

ISSUE BRIEF

Communicating to Beneficiaries about Medicare+Choice: Opportunities and Pitfalls

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A discussion featuring

Carol Cronin
Director
Center for Beneficiary Services
Health Care Financing Administration

Susan Kleimann, Ph.D.
President
Kleimann Communication Group, LLC
Washington, DC

Douglas M. Cook
Director
Florida Agency for Health Care
Administration

Joseph J. Martingale
Principal
Towers Perrin
New York

Mark V. Pauly, Ph.D.
Chair
Department of Health Care Systems
Wharton School
Philadelphia

Communicating to Beneficiaries about Medicare+Choice

The Balanced Budget Act of 1997 (BBA) opened up an array of new health plan options for Medicare beneficiaries under a new Medicare component—Part C, the Medicare+Choice program. Medicare+Choice is intended to give beneficiaries the opportunity to choose between the existing Medicare fee-for-service program and a wide range of alternative plans, including managed care options, such as health maintenance organizations (HMOs) with or without out-of-network coverage; preferred provider organizations (PPOs); and provider sponsored organizations (PSOs); as well as private fee-for-service plans and medical savings account (MSA) plans.

This fall, Medicare beneficiaries will receive information about these new options, although in a more scaled-down effort than originally planned by the Health Care Financing Administration (HCFA). As late as June 18, HCFA had intended to send a comprehensive handbook unveiling Medicare+Choice to all 36 million eligible Medicare beneficiaries in November. But drafts of the handbook received sharp criticism from several members of Congress and advocates for senior citizens, who were worried that Medicare beneficiaries would be “thoroughly confused” by these new options.¹

Thus, just days before the handbook was scheduled to go to the printer, HCFA announced it would limit distribution of the handbook and “pilot test” it in five states. Approximately 5.5 million beneficiaries in Arizona, Florida, Ohio, Oregon, and Washington will receive the comprehensive handbook with comparative plan information. The remaining beneficiaries will receive a four- to six-page “newsletter” that broadly describes the new Medicare+Choice options.² In 1999, HCFA plans to send out a comprehensive guide to all eligible Medicare beneficiaries; Medicare’s first annual open enrollment period does not take place until the fall of that year. In the meantime, many Medicare beneficiaries likely will receive promotional, plan-specific materials directly from the Medicare+Choice plans themselves, especially in competitive markets.

Communicating complex information to such a wide audience has significant implications for the future direction of the Medicare program. The Medicare Payment Advisory Commission’s most recent report to

Congress states that “informed beneficiaries are essential if the Medicare+Choice program is to succeed.”³ In creating Medicare+Choice, proponents hoped to move the program toward a market-based, consumer choice model. Yet, numerous surveys and focus groups, including those conducted by HCFA, indicate that most Medicare beneficiaries do not understand the basics of the traditional Medicare fee-for-service system, much less the panoply of choices that will become available under Medicare+Choice. As a result, many advocacy and employer groups fear that beneficiaries will not be adequately prepared to make informed health care decisions and could inadvertently be exposed to higher costs or reduced access to some services.

This Forum session will explore the opportunities and potential pitfalls in communicating to beneficiaries about Medicare+Choice. HCFA’s strategies for educating Medicare beneficiaries about their plan options will be discussed, as will the challenges of communicating complex information to a diverse group of older individuals. The session will also draw from the experiences of competitive Medicare HMO markets—focusing on the lessons learned in Florida, where Medicare HMOs have embarked on aggressive marketing campaigns—as well as the experiences of large employers who have used a variety of communication techniques to successfully move many of their retirees into HMOs.

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Analyst/Writer

Nora Super Jones

National Health Policy Forum

2021 K Street, NW, Suite 800

Washington, DC 20052

202/872-1390

202/862-9837 (fax)

nhpf@gwu.edu (e-mail)

www.nhpf.org (Web site)

Judith Miller Jones, Director

Karen Matherlee, Co-Director

Sandra M. Foote, Co-Director

Michele Black, Publications Director

NHPF is a nonpartisan education and information exchange for federal health policymakers.

BBA INFORMATION REQUIREMENTS

BBA contains many new information requirements intended to help beneficiaries make informed choices. BBA requires the secretary of health and human services to mail general information to all 36 million eligible beneficiaries, beginning in 1999. The mailing must include information on

- Covered benefits, cost sharing, and balance billing restrictions under Medicare fee-for-service.
- Enrollment procedures.
- Beneficiary rights, including appeals and grievance procedures.
- Medigap and Medicare Select.

