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Testimony before the Senate Special Committee on Aging

Thank you Senator Grassley and Senator Breaux for inviting me to testify before the Committee today. I hope my comments will assist you in making improvements to the Medicare managed care program. I retired from the Health Care Financing Administration (HCFA) three years ago, after thirty-six years of federal service. My last position was manager of the Managed Care Branch in the HCFA Atlanta Regional Office with responsibility for the managed care program in the eight southeastern states. Our primary function was contracting with HMOs and monitoring existing contracts. One aspect of this was review and approval of each contractor's marketing materials and other pertinent information distributed to the beneficiaries.

As I understand it, the Committee's objective is to assure that Medicare beneficiaries are clearly informed about what is covered by each HMO plan so that they can make informed decisions before joining. And after joining, beneficiaries are to be clearly and timely informed about changes through the annual notification. The committee is exploring what the HCFA review process of health plan materials contributes or fails to contribute to such beneficiary understanding of their benefit coverage and of their rights and responsibilities under the Medicare program.

Before I get specific, I want you to know that I think the greatest problem is attitudinal in terms of advocacy for the beneficiaries. The Medicare program exists for the beneficiaries, but decisions are not made with the beneficiaries best interests at heart. The main players are the government, the HMOs which are mostly publicly held companies, the medical profession, and last but not least, the beneficiaries. The government is a political entity subject to many influences which effect its performance and decision making. HMOs are interested in getting as many enrollees as possible and holding down costs. With respect to marketing material, how many HMOs take great pride in how well their prospective enrollees or current enrollees are informed, or is their pride in how many they enroll? I know there should be a balance here and perhaps the reason I think there isn't is that my experience included Florida, famous for the ping-ponging of enrollees. Medical practitioners are in a catch twenty-two. I believe that most want to give good quality care, but they are often limited when they practice in the HMO setting.

There are two major problems with marketing. The biggest is the marketing representative. This is the man or woman who sells the plan to the beneficiary. Unless things have changed, and I do not think they have, they are paid on commission. The incentive is to enroll, not help the beneficiary make an informed decision. When abused the effect can be disastrous to the beneficiary and the program. The solution is obvious, but apparently not politically palatable- third party verification of enrollment by some entity other than the plan.

The second problem is that material furnished by the plans is not standardized. Each plan is an individual business with it's own way of presenting it's product. This is the competitive American way and is usually healthy when applied to the population at large. However, the government contracts with these plans to serve a targeted population of aged beneficiaries, some who are very alert and astute and many who are vulnerable. I think it wise and fair to require them to temper their tactics in marketing to this population and in providing them with information on their rights, for example, appeal notices.

One of the thrusts of the marketing material review process is to assure that the material is correct and is not confusing to the beneficiaries. This includes advertizing as well as letters, contracts, notifications, handbooks, and whatever else the plan sends to the beneficiary. The reviewer is on the alert to notice anything which doesn't meet requirements and anything which is confusing. Often the reviewer is under

a deadline. When a new contract is being processed the plan wants the material approved so that it can be utilized immediately when the contract is approved. It is significant to note that the above effort is with respect to each plan individually. But from the beneficiaries point-of-view, that plan's material may be expressed or arrayed differently from other plans they want to consider and that is confusing. The challenge is how to permit plans their individuality and accommodate standardization and consistency across the board.

You would also be interested to know that the review process is inconsistent among the regions. Some regions are more strict than others. Some of this is dictated by the nature of the plans in the region. Some plans in the Atlanta region were so abusive we had to be more strict. Some is due to regional leadership attitudes or just different levels of expertise in personnel. Some is due to the particular central office personnel relating to their assigned region. I will generalize that implementation of national guidelines could be standardized and made more consistent.

Unless it has changed, and I do not think it has, there is variance in what plans furnish their enrollees in terms of annual notification. Some give clear information about changes and some do not. Some give updated handbooks and some give addendums which are confusing to use and easily lost. HCFA could and should have consistent requirements on this. I know producing a new handbook each year is expensive. Perhaps a new handbook could be required only if there are significant changes.

The fact that some plans are withdrawing wholly or in specific counties because of the Risk Adjustment Factor illustrates that profitability is the engine that runs the machine. It is unconscionable that we do not have requirements which notify and protect affected beneficiaries. There may be other areas, and this is certainly one, where HCFA could devise a standard form for this purpose and require that it be used. I understand that some plans continue to enroll in areas from which they plan to withdraw. This should be prohibited in the original contract and reiterated in any service area expansion. I can see how this works. If the plan has a contract HCFA would be interfering with the plans right to enroll if it forbade continued enrollment. HCFA might even get sued by the plan. So nothing gets done. Another instance of decisions being made without having the beneficiaries as first priority.

One of the problems for HCFA is allocation of resources to the managed care effort. Just before I retired I was on a task force which recommended decentralization of the health plan contracting function to the regional offices. This was recommended because it would eliminate duplication between the regional offices and the central office, thereby freeing central office personnel to concentrate on much needed policy and guidelines. This is another pendulum; centralization or decentralization. If it could be decided on the basis of good management thought instead of turf battles the program would run more efficiently.

The management in each region decides how many employees will work in the managed care area. Thus, the number of employees dedicated to managed care varies by region. In some regions there is a persistent shortage of staff in this area. There is no mechanism in place to reallocate personnel from the HCFA central office to the regional offices when such shortages occur.

Another resource problem is competence. Where do you get the skilled managed care workers? They must be trained or hired from the industry. HCFA is often not salary competitive to get such workers. One answer is to streamline and standardize, and even contract out if it can be done in a sensible way.

Two things in closing. First, I'd like to float the idea of a managed care ombudsmen at least in each region. This person's office could both assist beneficiaries and support the oversight effort through experiential feedback. Second, though I'm not on Medicare yet, I would like for you to know that I

belong to a good HMO. It communicates with me clearly, has many interesting health related programs, emphasizes prevention, gives me an appointment the day I call in sick, and has treated me extensively when I was seriously ill, and even paid all my bills when I was ill out of their service area.

Thank you for this opportunity.