

**Testimony of Geraldine Dallek  
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## **INTRODUCTION**

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

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

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

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

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

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

## **INFORMATION**

The Medicare+Choice program is built on the assumption that beneficiaries will be able to make a

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

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

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

### **BBA INFORMATION REQUIREMENTS**

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

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

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

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

Medicare+Choice plans must supplement information provided by HCFA by giving enrollees and prospective enrollees information on the plan's service area; plan benefits and supplemental benefits; the number, mix and distribution of plan providers; out-of-network coverage (if any) and any POS option; emergency services; prior authorization rules; plan grievance and appeals procedures; and a description of the plan's quality assurance program.

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

## **INFORMATION ISSUES FOR CONSUMERS**

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

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

### **Lack of HCFA Resources to Meet Beneficiary Information Needs**

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

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

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

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

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

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

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

An unknown number of hotline calls, perhaps as many as two or three million, will be referred to local and state ICA programs, local Area Agencies on Aging and other non-profit organizations that provide assistance to the disabled and elderly Medicare population. However, most of these organizations have very small staffs and a few volunteers and, even the best funded of them, are not able to handle the current demand for their services. The Center for Health Care Rights often receives more calls than it can handle by 11:00 A.M. and the New York-based Medicare Rights Center's hotline is available to take calls only four hours a day, four days a week.

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

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

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

## **Lack of Some Critical Information to Make an Informed Choice**

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

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

## **MARKETING**

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

High disenrollment rates and high "rapid disenrollments" are signs of marketing problems. Rapid disenrollments are disenrollments that occur within three months of enrollment. Medicare HMOs vary dramatically in the percent of enrollees who quit a plan and who do so within three months of enrollment. However, one recent study found that some plans have excessively high churning rates-with almost as many Medicare beneficiaries quitting a plan as joining. Learning to market to the Medicare population, a significant proportion of whom have never been in a managed care plan, takes time and resources. Add to this mix the fact that insurers will be marketing a range of plans they have never marketed before to a population with a significant number of individuals with low literacy levels and cognitive and physical impairments and we could see an explosion of marketing problems.

### **BBA Marketing Requirements**

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

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

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

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

### **MARKETING ISSUES FOR CONSUMERS**

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

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

## **Direct Marketing by Plans and Independent Insurance Agents:**

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

## **Review of Marketing Materials**

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

## **Marketing to Vulnerable and Cognitively Impaired Medicare Beneficiaries**

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

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

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

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

In focus groups of California Medicare beneficiaries sponsored by the National Academy of Social Insurance, dual-eligible participants reported that they believed they had to disenroll from managed care

plans so they could get Medicaid prescription drug benefits.

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

## **CONCLUSION**

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

## **INFORMATION AND MARKETING RECOMMENDATIONS**

### **FUNDING**

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

### **INFORMATION**

- The Secretary should consider requiring the standardization of all terms used in marketing.
- The Secretary should consider requiring plans to provide enrollees (and prospective enrollees on request) with:
  - a list of participating providers, updated quarterly, that includes their specialty, their ability to accept new Medicare+Choice enrollees, and languages spoken other than English. In addition, the Secretary should require plans to provide this information, updated weekly, on their web sites;
  - plan procedures for approving a non-formulary drug, and, on request, information about whether a Particular drug is on a plan's formulary. The Secretary should also consider requiring plans to provide a list of covered prescription drugs on their web sites;
  - on request and to the extent available, plan clinical guidelines or protocols for the treatment of specific diseases or illnesses.

### **MARKETING**

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

- If the Secretary allows independent insurance agents to market directly to Medicare beneficiaries, Congress and the Secretary should assess which of the Medigap insurance marketing reforms, including limits on agent commissions, might be appropriate for the Medicare+Choice program.
- The Secretary should prohibit marketing and insurance agents from filling out Medicare+Choice application forms.
- The Secretary should consider a range of regulations to prevent marketing problems:
  - prohibit agent compensation until a beneficiary has been enrolled in a Medicare+Choice plan for three months;
  - require standardized training of anyone selling a Medicare+Choice product;
  - mandate independent verification of Medicare+Choice enrollment; and
  - require plan enrollment forms to be translated in a beneficiary's primary language.

## **OTHER**

- The Secretary should continue the current practice of allowing Medicare+Choice enrollees to retroactively disenroll if they did not understand or were misinformed about the terms of enrollment.
- The Secretary should consider establishing specific rules relating to the education and enrollment of dual-eligibles Medicare/Medicaid beneficiaries.