BBA also requires HCFA to provide area-specific comparative plan information both in print and on the Internet to every beneficiary eligible for Medicare+Choice. This comparative information must include the following:

- Supplemental benefits.
- Cost-sharing.
- Choice of providers.
- Limits on out-of-pocket costs.
- Service area.
- Plan rules (for example, coverage of out-of-network services).
- Quality and performance measures (for example, selected HEDIS measures).⁴
- Disenrollment rates for the previous two years.
- Medicare enrollee satisfaction survey results.

BBA also requires HCFA to establish a toll-free hotline to respond to beneficiary questions about Medicare+Choice plans; HCFA must also make plan comparison information available on its Internet site (<http://www.medicare.gov>). Finally, the act requires HCFA to conduct an annual publicity campaign (referred to as a “health fair” in the statute).

Legislative drafters of BBA clearly intended for the Medicare+Choice plans themselves to be a primary source of information for beneficiaries. The Medicare+Choice plans are being assessed user fees to offset the costs of HCFA’s educational campaign, and the act requires the plans to provide enrollees (or prospective enrollees) with information on the service areas; plan benefits and supplemental benefits; the number, mix,

and distribution of plan providers; out-of-network coverage (if any); emergency services; pre-authorization rules; and descriptions of their grievance and appeals procedures and quality assurance programs. Upon request of the beneficiary, plans must also provide data on the number of grievances, redeterminations, and appeals; utilization review practices; and a summary of how the plan compensates participating providers. Also, based on experience with Medicare HMOs in competitive markets, the Medicare+Choice plans are expected to market directly to individual beneficiaries with promotional, plan-specific materials.

GETTING THE WORD OUT: HCFA’S GAME PLAN

To meet consumer information needs, HCFA has embarked on a National Medicare Education Program, the purpose of which, according to HCFA, “is to ensure that beneficiaries receive accurate, easily understandable information about their benefits, rights, and health plan options to assist them in becoming more active participants in their health care decisions.”⁵ The program is intended to be a five-year effort. HCFA plans to use a phased educational approach “moving from *awareness* to *understanding* to *use* of information by beneficiaries to make personal decisions about the best value health plan option for them.”⁶

HCFA plans to use six major channels of communication to get this information out to beneficiaries:

- Mass mailing (Medicare handbook with plan comparison supplement).
- Toll-free telephone lines (1-800-MEDICAR).
- Internet.
- National publicity campaigns (health fairs).
- Media.
- Community-based, face-to-face communication (through local aging and insurance agencies).

The presentation of comparative plan information represents HCFA’s first attempt to communicate this information to beneficiaries. Based on criticism from many fronts, HCFA decided to pilot test the handbook with plan comparison information before disseminating it to all Medicare beneficiaries.

Beginning in November 1998, Medicare+Choice benefit plan information and plan comparisons by zip code will be included in the “Medicare & You” handbook and mailed to the 5.5 million eligible beneficiaries

who live in Arizona, Florida, Ohio, Oregon, and Washington. Because of the timing of proposed regulations and printing deadlines, the 1999 "Medicare & You" handbook will only include information about Medicare HMOs and MSAs. As new plan options and plan performance data become available, HCFA will update its Web site. According to HCFA officials, these five states have been selected because they offer a snapshot of Medicare beneficiaries in terms of their population mixes and experience with managed care.⁷

As mandated by BBA, the year 2000 version of the handbook will be mailed to all eligible beneficiaries in the early fall of 1999 so that it can be used during the November open enrollment period. The year 2000 handbook is expected to include selected HEDIS performance measures, enrollee satisfaction results (selected measures from the Consumer Assessment of Health Plans), grievance and appeals procedures, and disenrollment rate information.

This year, HCFA plans to roll out the toll-free call center in the same five states that receive the handbook. Callers to the services will first receive an automated response unit that could be either touch-tone or voice activated. Spanish language and hearing impaired service will be provided. The call center service will be available 24 hours a day, seven days a week, allowing callers to receive recorded answers to frequently asked Medicare+Choice questions, order Medicare publications, or request a disenrollment form. To provide answers to more complex questions and comparative information about local health plan options, customer service representatives will be available from 8:00 a.m. to 4:30 p.m. local time.

COMMUNICATING WITH THE ELDERLY: WHAT WE KNOW

Simply considering the sheer magnitude of the Medicare program and the tight statutory deadlines imposed by BBA, HCFA's task is clearly enormous. Adding to these challenges are the difficulties inherent in communicating to elderly beneficiaries.

