government, after the operations of the Medicare Customer Service and Enrollment Center are funded.

The Informed Choice Fund would derive its income from a predictable revenue source, such as a fixed amount from each Medicare beneficiary or a flat amount or a percentage of the monthly Medicare premiums. One demonstration project might be to allow beneficiaries to designate all or a portion of their share of these funds to the Choice Facilitating Organization of their choice.

RECOMMENDATION 4

> The federal government should require all *Medicare choices* to be marketed during the same open season to promote comparability and to enable beneficiaries to adequately assess and compare the benefits and prices of the various options.

Coordination of Traditional Medicare, Medigap Insurance and Health Plans: *Medicare Choices*

Findings

Comparing the prices and benefits of the various *Medicare choices* is difficult at present because they are not marketed at the same time or under the same ground rules. For example, the beneficiary may not see the high cost (frequently $1,000 or more) of the traditional Medicare program with Medigap insurance relative to the cost of a managed care plan. In addition, beneficiaries who leave Medicare and their Medigap policy for a managed care plan may find that they cannot repurchase their Medigap policy because of a preexisting condition.

The committee finds that the division of responsibility for enforcing the rules of participation in and compliance with these programs between state and federal government complicates the process of informed choice, grievance and complaint resolution, and plan accountability and fragments the offering of health plans across state lines.

Subrecommendations

It is within this context that the committee recommends that the selection of *Medicare choices* be coordinated. All three types of plans should be offered during open enrollment periods and under the same conditions of participation.[5]

The federal government should work with state governments to coordinate the federal requirements surrounding *Medicare choices* with existing state regulations for Medigap insurance and private insurance. The U.S. Congress should consider what policy-making and enforcement activities are most appropriately and effectively conducted by the federal government and which can be delegated to state governments to ensure consistency and economy.

Standardized Packaging, Pricing, and Marketing of Benefits

Findings

Through the course of its deliberations, the committee found that although standardized benefits might simplify the choice process for elderly individuals, standardization is likely to dampen innovation and responsiveness to a broader range of consumer desires and preferences. However, the committee also appreciates the advantage for the beneficiary of the current standard benefit categories under Medigap insurance, which facilitate comparisons of the benefits and costs of different benefit options and comparisons of different insurers providing the same option. The committee acknowledges that many employers and private organizations have developed formats that allow the benefits of competing health plans to be clearly displayed and compared. It would be relatively simple for Medicare to do the same.

Terminology relating to the benefits offered by health plans varies greatly and makes it difficult to make clear comparisons among health plans. More research is needed on the types of information that beneficiaries want and need to exercise informed choice and how best to present that information.

Subrecommendations

The committee wants to preserve the general approach taken by the law governing Medigap insurance without restricting choice to the same extent. It believes that health plans should be moved toward standardized packaging, pricing, and marketing of selected benefit packages to allow beneficiaries to more easily compare the benefits offered by different plans. The committee recommends all plans be required to offer and price a basic benefit package (current Medicare Part A and Part B services) and have the option of offering and pricing two other popular benefit packages defined by the federal government and included in basic comparisons promulgated by the federal government. These popular benefit packages should include added benefits shown by market sales and surveys to be of special interest to the elderly (services such as pharmacy, eye care, and foot care) and ones that are popular given the cost. Health plans would be free to offer and price benefit packages other than these two that add to the basic benefit, but these other packages must be clearly identified as nonstandard, must offer substantial differences from the basic benefit package, and would not be included in the Medicare Customer Service and Enrollment Center's standard published comparisons. The federal government should commission the Medicare Customer Service and Enrollment Center to develop and use formats that allow beneficiaries to make easy and clear comparisons of benefits and other information on *Medicare choices*, drawing on the best practices used by employers and private and public organizations. The federal government should also suggest questions that Medicare beneficiaries should ask about nonstandard packages.

To make this process even easier, the federal government should promulgate common terminology related to benefits. All *Medicare choices* should use this terminology to describe the benefits of each of their offerings.

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[5] The Physician Payment Review Commission's 1996 Annual Report to Congress provides a worthwhile discussion of the pros and cons of annual versus continuous open enrollment seasons.

The federal government should coordinate its activities with those of state governments to ensure consistency between these benefit packages and those of Medigap insurance.

RECOMMENDATION 5

The committee is concerned about the increasing restrictions on physicians (and the potential conflict of interest of physicians) when they act in their professional role as advocates for their patients and carry out their contractual responsibilities and receive economic incentives as health plan providers. The committee favors the abolition of payment incentives or other practices that may motivate providers to evade their ethical responsibility to provide complete information to their patients about their illness, treatment options, and plan coverages. So-called anticriticism clauses or gag rules should be prohibited as a condition of plan participation.

Physicians and Professionalism

Findings

The committee recognizes that physicians' advice to beneficiaries is a quintessential part of ensuring informed choice. Because of the inherently personal nature of the physician-patient relationship and its special importance to elderly patients, the committee is concerned about the increasing restrictions on physicians (and the potential conflict of interest of physicians) when they act in their professional role as advocates for their patients and carry out their contractual responsibilities and receive economic incentives as health plan providers. The committee is particularly concerned about reported contractual restrictions (such as anticriticism clauses) on physicians acting in their professional role as a source of advice to their patients. Physicians must maintain their freedom to talk to their patients with full honesty about the clinical aspects of their care and treatment options.

Subrecommendations

The committee recommends that neither the *Medicare choices*' payment incentives nor their coverage and treatment protocol policies motivate providers to evade their ethical responsibility to provide patients with complete information about their illness and treatment options (such as referrals to a specialist), what to the best of the provider's knowledge the patient's plan covers, and which health plans in the provider's experience provide the broadest range of services to the patient in question.

Competition among *Medicare choices* is likely to restrict the definitions of *inappropriate services* by refining the definitions of *medical necessity* and *appropriate services* to contain costs and ensure quality. The committee finds that it is important for beneficiaries to have access to the unbiased judgments of their practicing physicians regarding their health needs in the context of plan procedures and protocols so that they, as patients, can make informed choices and thereby shape this new understanding of "appropriate."

Within the scope of its responsibilities, the federal government should identify practices that inhibit open communication between a provider and a patient in any setting and either prohibit them as conditions of participation of plans or require the plan to disclose such practices to potential enrollees. The committee recommends that the federal government require plans to disclose to plan enrollees how physicians get paid, whether they are rewarded for withholding referrals, and any other restrictions affecting how physicians can inform or treat plan enrollees. Similarly, educational materials should make clear the incentives in traditional Medicare and Medigap insurance to provide unnecessary care and the risks of these incentives.

RECOMMENDATION 6

The federal government should hold *Medicare choices* accountable by requiring them to meet comparable conditions of participation as a Medicare option and by monitoring and reporting on their compliance with these conditions.

Conditions of Participation for *Medicare Choices*

Findings

Some private and public employers have administered choice programs for many years and have developed and are continuing to improve the conditions of participation of health plans for ensuring that beneficiaries can make informed choices and for ensuring accountability on the part of the health plans. The very nature of accountability for Medicare health plans suggests that minimum standards should be established for health plans in areas where beneficiaries cannot reasonably be expected to make informed choices or where they might be easily confused or misled. This process of informed choice should be facilitated so that plans compete to exceed those minimum standards.

The committee finds that managed care plans not only pay for the services of providers but that they also use contractual arrangements to establish incentives for and place controls on providers' services. Thus, a beneficiary's choice of health plan can affect not only whether services are covered but also how they are provided. To further the responsiveness of plan management and providers to the special needs and demands of Medicare beneficiaries, the committee suggests that plans actively and meaningfully include beneficiaries in their governance and board activities and otherwise integrate the consumer voice into the plan's management and decision-making structure.

This said, the committee acknowledges that performance and disclosure requirements cannot compensate for limits on monetary resources for coverage. No amount or type of oversight and regulation can offset the intrinsic limitations on quality and access that necessarily follow from low levels of funding by the political process or the inability or unwillingness of beneficiaries to pay additional fees for health services.

Subrecommendations

The committee recommends that the federal government be given the flexibility to adjust the conditions of participation to take into account the evolution of higher standards and new systems and structures for ensuring informed choice and public accountability of *Medicare choices*.

Quality Assurance and Outcomes

Findings

The availability of *Medicare choices* introduces a potential for competition among plans on the basis of improvements in quality of care. To capitalize on this potential, the quality of service provided by health plans must be measurable and must be communicated to beneficiaries in a way that is relevant to them so that quality can be taken into account and so that a beneficiary can make an informed choice. Choice in health care, as in any environment, also introduces incentives to restrict the provision of or payment for services to remain competitive. This can produce effective and needed economies by reducing inappropriate or noncovered services. It may also, however, reduce the amount of appropriate care provided. Quality measures, monitoring, and meaningful ways of disclosing and communicating findings are needed so that the federal government and beneficiaries can hold plans accountable for reaching an appropriate balance between restricting inappropriate care and providing appropriate care.

The committee finds that quality measurement and communication are still in the early stages of development, especially quality measurements based on outcomes. Important initial efforts are under way by private credentialing agencies, such as NCQA's HEDIS, JCAHO, the Foundation for Accountability,

BOX 3-2
Conditions of Participation

The committee recommends that all *Medicare choices* meet the following minimum standards:

- participate in the annual open season and sell policies to Medicare beneficiaries during that open season or on certain other occasions, such as when a beneficiary first becomes eligible;
- offer open enrollment, guaranteed renewal, and no clauses precluding enrollment because of a preexisting condition for newly eligible beneficiaries and for beneficiaries changing plans;
- offer Part A and B benefits (except for Medigap policies) and meet other Medicare benefits requirements;
- provide information specified by the federal government to ensure informed choice by beneficiaries;
- meet quality certification requirements comparable to those already in use and in development by recognized national private accrediting entities and require appropriate progress and improvement against such standards over time;
- have resources, including appropriate mixes of specialists and referral resources, to provide benefits throughout service areas to a reasonable degree defined by the federal government so as not to divide metropolitan areas or counties except when natural barriers or other conditions divide service areas;
- provide a user-friendly, well-communicated, and responsive appeals and grievance process and allow retroactive disenrollment of beneficiaries who are determined by a fair and appropriate process to have misunderstood the implications of their choice and who have suffered serious financial or other consequences;
- meet fair marketing standards;
- meet specified fiscal solvency and financial disclosure requirements, allow compliance audits of financial and quality assurance operations, agree to use federal government-promulgated terms for describing coverages, and agree to accept enrollees without prejudice in all circumstances and particularly when the beneficiary has been enrolled in a plan that has gone out of business or become insolvent within the prior 60 days;
- not discourage providers from advising patients regarding their treatment options and plan coverages;
- provide such data to the federal government as required for it to test the plan's performance and compliance; and
- provide such information as it may require to the Medicare Customer Service and Enrollment Center.

and others, to develop reporting systems and measures of health plan quality. These efforts, however, reduce but do not eliminate the risk of poor quality.

Subrecommendations

To best ensure quality, all *Medicare choices* should be subjected to comparable state-of-the-art standards and monitoring for quality. The federal government should use the best of the currently available technology to set standards and monitor the quality of health plans. When the standards and processes of private credentialing agencies meet or exceed those of the federal government, private organizations should be used to reduce duplication in the market. The federal government might well foster competition and innovation among private credentialing agencies for different aspects of this function.

Communication with beneficiaries about the quality of a health plan and traditional Medicare plans should be done by the Medicare Customer Service and Enrollment Center by using the latest information available from credentialing processes and the latest techniques for communicating plan performance. In this vein the federal government should give priority to research and demonstrations on communicating quality performance information to beneficiaries.

The committee recommends the development of common definitions for reporting quality for use by individual plans and for auditing plans against their own published reports to the federal government.