Medicare Demographics

Medicare beneficiaries are extremely diverse in terms of socioeconomic characteristics and health needs. Although nearly half were between 65 and 74 years old in 1995, the most rapidly growing beneficiary groups comprise people under age 65 (who receive benefits based on disability or end-stage renal disease)

and people age 85 and older. Fifty-seven percent of Medicare beneficiaries are women; 43 percent are male.

Today, the majority (86 percent) of Medicare beneficiaries are white; 9 percent are African American, and less than 1 percent are Hispanic.⁸ However, minority populations are projected to represent 25 percent of the elderly population in 2030. Between 1990 and 2030, the white non-Hispanic population over age 65 is projected to increase 91 percent, compared with 328 percent for minority populations over 65, including Hispanics (570 percent) and non-Hispanic blacks (159 percent); American Indians, Eskimos, and Aleuts (294 percent); and Asians and Pacific Islanders (643 percent).⁹

In 1996, the median income was \$16,684 for men aged 65 and older and \$9,626 for women. Households containing families headed by persons 65 and older reported a median income in 1996 of \$28,983. Nearly 16 percent of family households with an elderly head had incomes less than \$15,000 and 40 percent had incomes of \$35,000 or more.¹⁰

Communicating plan comparison information to this population requires different strategies from those employed on younger health care consumers. As a group, Medicare beneficiaries are older and sicker than patients who have traditionally used managed care plans. They also tend to have less schooling and lower literacy levels than the general population. According to the Department of Education's National Adult Literacy Level assessment conducted in 1992, 53 percent of elderly Americans cannot read at all or can locate only one piece of information in short, uncomplicated text (level one literacy level). For comparison, 23 percent of the total population fall into this category. Thirty-two percent of older Americans are able to locate two or more pieces of information in text or tables and can integrate information from various parts of the simple text or table (level two). Thirteen percent can identify multiple pieces of easily identifiable information and can cycle through rather complex tables, for example, multiple columns (level three). Only 2 percent are able to explain, summarize, and interpret multiple pieces of information in lengthy and complex materials (levels 4 and 5).

Physical conditions common in the aging process also affect communication needs. Seniors usually experience loss of visual acuity, color sensitivity (for example, trouble reading materials with pastel colors), hearing deficits, and some memory loss. In general, older adults need more time and assistance in making decisions and have more difficulty processing novel information.

Thus, “one size fits all” approaches will definitely not meet the needs and demands of this diverse population. Many elderly, especially those with access to group retiree health coverage, are prosperous and lead active, busy lifestyles. An estimated 7 to 15 percent of senior citizens use the Internet. More affluent seniors also tend to be politically active and can be a powerful voting bloc. Policymakers will remember the reception of the Medicare Catastrophic Coverage Act of 1988. A sizable group of senior citizens, primarily those who had employer coverage and would have had to pay more and get no additional benefits, were unhappy with the new law and mounted an intense grassroots campaign against it. The law was quickly repealed.

Minimal Experience with Managed Care

The vast majority of current Medicare beneficiaries have had no experience with managed care or health plan choice. Eighty-five percent still receive their health care through the original fee-for-service system. Because they have had little exposure to managed care, other than negative press accounts, many seniors may be less likely to want change and may view change in the context of cutbacks in the program.¹¹

A new study by the American Association of Retired Persons (AARP) found that nearly one-third of beneficiaries in the study knew almost nothing about HMOs. More than half of these were enrolled in HMOs. Indeed, beneficiaries in the traditional Medicare program knew more about the differences between the traditional Medicare program and HMOs than did HMO enrollees.¹²

Results of recent focus groups conducted with Medicare beneficiaries in the California market by the National Academy of Social Insurance (NASI) and the California HealthCare Foundation echo these findings.¹³ The large majority of people in the focus groups—who were distributed by age, race, income, and education—did not know if they were in traditional, fee-for-service Medicare or not; some thought they were not in Medicare if they were in an HMO.

The NASI focus group participants said they wanted information presented by neutral people who were unattached to plans and would give them a chance to talk. Research evidence consistently shows that most Medicare beneficiaries prefer to get information one-on-one, from individual counselors, or in small groups where they can get answers to their specific questions.