Managed Care and Underserved Populations

Findings

The committee is concerned about ensuring access to health plans and their services for all beneficiaries, including those in vulnerable populations and underserved areas. Although the average Medicare beneficiary has been shown to have good access to care, certain groups who have been identified as vulnerable in traditional Medicare may be at risk for access problems in Medicare managed care. These groups have been identified by PPRC to include African-American beneficiaries and those who live in Health Professional Shortage Areas or urban and rural poverty areas. Evidence indicates that managed care arrangements have been slow to include underserved populations, especially those in rural areas (Institute of Medicine, 1996).

At the workshop and through the commissioned papers the committee was made aware of the special value that elderly individuals place on having easy access to their physicians, and the importance that they place on being treated by their providers in a respectful and a socially and culturally sensitive way. The committee heard again and again that elderly individuals place key importance on their ability to have access to "their" traditional providers with whom they have developed a personal relationship.

The importance of considering the effect of personal and cultural factors on access is heightened by the changing demographics of the U.S. population. The committee heard that certain Medicare beneficiaries (particularly low-income and minority groups) may be at significantly higher risk of not being able to continue to be seen by their traditional network of providers in an environment of managed care. Because of the lower socioeconomic status of many individuals who are members of minority groups, a managed care plan may be the only delivery option that is affordable.

As managed care plans continue to develop they will have an increased responsibility to improve access for underserved populations. The committee believes that health plans should be held responsible for serving their entire service area without compromising access or quality of care. The committee found that some providers who have served their communities for many years or who are part of essential community provider networks, have not obtained the credentials required by some managed care organizations either because of institutional racism or common practice within their specialty to forego board certification. It is important that health plans develop several measures of clinical competence that are sensitive, valid, and reliable in their ability to assess clinical competence through both outcome and process indicators. The committee heard testimony that managed care plans often do not disclose their

credentialing standards and policies. At the very least, such disclosure should be required. The committee lauds the efforts under way in HCFA, PPRC, a number of health foundations and other groups to track and address key issues that could arise in monitoring access to care under a restructured Medicare program.

Subrecommendations

Broad access for Medicare beneficiaries is key. The committee recommends that the federal government ensure that there is adequate access and choice of plans for individuals in all socioeconomic, cultural, and language groups and for underserved areas and populations. Elderly beneficiaries particularly value care that is respectful, personalized, and culturally sensitive. When warranted and documented (i.e., when access is demonstrably inadequate), the federal government should require the plans in an area to improve their contracting with community-based providers who meet quality-of-care standards as a condition of participation.

RECOMMENDATION 7

Serious consideration should be given and a study should be commissioned for establishing a new function along the lines of a Medicare Market Board, Commission, or Council to administer the *Medicare choices* process and hold all *Medicare choices* accountable. The proposed entity would include an advisory committee composed of key stakeholders, including purchasers, providers, and consumers.

Medicare Market Board and HCFA

Findings

Bearing in mind the recommendations that the committee has made regarding ensuring public accountability and informed purchasing for beneficiaries in an environment of choice, the committee had a number of concerns as it relates to the choice management capabilities of HCFA, as it is currently structured, to effectively manage *Medicare choices*. The committee spent considerable time discussing the challenges and complexities of effectively managing two very different and potentially competing programs. For example:

- The administration of the multiple choice program and the management of the traditional Medicare programs involve very different missions and orientations.
- The two functions require different types of management, staff expertise, backgrounds, and knowledge. The committee is concerned that staff and senior managers with extensive experience in managing various aspects of multiple choice in the private sector be recruited and employed for this effort.
- The functions call for different organizational and corporate cultures, one operating a stable traditional public indemnity insurance program and the other a purchaser- and customer-oriented program that is required to be responsive to a diverse group of private programs in a rapidly changing and dynamic marketplace.
- A faster response to changing market conditions and opportunities is required for the effective management of competing plans to provide the best options for beneficiaries. Such responsiveness may be hard to achieve with the regulatory constraints of HCFA.
- The committee believes that these strengthened and new responsibilities for managing the choice of plans must be supported by adequate organizational, financial, and staffing resources, which are needed to effectively and efficiently accomplish the mission described here.

Subrecommendations

The committee believes that these growing choice management functions would benefit from an organizational identity with the stature to facilitate recruitment of the needed leadership and staff and to build public trust. For that reason the committee recommends that serious consideration be given to establishing a new function along the lines of a Medicare Market Board, Commission, or Council that would include an advisory committee with key stakeholders (i.e., purchasers, providers, and consumers).

The committee was not able to research adequately the question of where this function should be located in government. The committee is aware of current initiatives to simplify and streamline government regulations as well as the efforts being made by HCFA to address some of the committee's concerns. The committee's discussions included the option of incorporating the new Medicare Market Board entity within HCFA, but with dedicated management and resources; establishing a Federal Reserve Board type of agency that has greater flexibility in rule making; establishing a PPRC- or ProPAC-type entity reporting to the Congress; as well as other possibilities.

With that in mind and given the potential impact of the proposed new entity on the health care economy and the well-being of 37 million beneficiaries, the committee recommends that the U.S. Congress commission a study on what functions should be included in any new entity and what functions should stay with the present organizational structure, the roles and experience of federal agencies with a comparable mix of functions, the rationale for their structure, their organizational placement (including their relationship to the U.S. Congress and the executive branch) to better assess the advantages and potential shortcomings of moving in this direction.

In recommending the consideration of a new function such as a Medicare Market Board, the committee was cognizant of the fact that even a new entity will be limited or circumscribed by the realities of the political and fiscal environments in which it must operate and be accountable.

The committee envisions any proposed entity to have general responsibilities in the following areas:

- *Data collection, data publication, consumer education, and support*

  Contract with a Customer Service and Enrollment Center for these functions and augment the Center's services by using Choice Facilitating Organizations.

- *Health plan standards*

  Consult experts and conduct research and demonstrations to refine the conditions of participation by health plans on an ongoing basis to reflect the service and quality that the government expects for Medicare beneficiaries, regardless of the plan that they choose. The conditions would be set on a national basis and would be measurable and subject to an annual evaluation of compliance. To the greatest extent possible they would be consistent with standards used by the private sector to minimize duplication.

  Invoke specific sanctions in the event that the standards of a plan fall below the set standards.

- *Benefits, quality, and fair payment to health plans*

  Continually review clinical developments and services pertaining to what constitutes quality or appropriate care and refine the definitions of benefits under Medicare Part A and Part B.

  Review developments in the health insurance marketplace and refine the standard benefit description, pricing, and marketing requirements.

  Review risk selection in the traditional Medicare program and health plans and develop procedures or recommendations to the U.S. Congress for controlling or adjusting for adverse and favorable selection.

- *Evaluation and improvement of multiple choice in Medicare*

  Review the workings of the multiple choice market for Medicare beneficiaries and report to the U.S. Congress on the extent to which beneficiaries are able to make informed choices, the extent to which government and beneficiaries are succeeding in holding plans accountable for ensuring quality of care and containing costs, and ways to improve the system's performance.

  Review traditional Medicare and health plan costs and performance to determine whether the amount and form of the federal government's contribution to costs (e.g., premium payment) yields the government and its beneficiaries both containment of costs and assurance of quality.

  Report and recommend changes to the U.S. Congress to better hold plans accountable to these ends.

  In conducting each of its responsibilities, it would adhere to rigorous conflict-of-interest standards.

The CHAIRMAN. Thank you.
Ms. Stanley.

STATEMENT OF MARGARET STANLEY, ASSISTANT EXECUTIVE OFFICER, HEALTH BENEFITS SERVICE, CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM (CALPERS), SACRAMENTO, CA

Ms. STANLEY. Thank you, Mr. Chairman.

CalPERS is the second-largest purchaser of employee health benefits in the country. Only the Federal Government is larger. We cover over 1 million public employees, retirees and their dependents and spend about $1.5 billion per year on their health benefits. We operate like a health plan purchasing cooperative for public agencies. In addition to the California State Government, we cover over 1,100 local public agencies in California.

Today, I will share with you how CalPERS communicates with its 117,000 Medicare enrollees about the quality of care benefits and customer service provided by our contracting health plans. Several years ago, CalPERS standardized its benefit programs. We did this for several reasons. The main reason was to make it easier for our members to make informed choices about the health plans. We also felt that it would encourage the health plans to compete on quality, service and price rather than on how to design their benefit packages to attract the enrollees who were the best health risks.

Standardized benefits allow purchasers to make apples-to-apples comparisons. They also allowed us to simplify our benefit comparison chart considerably, and this is the benefit comparison chart that we used before we standardized the benefit package, front and back. As Senator Breaux pointed out, we still have a way to go with our new benefit chart, but it is better than the old one.

Senator BREAUX. That is newer than the one that I was showing in the pamphlet? That is a new and improved model?

Ms. STANLEY. This is the one we are using now. This is the new and improved one, and this is the old one.

Senator BREAUX. Ah, OK.

Ms. STANLEY. For our Medicare members, we wrap our standard benefit package around the Medicare risk and Medicare supplement plans so that all Medicare members receive the same core benefits. We offer 18 health plans to our Medicare members. Every year, we produce a health plan quality and performance report, which I think you should have a copy of, which we mail to every member's home. It contains information to help them make an informed choice of health plans. Last year, we asked those members who changed health plans during our open enrollment period whether they had used the quality and performance report to help them choose their new health plan. Two-thirds of them reported that they had.

The report contains three key pieces of information for each health plan we offer: the results of our consumer satisfaction survey; the results of our open enrollment exit survey, which gives the reasons why members left their health plans and how the health plans score on standardized quality of care measures. On these quality of care measures, we do not accept data submitted by the

health plans. We collaborate with the Pacific Business Group on Health, a coalition of large California employers, to obtain independently audited HEDIS quality of care data.

We also ask our members if they find the report useful and what we can do to make it more helpful to them. We then modify the report each year based on our members' feedback. This year, we plan to make the type larger, simplify the wording and add information on what percentage of our members disenrolled from each plan in the last year.

Our open enrollment materials, which include this quality booklet as well as a more general information booklet, cost about 63 cents per member for printing and postage. It is designed and written by our staff with the assistance of a public relations firm. We charge the cost of the booklets to our contracting health plans, as these booklets are a substitute for the marketing materials they would otherwise produce and mail to our members.

To support our members, we also have a customer service staff within CalPERS. During the month of September last year, when we held open enrollment, our staff received 149,000 phone calls, and we processed 180,000 enrollment documents. We have an ombudsperson function to assist our members in resolving complaints with health plans. We have 17 employees dedicated to customer service, at an annual cost of about $782,000. The total CalPERS administrative expense for the health benefits program is less than one half of 1 percent of premium.

For health plans to be accepted by CalPERS, they must meet and maintain high standards for quality, access and service. They also must be competitive on price. We hold our health plans accountable for demonstrating that they are providing good value to our members. We try to provide our members with meaningful information so that they, too, can hold the health plans accountable by voting with their feet. We believe that in the long run, this is the best way to improve quality and service and hold down costs.

This approach is working well for us, and we would be glad to work with the committee and your staff in exploring options for its application to the Medicare program.

Thank you.

[The prepared statement of Ms. Stanley follows:]

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United States Senate
Special Committee on Aging

Hearing on "Improving Accountability in Medicare Managed Care: The Consumer's Need for Better Information."

Thursday, April 10, 1997

PROVIDING HEALTH PLAN INFORMATION TO MEDICARE BENEFICIARIES

Written Statement

Margaret T. Stanley
Assistant Executive Officer
California Public Employees' Retirement System

Good morning, Mr. Chairman and members of the Committee. My name is Margaret Stanley and I am Assistant Executive Officer in charge of purchasing health benefits for the California Public Employees' Retirement System, known as CalPERS. We are the second largest purchaser of employee health benefits in the country; only the federal government is larger. We cover over one million public employees, retirees and their dependents and spend about $1.5 billion per year on their health benefits. We operate like a health plan purchasing cooperative for public agencies. In addition to the California State government, over 1100 local public agencies in California have opted to buy their employees' health care through CalPERS.