The Lessons of Market Experience

There are two distinct market segments among the Medicare population—seniors who purchase as individ-

uals (who pay for any services not covered by traditional Medicare, either through supplemental insurance or out of pocket) and corporate retirees (for whom a former employer finances some or all of the services not covered by traditional Medicare). Nearly half of those eligible for Medicare purchase as individuals, while just under 40 percent receive some assistance from a former employer. (The remainder receive governmental assistance, such as Medicaid, for their supplemental needs.)¹⁴

Plan marketing strategies. Because most seniors join plans as individuals, rather than as part of a group, HMOs participating in the Medicare market have had to adjust their strategies to convince seniors to join HMOs. Since most seniors join HMOs to save money, the majority of HMOs focus their marketing strategies on those benefits and services that offer attractive cost savings to beneficiaries (for example, prescription drug benefits, dental care, and vision care). And some critics contend that HMOs use highly sophisticated marketing strategies to target seniors who are better health risks.

HMOs tend to use a standard menu of communication tools, including general advertising (for example, television, radio, billboard, print), direct mail campaigns, telemarketing, group meetings (usually with “freebies,” such as food and door prizes), and individual meetings with seniors. The largest Medicare HMOs have built very high brand name awareness by virtually saturating the market with advertisements and through liberal use of group meetings and home visits for sales presentations. Two leading Medicare HMOs in the Los Angeles market—PacifiCare of California and Kaiser Foundation Health Plan—have reported that the majority of their individual sales occur through their home-visiting programs.¹⁵

Market experience has shown that seniors rely heavily upon peers or others whom they trust when seeking information and advice on whether to join an HMO (and on which plan to join). HMOs report that at least half of all new enrollees joined because of a recommendation from a peer or other trusted adviser; some HMOs report figures as high as 70 percent.¹⁶ HMOs have gained market advantage by carefully selecting who represents them to the senior. Many HMOs have adopted a “senior ambassador” program which typically brings a senior who is an enthusiastic member of the managed care program to the group sales meetings to answer questions from prospective enrollees. Some HMOs report success with using physicians at sales meetings to explain how they treat patients in the HMO, emphasizing “the idea that access and quality are comparable, if not superior, to that found in a fee-for-service plan.”¹⁷

Employer strategies. Many large employers have recently made significant strides toward moving their retiree population into Medicare managed care. In 1997, 39 percent of large employers offered Medicare-risk HMOs (up from 7 percent in 1993, according to Mercer/Foster Higgins data), and 38 percent of their retirees were enrolled in them.¹⁸ With significant incentives to save money (and limit their financial liability), many large employers are motivated to market Medicare HMOs to their retirees who live where these plans are available. According to a 1997 report by Hewitt Associates LLC, a company that moves about 25 percent of its retirees into a Medicare HMO can expect to see accounting cost reductions of about 10 to 15 percent.¹⁹

Employer experiences in educating retirees about new HMO options provide useful lessons for the Medicare program's beneficiary education efforts. Over the past two years, Towers Perrin, a national employee benefits consulting firm, has coordinated the Medicare HMO Initiative, a coalition of more than 70 employers who jointly evaluate and negotiate with more than 340 Medicare HMOs nationwide. Towers Perrin has also managed the implementation of retiree benefit strategies for companies such as Allied Signal, AT&T, Citibank, First Union Corporation, and Lucent Technologies.

Medicare beneficiaries in the group market tend to rely heavily on their former employers for advice and information about their health plan options. Employers participating in the Medicare HMO Initiative have found that cost incentives, coupled with hands-on, long-term educational campaigns, can persuade seniors to move to managed care.²⁰ However, they have learned that the process is slow-moving and requires quite different strategies than those they use in communicating with current employees. For example, while current employees value the speediness of call centers and ability to get answers quickly, retirees value more time and attention to their particular questions, and they dislike phone trees. Many employers have found that meetings are the key decision making factor in the process. Their experience has shown that 70 to 80 percent of retirees attending a meeting will enroll.²¹

Yet, despite the success of many health plans and employers in persuading seniors to join HMOs, some Medicare HMOs have experienced high disenrollment rates in certain markets. In 1996, disenrollment rates exceeded 20 percent of plans' average monthly membership at more than 40 Medicare HMOs. While there is strong disagreement among policymakers, health

industry representatives, and advocates for the elderly about the reasons for high disenrollment rates, the General Accounting Office (GAO) has stated that poor education of enrollees during an HMO's marketing and enrollment process may be one cause: "enrollees may be ill informed about HMO provider-choice restrictions in general or the operation of their particular plan."²²

OPPORTUNITIES FOR EDUCATION

Proponents of the Medicare+Choice program believe it will transform Medicare from a fragmented fee-for-service system to a more competitive, consumer-driven program featuring a variety of delivery system options. Following on the heels of the private-sector revolution toward managed care, supporters of Medicare+Choice hope to see similar cost savings and lower utilization of unnecessary care. In addition, beneficiaries may receive added benefits and a more coordinated approach to care.