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Risk and Medicare Supplement plans so that all Medicare members receive the same core benefits. We offer 18 health plans to our Medicare members.

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for us and we would be glad to work with the Committee and your staff in exploring options for its application to the Medicare program.

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The CHAIRMAN. Well, thank you very much. I appreciate the testimony, and one of the things I want to talk about is cost-benefit, and I think you have just addressed some of that when you say less than one half of 1 percent is allocated toward administrative costs.

Let me ask you, in regard to costs versus benefit, we have to consider this when we add new requirements to Medicare, and you, obviously, have to think about costs versus benefits for program initiatives such as consumer service and plan-specific information. So, I would like both of you to address what the costs are of providing information and customer service that you presently offer and talk about the benefits in relation to that.

Ms. STANLEY. Mr. Chairman, I think it is terribly important to give the members adequate information, so that they can judge the value of the health plans. We are challenged to do it in a cost-effective way. These booklets amount to 63 cents, as I mentioned in my testimony, per member that we cover. But when members choose health plans that are more cost-effective and higher quality, the purchaser also saves money if they are choosing managed care plans, so that when Medicare looks at the cost of providing this information, the Medicare program could be restructured so that some of the costs of the additional consumer information are offset by the savings in the delivery of care through the managed Medicare program.

The CHAIRMAN. Ms. Darling.

Ms. DARLING. Yes, while I would just also add that if—you probably do not yet get these, but once you are eligible for them, and you sit in a given community, you will see stacks of material with, sometimes, very slick and glossy materials and little refrigerator apples and things like that to try to sell to you in a market. What is spent by marketing now by these health plans would, indeed, be replaced if they were not allowed to do that. You would have the information that you need. The argument for replacing it is that it is misleading and uninformative.

But these are serious decisions, and it is one thing to allow a lot of diversity and glitz and slickness for something like, you know, a car. But if you are doing that, and that, in fact, misleads—and it can do it terribly—then, the Medicare program is hurt. Obviously, the beneficiaries are hurt, and a lot of harm occurs. So, it is a replacement cost for costs that you are already paying for in the Medicare program through the health plans.

The second thing I would say is that there are tremendous costs at the health plans for the failure of these systems. Disenrollment and enrollment—very many of the first year costs or the first month costs are the enrollment, the ID cards. I mean, the costs are huge to enroll somebody and disenroll, so much so that it is always amazing that it is not in the financial interests of the plan to actually do a better job. In fact, over time, we will see that, but we will not see it soon enough.

The best plans—it is not an accident that the ones with the lowest disenrollment rates; it almost does not matter how good or bad the data are; generally it is true. The plans that have been dealing with Medicare beneficiaries the longest spend the most money on new member orientation and the least amount of steps that, in

fact, mislead. So, it is very much in everyone's cost-effectiveness benefit to, in fact, make these steps.

Then, finally, in terms of the costs that we have, very much like CalPERS, at Xerox and the other large companies that I have seen, is that there is an annual cost to put out a certain amount of information, make customer service centers available. It is a cost to the program. Much of that is already being paid for, but, to be honest, the evidence from our own study is that it is not terribly effective.

The CHAIRMAN. I think you just spoke to a point that I asked Dr. Scanlon following on something Senator Wyden said, that when there is an effort to be fully informative and to work with people and to be very open with people that you have lower disenrollment rates.

Ms. DARLING. Absolutely; it is dramatic. it is quite dramatic and you also have very good satisfaction. You have trust, and when you look at the data on things like compliance of patients to a, say, prescription drug regimen, if you trust the program you are in; you trust your doctor; you are comfortable, then, you are much more likely to take the steps that, in fact, the health plan—in this case, the doctor—are recommending. In fact, I have not seen this figure in awhile, so, it is a little bit dated, but something like 7 percent of all hospitalizations are due to problems with prescription drugs: not taking enough, taking the wrong kind or something like that.

So, you already pay for, in the Medicare program, probably millions of dollars for things that will be averted by these kinds of steps.

The CHAIRMAN. The Institute of Medicine has indicated in its report that providing disenrollment data is useful. You have just said that as well. But I am also interested to know what both of you thought about information being provided on the number of appeals reversed or denied by a health plan and the number of appeals reversed and denied by HCFA. Do you think this would be useful to Medicare beneficiaries?

Ms. DARLING. Well, I certainly think so, and, in fact, the Institute of Medicine study, the customer service center, as I mentioned—I will elaborate a little bit on it. What we want to see, because, you know, we can define problems that hurt people. We have known for years that the appeals and grievance system is inadequate, but what we want to do is to change the behavior of the people who are in these situations on a fast turnaround basis, and one way to do that is to give a monthly report of all of the problems and complaints and grievances, and you could add the ones that move up the line, to have an individual from the customer service center sit down or send a report once a month and have a personal conversation with a CEO of the health plan. That will get their attention.

Ms. STANLEY. Thank you. I think it would be important to publish the information on the appeals and grievances, but I think it is even more important to avoid having the appeal happen in the first place, and I think you can do so by providing good information to members when they are making their selections and after they become members of the health plan. I think publishing the consumer satisfaction scores and the disenrollment rates will help a lot to

have people choose the health plans that are more likely to be satisfactory for them.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. I thank the panel very much for their presentation, and, Ms. Darling, your comments are very well taken.

I have been talking about CalPERS ever since I heard about it and congratulate you all for the good work that you have done. What is your disenrollment rate?

Ms. STANLEY. Our overall disenrollment rate, including both our employees and retirees, is about 4 percent a year.

Senator BREAUX. Your rate increases, cost increases, have been running what?

Ms. STANLEY. For the last 4 years, there have been premium rate decreases every year.

Senator BREAUX. That is a real good example of how a group has really put together a program that provides, obviously, adequate health care. I mean, the disenrollment rate is only 4 percent. Look at some of these up here, on the GAO chart which have 30 and 40 percent of the people bailing out every year. You have only got 4 percent disenrolling, and your increase in your costs has been averaging what?

Ms. STANLEY. There have been decreases every year.

Senator BREAUX. Decreases.

Ms. STANLEY. Last year, it was about 2.6 percent decrease.