Medicare+Choice represents a historic change in Congress's approach to the Medicare program. Introducing consumer choice, proponents maintain, allows consumers to drive changes in the system and lets Congress avoid micromanaging Medicare. Moving to this model gives seniors an opportunity to exercise more control over the type of care delivery and financing system through which they obtain care. Proponents believe that this type of consumer empowerment and assumption of responsibility can result in greater satisfaction with and more appropriate use of services.

BBA requirements to provide information to beneficiaries on quality standards represent an important step toward raising the visibility of quality and performance standards. Private-sector experience has shown that the publication of quality data can positively influence health plan and provider behavior.²³ Given the huge market presence of Medicare, publication of disenrollment data, enrollee satisfaction, and other performance measures will create incentives for health plans to improve in these areas.

In addition, many observers predict that, as individuals who have had experience with managed care become eligible for Medicare, they will want to remain in managed care, and the Medicare+Choice program will give them the opportunity to do so. BBA is expected to accelerate enrollment in managed care plans by a large percentage; the Congressional Budget Office estimates that 39 percent of Medicare beneficiaries will be enrolled in private plans by the year 2007.²⁴

POTENTIAL PITFALLS

While offering numerous opportunities for improving the Medicare market, giving so many choices to beneficiaries has a number of drawbacks and potential pitfalls as well. In rolling out Medicare+Choice, HCFA will likely encounter several communications and programmatic challenges related to information overload, marketing concerns, lack of uniform standards, lack of infrastructure, and the vulnerability of various subpopulations.

Information Overload

Once all of the Medicare+Choice options have been introduced in the market, many Medicare beneficiaries will be faced with a flood of information. Medicare+Choice plans will likely embark on aggressive marketing campaigns, in addition to the information provided by HCFA in 5 states this year and 50 states next year. In some markets, Medicare beneficiaries may see little activity, but in others the competition for enrollees is expected to be intense. In fact, today in mature managed care markets such as southern California, beneficiaries are choosing among as many as 12 HMOs, even before any of the additional Medicare+Choice options have been introduced.

Moreover, as stated earlier, BBA requires HCFA and the plans to provide beneficiaries with tremendous amounts of information (for example, benefits, rights, election procedures, potential for contract termination, and disenrollment data). This inundation of information could confuse some Medicare beneficiaries and potentially overwhelm them.

Decision research suggests that *experts* in a field cannot handle more than five to eight variables at a time when making a decision.²⁵ Even if HCFA successfully gets all of this information into charts or a booklet (which, to start with, must be easy for the elderly to read), several communications experts question whether the plan comparison information will actually be used in the decision-making process. Evaluations of report cards show that few people (including employers and other purchasers) use them now to make decisions.²⁶ Adults generally read functional documents (such as the Medicare handbook) by skimming the text for answers to questions. If they are unable to find the answers to their specific questions or they are intimidated by the size of the document, they simply quit.²⁷

The NASI focus group participants said information about specific benefits and out-of-pocket expenses make a big difference to them. For example, they

wanted to know whether or not specific drugs are included in a formulary and the actual costs of dental procedures or getting new eyeglasses—information that is far too specific to be included in a comparison chart.

To avoid information overload, communication specialists and advocates for the elderly suggest, HCFA should focus on the most essential basic messages that beneficiaries need:²⁸

- There are new options in Medicare.
- You do not need to change plans, but should find out about these options sometime.
- There are places you can call and people who will help you get more information.

Indeed, a key recommendation of the Institute of Medicine's Committee on Choice and Managed Care was that the elderly should be assured that they are not in danger of losing traditional Medicare coverage if they prefer to keep it and that they can delay making a choice at all indefinitely and still remain covered by traditional Medicare.²⁹

Marketing Concerns

Assuring beneficiaries that they do not have to do anything will be a critical message, given the potential flood of mailings anticipated from Medicare+Choice plans. In AARP's study, Medicare beneficiaries reported HMO advertisements to be the most common source of information about HMOs.³⁰ The IOM study found that marketing materials frequently include misleading or incomplete information, giving the elderly the impression that managed care provides all the care they need, without any limits or restrictions, at zero premium costs, beyond the current Part B contribution.