Senator BREAUX. Decrease in the cost.

Ms. STANLEY. Yes.

Senator BREAUX. Medicare is increasing at 10 percent a year now. It used to be a lot higher than that.

So, if we cannot figure out how to take what you have done and incorporate it into Medicare, we should not even be here.

Ms. STANLEY. Well, we would be happy to assist if we can. [Laughter.]

Senator BREAUX. I mean, hardly anyone is leaving your program. Your costs are actually going down every year, while we have got people in Medicare—I mean, I have got a 50 percent increase in HMO's annually in Louisiana, people bailing out of Medicare because they are dissatisfied with it. The costs are going up; people are leaving it, and Congress is trying to fix it by reducing the reimbursements to doctors and hospitals. I mean, that has got to tell us that we are moving in the wrong direction. More and more doctors and hospitals are going to want less and less to treat Medicare patients, because we are paying them less and less each year.

The only thing we are looking at right now in the Finance Committee is cutting back reimbursements to doctors and hospitals. That is not reform. That is tinkering around the edges, probably in the wrong way.

What you all are doing in the private sector, it is so obvious that it is working. People are staying with your program, and your costs are going down. Having said all that, would you like to take over Medicare?

Ms. STANLEY. No, thank you. [Laughter.]

Senator BREAUX. I think that there is another point I wanted to add. Do you all negotiate with the providers? You do, do you not?

Ms. STANLEY. Yes, we negotiate.

Senator BREAUX. Could you talk about that a little bit?

Ms. STANLEY. Yes; we negotiate with the health plans every year. In fact, we are just concluding our negotiations for 1998, and we do have a reputation for being tough negotiators.

Senator BREAUX. So, how many plans are out there that make a presentation to CalPERS to try to sell you their business?

Ms. STANLEY. We contract with 14 HMO's currently, and that number is decreasing because of the mergers and consolidations that are underway.

Senator BREAUX. Would you describe your plan as a defined contribution or a defined benefit plan or sort of a combination of the two?

Ms. STANLEY. It is a defined benefit plan, and we have over 1,100 employers participating, and they have different systems for deciding how they contribute to the premium, so, that varies a lot.

Senator BREAUX. So, is it pretty well a defined benefit plan, and you ask people to come bid on it?

Ms. STANLEY. Yes; we standardize——

Senator BREAUX. If the bids are not good enough, you sit down and negotiate with them to get them down even further.

Ms. STANLEY. That is correct, and we do an analysis of where we think their rates ought to be, based on their experience and the demographic makeup of their population, and it helps to have a standardized benefit package, because then, you really can make these comparisons.

Senator BREAUX. How does your plan of defined benefits compare with what Medicare offers?

Ms. STANLEY. It is much more generous. For example, for the Medicare HMO's, they can get 3 months' worth of prescription drugs for a $1 copayment.

Senator BREAUX. How about any extended care?

Ms. STANLEY. The HMO's do not have long-term care. CalPERS does offer a separate, free-standing long-term care insurance program, though.

Senator BREAUX. Eyeglasses?

Ms. STANLEY. Yes; eyeglasses are covered for the Medicare beneficiaries.

Senator BREAUX. Well, I thank both of you for your recommendations. I think they are very, very helpful, and we have a lot to learn as a Congress. Medicare is a wonderful system, but it is still a 1965 model. We, as political leaders, have to somehow convey to seniors in an understanding fashion that when we try to change Medicare, we are not trying to hurt them, but help them. We will help by giving them something that is far more efficient, less costly and is going to be there for the duration rather than going broke.

Thank you.

The CHAIRMAN. Do you want to respond to Senator Breaux?

Ms. DARLING. I would just like to add a point to put the financial situation in a little national perspective. There are many markets in this country—and, actually, many of the Senators on this committee, including the chairman are affected by the fact that one of the reasons California can have all of these rich extras for the amount of money is that the payment of the Medicare program per capita is sometimes anywhere from 2 to 3 times higher than it is

in other parts of the country including your States. I do not know your AAPCC, but I would bet it is quite a bit lower. So, the health plan is given considerably less money, and, as a consequence, it cannot provide all of these extras, or it feels it cannot provide all of these extras.

Now, the question—and, I think, we tried to grapple with this in the Institute of Medicine study—is not just what is happening today but what is going to happen as the problems in other areas where the AAPCC is very low, and we try to put into that system—people want whatever they can get out of the benefit, but, at the same time, it is not going to be rich. It is going to be tougher and more complicated, and that is without any kind of changes. So, any solution has to really keep in mind that the vast majority of counties in America have really, really low AAPCC's, not like California and Dade County, FL and Baltimore, MD, just to name a few.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. One quick one: when you talked about eyeglasses, when you got your first pair, just a question I have always wondered. If you get sick, and you have a $1,000 deductible; you get sick in December, and you get well in February, is it a $2,000 deductible in most all plans?

Ms. DARLING. Yes.

Senator JEFFORDS. That does not seem very fair, does it?

But anyway, everyone talks about using HEDIS quality of care measurements in their assessments of plans. In your testimony, Ms. Stanley, you state that you used the HEDIS measurements in your annual performance reports. Can you explain how HEDIS captures quality of care information and how this is translated into objective data?

Ms. STANLEY. Yes; we collaborate with the Pacific Business Group on Health to collect independently audited HEDIS quality of care data, and that is important, because the data that the health plans supply often is not very good or very complete. So, this took a lot of work for these major purchasers working together, and in this quality and performance report, we report on 6 quality of care measures. There are many more, but this is a start and these are: childhood immunization rates, cholesterol screening, prenatal care, cervical cancer screening, breast cancer screening, and diabetic eye exams, and we report on whether they are above average, average, or below average.

One of the challenges we have is trying to figure out what quality of care data is meaningful to people in making their choices about health plans and how you can present it in a way that is understandable, and I do not think we have all of those questions answered yet, but we keep refining it each year.

Senator JEFFORDS. Well, is there any reason why HCFA could not do the same thing?

Ms. STANLEY. No; I think HCFA should do the same thing.

Senator JEFFORDS. Well, thank you, Mr. Chairman. You have three members of the Finance Committee here now, so, we are all very interested in what you are saying, and I deeply appreciate your testimony.

The CHAIRMAN. We will be in a very good position to carry out some of these recommendations that we are learning about at our hearings.

If I could go to a second round, and I do not have a lot of questions, so we will be done very shortly, but I was wondering, in regard to your testimony, Ms. Stanley, where you outlined the benefits of standardized benefits for Medicare, I would be interested in knowing if there are any disadvantages that you might see to standardized benefits.

Ms. STANLEY. I think that you could model this after the Medicare supplement standards, where you have several types of plans but not as much diversity as shown on your board. One of the differences is that Medicare is mainly an individual program, and we are administering it on a group basis. So, it makes it easier for us to standardize for all our enrollees.

Medicare individual enrollees, perhaps, might want a less expensive plan, where they would forego some of the additional benefits in order to have a lower premium. So, I would suggest that you have several standard plans, sort of a low cost, a medium cost, and a high cost. Standardization is very helpful, because then, you can really compare the plans in terms of what they are delivering in terms of value.

The CHAIRMAN. So, there is really not a disadvantage.

Ms. STANLEY. No; I think there are more advantages.

The CHAIRMAN. Do you want to add to that?

Ms. DARLING. Well, the Institute of Medicine Committee did comment on that and did recommend that there be a sort of core, standardized package, definitely. We actually felt that it would, in terms of public policy, be very complicated, because you do have places like California, where the basic benefits are already considerably richer than the basic benefits would be in Rochester, NY, for example. So, the recommendation was that everybody agree and require a core, standardized package but then, there are very clear information about additional benefits and what they might cost if there were any additional premium for that. But all of that had to be standardized in terms of terminology and understanding from the beneficiaries' perspective.

The CHAIRMAN. You mentioned that CalPERS is going to start publishing disenrollment data. Have you run into any resistance from participating health plans? How do they feel about that?

Second, what is your rationale for including disenrollment data?

Ms. STANLEY. We have not received any objections to our publishing the disenrollment data. In fact, we report the results of our open enrollment season to our Board of Administration every year, so it has been public information. This will be the first time that we put it in our open enrollment materials that are mailed to members.

So, we see no disadvantage. The disenrollment can represent a number of different things. It could be overall dissatisfaction, or it could be major disruptions in the provider network, which is something we are experiencing in California. One of our health plans lost 10 percent of its enrollment this year due to a termination of a major clinic in the Sacramento area. So, the disenrollment rate

covers a lot of different things, but we think it is important information for members to have.

The CHAIRMAN. You mentioned that the Institute of Medicine, in its report, has recommended establishing a national customer service center for Medicare beneficiaries.

Ms. DARLING. Yes.

The CHAIRMAN. Would that be a very costly operation, and how might it work?

Ms. DARLING. Well, it should not be. Again, it would be a substitute for a lot of costs that are already being paid, in this case, by the health plans or by Medicare because of people enrolling and disenrolling. There are costs associated with that. Our vision was statement much like some of the best catalog operations, where you have individuals who are highly trained and specialized and are comfortable with and, in fact, love working with retirees and the disabled and to play, really, a very powerful helping role to help them to understand the written materials they have.

We found in the study—it is no surprise at all for many who deal with Medicare beneficiaries as your own constituents—they like to have a conversation. Even if they have written material, they want to be able to say does this mean that I have to—as Senator Jeffords just said—it is $1,000 at the end of the year, $1,000, and have somebody to sort of talk it through. They tend to do it with their families now or their friends, and it is not nearly as helpful.

So, the costs would be substitutes for costs that are currently borne either by the health plans or the Government, because there is confusion, misinformation, high costs of enrollment and re-enrollment. We think that, in fact, it could be very much paid for by itself.

If you look at the best commercial operations: the Talbots, the L.L. Beans, the Land's Ends, G.E. Service Center, there are lots of really top-notch models out there that really run very efficiently with well-trained people who are very helpful and provide very personalized service.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you very much.

One follow-up point, Ms. Darling, on the point you were making about California being a high-cost fee-for-service area, and, therefore, the reimbursement rate to the managed care operators would be higher, differing in rural and smaller areas. I am trying to figure out the point that you are trying to make, because it would seem to me that if you are in a rural area, where the fee-for-service costs are less, the reimbursement, obviously, for the managed care would be less. But would that not be in keeping with the cost of doing business in that area? In other words, for an HMO in that area, would their cost of doing business also be lower, because the cost of doing business in a rural area is lower? Or is it because of the lack of large numbers?

Ms. DARLING. Well, it is a complex combination, but it is obviously not enough for them to turn around. I mean, you look at the extra benefits people get in L.A. County and Dade County, FL, and companies can make profits—not just non-profits breaking even by providing services; they make very high profits, and they still can

provide very expensive and complete drug benefits. They can run shuttles to recreation centers. They can give you eyeglasses.

So, there is something about the combination of their ability to get a very good deal in an oversaturated, overcapitalized market. Many hospitals, many hospital beds are willing to give greater discounts. But it is a lot easier to give a discount off of $300 than $150. So, you start with a very kind of slim and, if you will, undercapitalized health system—perhaps Monroe, LA, would be an example—where there may not be excess capacity, lots of hospitals, lots of doctors. I do not know that is the case. But you have areas like Los Angeles and Dade County, Florida, where the total costs of the system are considerably higher, and the Federal Government goes in and gives them 95 percent of that total cost, and then, they can turn around and, if you will, cut better deals.

Senator BREAUX. But would not 95 percent of a fee-for-service in a rural area be lower than 95 percent of fee-for-service in Los Angeles or Dade County, and, therefore, HMO's would get 95 percent of a lower amount in those rural areas?

Ms. DARLING. It definitely would, although there are some people who say that it is not just the price; it is the volume. So, let us say an x-ray is $95 in Monroe, and it is $125 in L.A. County, just as an example. But in L.A. County, they also tend to do three of those x-rays, and maybe they only do one in Monroe. So, that drives up the cost. They turn around; now, they are only doing the one x-ray, because they do not need to do the three, because they have got managed care. They still need to do the one in Monroe.