While this may be true in some instances, experience with Medicare-risk HMOs suggest that enrollees often do not understand common managed care techniques, such as physician network limitations and prescription drug formularies. Several employers who have moved retirees into Medicare-risk HMOs have experienced cases in which retirees join an HMO to receive unlimited drug benefits (an attractive feature because Medicare does not traditionally cover prescriptions) but still expect to see their regular specialist (who is not part of the HMO network). These beneficiaries are then dismayed when their medical claim related to the specialist is denied. Also, employers have found that retirees often do not understand that they may no longer be eligible for employer-sponsored retiree coverage if they sign up instead with an HMO.

Some employers worry that this problem could be exacerbated with the creation of Medicare+Choice because the program is also referred to as Medicare Part C. They believe their retirees will see Part C as adding to their current benefits rather than replacing Medicare Part A and B. A recent Kaiser Family Foundation study of Medicare insurance counselors reported that beneficiaries often want to switch out of HMOs when they lose easy access to specialists. Counselors also report problems for beneficiaries who disenroll from the Medicare HMO to return to traditional Medicare coverage and discover—often too late—that they cannot purchase Medigap to fill in gaps in coverage.³¹

The ability to switch in and out of Medicare+Choice is structured to become more restrictive over the next few years; seniors will no longer be able to enter or drop out of managed care plans on a monthly basis. Beginning in 2002, BBA requires beneficiaries to stay enrolled in most Medicare+Choice options for six months; beginning in 2003, the lock-in period will be nine months. Beneficiaries enrolling in Medicare MSAs will be locked in for one year starting in 1999.

Advocates for the elderly, GAO, and the DHHS inspector general have long criticized HCFA for its failure to institute reforms to reduce marketing problems. Some marketing practices are prohibited by Medicare (for example, door-to-door advertising is not permitted) and Medicare+Choice marketing materials must be approved by HCFA. However, many critics believe HCFA's process is lax and permits most materials to be sent out. These critics point to misleading marketing materials, forged signatures, and other unscrupulous marketing and enrollment techniques.³² In addition, many point to marketing abuses that occurred during the early years of the Medigap industry. These abuses eventually led to strict federal standards, monitoring, and enforcement.³³

Lack of Uniform Information Standards

Even plan marketing materials designed with the best intentions are likely to confuse and mislead beneficiaries, simply because the information is not standardized. Today, Medicare HMOs use widely varied formats and definitions in their marketing literature. BBA does not require plans to standardize information, and, so far, HCFA has made no attempt to require plans to do so.

GAO has recommended for the last few years that standard benefit descriptions could help beneficiaries compare plans' benefits and costs. The lack of a standard

format and terminology can result in misleading comparisons.³⁴ For example, analysis of eight Medicare HMOs' marketing materials from the Tampa Florida market revealed that only five mention mammograms in their benefit summaries, even though all plans covered them.

The value of plans' prescription drug coverage—a benefit that greatly influences a Medicare beneficiary's decision to join an HMO—may be the most difficult to compare. GAO found that plans differ in how they calculate the dollar amounts of drugs used by beneficiaries. For example, some plans use retail prices, while others use average wholesale prices (AWP) or a lower price discounted from AWP to calculate a member's total drug usage in dollars. Therefore, a beneficiary comparing one plan with an annual cap on prescription drug coverage of \$1,200 with another offering coverage up to \$1,000 may incorrectly assume the first plan is more generous. In fact, the consumer value of the drug benefit could vary substantially, depending on how the HMOs compute drug cost.

The Federal Employees Health Benefit program and most corporate purchasers require plans to use standard language. GAO has suggested that Medicare information standards could reduce the amount of time HCFA and plan staff spend reviewing and reworking marketing materials.

Some advocates of the elderly have gone a step further to suggest standardization of benefit packages for Medicare+Choice plans similar to that required for Medicare supplemental plans. They believe standardized benefit packages would give beneficiaries a better sense of the comparative values of the plans at the premiums quoted.

Lack of Infrastructure

Many advocates for the elderly have pointed to the inadequate infrastructure and resources available to answer both the volume and content of the inquiries likely to result from HCFA's mailing and health plan marketing materials. As noted earlier, research shows that most Medicare beneficiaries consistently prefer to get information one-on-one from individual counselors or in small groups.