So, there is not as much—as one hospital administrator once referred to—much wiggle room in some of these small towns and lower cost areas, and there still is sort of a basic, fixed cost of delivering health care. I mean, if you buy Naprosyn, Naprosyn will cost the same thing in Monroe, LA as it costs, probably, in Dade County, Florida, and you are getting a lot more in Dade County, Florida, for that.

Senator BREAUX. OK; I appreciate that. Thank you.

The CHAIRMAN. Yes; we thank you very much for the dialog we have had. You have contributed a great deal to this discussion, particularly your varied experiences and being both public and private sector involvements.

We thank you very much, and we dismiss you and adjourn the meeting.

[Whereupon, at 11:05 a.m., the committee adjourned, subject to the call of the chair.]

[Additional material submitted for the record follows:]

APPENDIX

GAO RESPONSES TO SENATOR JEFFORDS QUESTIONS

Question. Do you think that HCFA's selected HEDIS 3.0 measures are the only or the best sources of data for measuring health plan performance? Are there any other HEDIS measures that you'd suggest?

Answer. The Medicare program should measure health plan performance by referring not only to HEDIS but to additional indicators.

Perhaps the most important aspect of HEDIS is that it represents a commitment by large purchasers and HMO's—joined recently by regulators and beneficiary advocates—to continually reevaluate existing measures and develop new ones. In fact, the current version of HEDIS 3.0 includes a number of measures that are being tested for possible inclusion as standard measures in future versions of HEDIS. We believe it is important for the National Committee for Quality Assurance to continue in its efforts to develop more accurate and comprehensive indicators of health plans' quality and performance.

Apart from HEDIS, HCFA has access to data, such as voluntary disenrollment rates, that can indicate the relative performance of health plans. Because the Medicare managed care program and the population it covers are unique, certain performance indicators available to HCFA may not be appropriate for commercial enrollees. We believe HCFA should evaluate the information it already collects with an eye towards developing new performance measures unique to Medicare managed care.

Question. I've always thought that plans should compete with one another based on the quality of their services—not on a better marketing ploy. You've testified that rates of early disenrollment may indicate beneficiary confusion and marketing problems. In other words, that the plan is focussing on recruiting new enrollees to replace the many who have disenrolled, rather than on quality care.

Do you think this practice is widespread?

Apart from dissemination of more and better information, how can it be addressed?

Answer. HCFA has long expressed concern over the marketing practices of some south Florida HMO's. In our analysis of two large Medicare managed care markets—south Florida and Los Angeles—we found indications of marketing problems at several HMO's. In these plans, a relatively high proportion of beneficiaries either canceled their applications or disenrolled shortly after their effective enrollment date. Although beneficiaries disenroll for many reasons,

when a large proportion of beneficiaries leave a plan after so little time it is reasonable to suspect that these beneficiaries were not fully informed—or were misled—about the restrictions, costs, or availability of providers in the HMO they joined.

Publicizing HMO's disenrollment rates and other performance indicators may reduce some of these marketing problems. For example, if beneficiaries can readily compare disenrollment rates, competitive market forces may encourage HMO's to do a better job of informing potential members and serving existing ones. These market forces could then complement HCFA's monitoring approach to reduce HMO marketing problems.

Alternatively, HCFA could limit HMO's direct marketing activity and rely instead on independent enrollment counselors. This option is used by some State Medicaid programs with mandatory managed care enrollment. Because managed care enrollment is voluntary in Medicare, this option has a potential disadvantage for Medicare. Independent counselors may not be as knowledgeable about specific plans and may be less successful than HMO sales representatives in encouraging beneficiaries to try managed care.

Question. Assuming HCFA adopts the measures you recommend, how can we best coordinate those efforts with private efforts to measure and publicize health plan quality?

Answer. The measures we recommended are ones that we believe Medicare is uniquely positioned to implement. Some of these measures may not have natural counterparts in the private sector. Disenrollment rates, for example, are especially useful in comparing Medicare HMO's because disenrollment for Medicare beneficiaries is an individual decision. In contrast, disenrollment among commercial enrollees may reflect an employer's decision to contract with a different health plan. Moreover, Medicare beneficiaries are free to change plans each month while commercial enrollees are typically locked into a plan for a year.

Coordination is important, however. Health plans benefit when the burden of collecting and reporting data is reduced by the existence of a standard set of measures. In addition, beneficiaries can make better health care decisions when they can easily compare plans across standard dimensions. Because increased coordination of efforts to construct Medicare and non-Medicare measures is a worthwhile goal, we believe that HCFA's participation in the development of HEDIS 3.0 is a step in the right direction.

Question. A recent U.S. District Court case looked at the minimal grievance procedures that Medicare managed care plans should have in place.

Have you looked at this at all?

Answer. Our work for the Committee in 1995 addressed deficiencies in beneficiaries' right to appeal when they thought their HMO had wrongly denied care. However, since our study HCFA has drafted new regulations to improve the appeals process. We have not studied the impact of HCFA's new regulations.

Question. Do you think this should be standardized for Medicare managed care programs?

Answer. Although standardization of grievance procedures in Medicare would seem to be a simple matter of equity—not just among managed care plans, but between managed care and fee-for-

service Medicare—such uniformity has not always been the case. Until fairly recently, hospitalized managed care patients had weaker protections from wrongly denied care compared to similar fee-for-service patients. In 1994, however, HCFA issued regulations to correct this apparent inequity.

Question. Should it be included as a performance indicator?

Answer. We support the reporting of complaint rates as a broad indicator of performance differences among HMO's. HCFA regions routinely receive inquiries and complaints from beneficiaries, and some regions already compile statistics on this information. Like disenrollment rates, relative complaint rates can be a useful indicator of overall beneficiary satisfaction. The rate of appeals and the outcomes of those appeals may be useful performance indicators too. However, HCFA may need to conduct additional analysis before that information can be presented in a useful and meaningful way.

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