Since 1990, the Health Insurance Information, Counseling, and Assistance Program (known as ICA or HICAP) has been providing beneficiaries in every state—through paid and volunteer staff—assistance regarding complex program issues, including Medicare and Medigap, long-term care, and Medicaid. Yet representatives of these programs consistently report

that they are already financially strapped, even without the additional demands expected for Medicare+Choice education and counseling. For example, the Pima Council on Aging in Tucson reports that the program's ICA grant funds one staff member for 8 hours a week and another for 12 hours a week. Lack of resources and a 15-year-old telephone system will make it impossible to serve the expected increase in Medicare callers, according to recent congressional testimony.³⁵

Several advocates for the elderly have also criticized HCFA's plans for its hotline. HCFA reportedly projects 7.9 million calls to the new HCFA Medicare+Choice toll-free line during October and November 1998. HCFA expects to hire approximately 2,800 to 3,000 operators to handle these calls. This ratio of calls to operators would leave approximately seven minutes per call. Local and state ICA programs that currently operate Medicare hotlines report that it often takes at least seven minutes to understand the concerns of a confused or anxious caller, let alone respond to these concerns.³⁶

Some critics believe the recognizable toll-free number itself (1-800-MEDICAR) may exacerbate the heavy load on the telephone line because beneficiaries are likely to call the number for claims issues and many other reasons unrelated to Medicare+Choice. Moreover, because the toll-free line will be limited to just five states during 1999, seniors living in other states may be frustrated by their inability to access information from this source.

Geographic Hot Spots

Because of the way Medicare has historically paid HMOs, plans have been attracted only to certain markets and therefore Medicare HMO enrollment has been generally uneven across the nation. BBA made changes to the payment formula, which should increase the availability of managed care options in some areas. Nonetheless, market experience provides important clues about where the most intense market competition is likely or not likely to occur.

Medicare HMO enrollment is highly concentrated in a few states. Seventy-five percent of all Medicare managed care enrollees reside in just ten states: California, Florida, Pennsylvania, New York, Texas, Arizona, Ohio, Massachusetts, Washington, and Oregon. California alone accounts for 25 percent of national Medicare managed care enrollment, and more than 50 percent of enrollees are concentrated in just four states: California, Florida, Pennsylvania, and New York.

HCFA data show growth in enrollment in other states, such as Illinois, Missouri, Louisiana, Maryland,

and Colorado. Due to the predicted payment rates, market analysts anticipate managed care enrollment growth in the Detroit area and in Georgia, New Jersey, and Tennessee.³⁷

As stated earlier, HCFA has decided to target its educational efforts to five states in the beginning stages of its Medicare Education Campaign. Concentrating in these markets could help minimize confusion among the elderly. At the same time, beneficiaries in other competitive areas may be at a loss for information during the coming year.

Vulnerable Populations

Even under the best of circumstances, Medicare beneficiaries are expected to be confused about their options. Adding to this potential is the fact that many Medicare beneficiaries represent the most vulnerable in the U.S. population (for example, 4 million with Alzheimer's, 1.7 million in nursing homes, 2.4 with terminal illnesses, and 11 million with less than a high school education).³⁸ And, given the anticipated increases in elderly, non-English-speaking individuals, language will likely represent a growing barrier to effective communication.

In 1994, 12 million (nearly 40 percent) of the elderly not living in institutions suffered from chronic conditions. Of these, three million (about 10 percent of the elderly) were unable to perform activities associated with independent living (such as bathing, shopping, dressing, or eating). Several of the conditions most prevalent among the elderly tend to be disabling. Conditions such as arthritis, high blood pressure, and heart disease may begin in middle age, but often progress in terms of severity of symptoms and the degree to which they limit a person's ability to function.³⁹

Because Medicare+Choice plans are currently paid on a capitated basis, those health plans that enroll the healthiest seniors will be the most successful financially.⁴⁰ As a result, to avoid attracting expensive patients, plans do not advertise their capabilities for managing complex cases. Hence, it may be difficult for patients with complex problems to evaluate which plans may serve them best.

THE FORUM SESSION

At this Forum session, Carol Cronin, director of HCFA's Center for Beneficiary Services, will lay out the agency's strategy for educating beneficiaries about their Medicare+Choice options. Susan Kleimann, a

communications expert who has conducted several focus groups with Medicare beneficiaries in California, will discuss beneficiaries' reactions to plan comparison information and research regarding decision-making. Joe Martingale of Towers Perrin will share the lessons learned in his work with the National Medicare HMO Initiative, assisting large employers in efforts to move retirees into managed care plans. Doug Cook, director of the Florida Agency for Health Care Administration, will speak on plan marketing practices in Florida. Finally, Mark Pauly of the Wharton School will provide a summary of the presentations and discuss the work of IOM's Committee on Choice and Managed Care and its recommendations in this area.

Issue Questions

The discussion will center on the following questions:

- What is HCFA's strategy for communicating to beneficiaries about Medicare+Choice? Which markets are being targeted? What kinds of pilot projects/test marketing are in place?
- Why did HCFA change its initial plans to send out the handbook to all eligible beneficiaries? What does HCFA's decision mean for beneficiaries who do not live in one of the five states chosen?
- Even if there is no official open enrollment season this year, will Medicare beneficiaries know the difference?
- What can be learned from employer experiences with Medicare-risk HMOs? What strategies have been successful and which have not?
- What can be learned from beneficiaries' experiences in areas where Medicare HMOs are prevalent, such as Florida and California? How do they make plan decisions? What information do they find valuable?
- Should HCFA require plans to use standard formats and terminology in its marketing materials? What are the pros and cons of this approach?
- Which markets are likely to experience the most growth in managed care options? Which will experience the least?
- What lessons can be learned from past plan marketing practices (or abuses) in the Medigap or Medicare HMO markets?
- Is the time frame Congress legislated appropriate to the task and are HCFA resources adequate? Should

the move to Medicare+Choice be rolled out in a staggered fashion?

- What are the implications of this communications effort for the future of the Medicare program? More specifically, what are the implications for those who will become eligible in the next few years? Does Medicare+Choice herald the end of fee-for-service Medicare?

Speakers and Discussants

Carol Cronin joined HCFA as director of the Center for Beneficiary Services in April 1998. Previously, Ms. Cronin served as senior vice president for *Health Pages*, a New York City-based consumer health magazine and online service that provides community-specific comparative information about doctors, hospitals, health plans, and other providers through partnerships with major newspapers and large employers. From 1992 to 1994, Ms. Cronin served as part-time executive director of the Managed Health Care Association; from 1984 to 1992, she worked in a variety of capacities for the Washington Business Group on Health, including vice president of policy and director of the Quality Resource Center.

Susan Kleimann, Ph.D., is the president of Kleimann Communication Group, LLC, a small business that works with clients to communicate complicated information so that people can use it. Dr. Kleimann has over 30 years' experience in the analysis, testing, and design of documents. She recently conducted a series of focus groups with Medicare beneficiaries for the National Academy of Social Insurance and the California HealthCare Foundation. The focus groups, conducted in three different areas of California in February 1998, provided an opportunity to hear in some detail about the experiences of individuals who are already dealing with a complex Medicare marketplace that offers an array of choices among managed care options and physician groups contracting with numerous health plans.

Joseph J. Martingale is a Towers Perrin principal located in the New York consulting office and is one of the founders of the firm's managed care consulting practice. Among the companies for which he has helped develop innovative health care cost strategies are AlliedSignal, Inc.; AT&T; McGraw-Hill; NYNEX Corporation; Paramount; Time Warner Inc.; the U.S. Postal Service; and the nation's railroads. Over the past four years, Mr. Martingale has led the Towers Perrin Medicare HMO Initiative, a coalition of employers who

jointly evaluate and negotiate with Medicare HMOs all over the country.

Douglas M. Cook is the director of the Florida Agency for Health Care Administration. The agency is responsible for coordinating health care planning and policy for the state, including publishing health care data and consumer information. Under Mr. Cook's leadership, the agency negotiated and passed Florida's first major HMO reform bill in 1997. Prior to being appointed director, Mr. Cook served as director of the Governor's Office of Planning and Budgeting.

Mark V. Pauly, Ph.D., currently holds the positions of vice dean of the Wharton Doctoral Programs, Bendheim Professor and chair of the Department of Health Care Systems. He is professor of health care systems, insurance and risk management and public policy and management at the Wharton School and professor of economics in the School of Arts and Sciences at the University of Pennsylvania. One of the nation's leading health economists, Dr. Pauly has made significant contributions to the fields of medical economics and health insurance. He is a former commissioner of the Physician Payment Review Commission, an adjunct scholar of the American Enterprise Institute, and an active member of the Institute of Medicine, where he recently served on the Committee on Choice and Managed Care: Furthering the Knowledge Base to Ensure Public Accountability for Informed Purchasing by and on Behalf of Medicare Beneficiaries.

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