Developing an Information Infrastructure for the Medicare+Choice Program: Summary of a Workshop

Valerie Tate Jopeck and Marion Ein Lewin, Editors; Committee on Choice and Managed Care: Furthering the Knowledge Base to Ensure Public Accountability and Information for Informed Purchasing by and on Behalf of Medicare Beneficiaries, Inst. of Medicine

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Committee on Choice and Managed Care: Furthering the Knowledge Base to Ensure Public Accountability and Information for Informed Purchasing by and on Behalf of Medicare Beneficiaries

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Committee on choice and Managed Care: Furthering the Knowledge Base to Ensure Public Accountability and Information for Informed Purchasing by and on Behalf of Medicare Beneficiaries

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Particular thanks are extended to The Robert Wood Johnson Foundation for its continuing support of this committee's work as well as the support and encouragement of several members of its staff.

Preparing the workshop and completing this summary in light of the quickly changing Medicare+Choice environment could not have been accomplished without the background information and key perspectives provided by several people.

At the Health Care Financing Administration (HCFA), appreciation is extended to Michael Hash, Kathleen M. King, Kathleen Buto, Carol Cronin, and Michael McMullan. The committee particularly thanks Mary Agnes Laureno for serving as HCFA's liaison to the committee and providing us with salient information.

Sincere thanks go to all of the participants at the workshop held on March 4 and 5, 1998. The speakers and resource experts (Appendix B) gave generously of their time and expertise to help inform and guide our work. We are particularly indebted to Lynn Etheredge. His commissioned paper set the stage for the workshop, and his advice throughout the committee's work has been greatly appreciated. We also appreciate Michael Hayes's careful editing of this text.

The committee wishes to point out that the body of this workshop report reflects only those events that occurred prior to March 5, 1998. As is not uncommon in the health care arena in Washington, D.C., a number of significant changes that relate to the implementation of Medicare+Choice (Medicare Part C) under the Balanced Budget Act of 1997 have occurred since then. The first and most important event was the HCFA announcement on June 18, 1998, that it would step back from its intentions to launch a nationwide education and publicity campaign in October 1998 and a planned mailing of a new *Medicare & You* handbook (with a description of all the options) to every Medicare beneficiary household. Federal officials had tested the handbook materials in several focus groups of beneficiaries and found a high level of misunderstanding and confusion. As a result, HCFA decided to test market the handbook in only five states: Oregon, Ohio, Washington, Florida, and Arizona, home to 5.5 million beneficiaries. It should be noted that a major finding of this report and a focus of the committee's *Letter Report* (Chapter 9) to

HCFA in June 1998 was the suggestion that "HCFA should stagger its mailings over a period of several months, both to reduce and spread out the certain upsurge in the volume of inquiries and to allow some level of market-testing of the materials."

The second notable development has been the recent withdrawal of several of the nation's biggest health maintenance organizations (HMOs) from select Medicare markets. By early October 1998, HMOs withdrew from their Medicare line of business in 300 counties in 18 states, affecting more than 400,000 seniors. Plans that exited the market claimed insufficient payments as the major reason. The current market turmoil may affect the number of plan options available to Medicare beneficiaries in many states and may temporarily divert HCFA's continuing efforts to develop an adequate and responsive health plan information infrastructure for the nation's elderly citizens.

The committee wants to give special thanks to the dedicated and hard working staff at the Institute of Medicine (IOM). Study Director Marion Ein Lewin's expertise in health policy and professionalism successfully advanced the progress of the committee's June 1998 *Letter Report* (Chapter 9) through several drafts and a rapid report review process. Valerie Tate Jopeck, who served as research associate, worked closely with the study director on many aspects of this study. She assumed primary responsibility for both coordinating the March workshop and drafting this summary of the workshop. Administrative assistant Kari McFarlan is also to be commended for her thorough and diligent administrative support of our efforts. We are especially grateful to them.

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This report was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making the published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process. We wish to thank the following individuals for their participation in the review of this report:

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Finally, the committee would like to thank the co-chairs, Harry P. Cain II and Stanley B. Jones, for their outstanding work and dedication to this project.

IOM Committee on Choice and Managed Care

Contents

1

Introduction

On March 4 and 5, 1998, the Institute of Medicine (IOM) Committee on Choice and Managed Care held a 2-day workshop entitled Developing the Information Infrastructure for Medicare Beneficiaries. This workshop was a follow-up to the IOM report entitled *Improving the Medicare Market: Adding Choice and Protections* (Institute of Medicine, 1996). Among that study's seven major recommendations was the following (p. 89):

> *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.*

The March 1998 workshop focused on the Medicare provisions in the Balanced Budget Act of 1997, which mandate that the Health Care Financing Administration (HCFA) develop a "nationally coordinated education and publicity campaign" in 1998 and move Medicare beneficiaries to an open-season enrollment process by the year 2002. Approximately 50 individuals from the public and private sectors were invited to the workshop. These individuals were selected for their special expertise on the information needs of Medicare beneficiaries as well as the technologies that can be used to assist this group with choosing the appropriate health plan in a competitive, managed care environment (see Appendix B for a list of the workshop participants). To provide focus to the workshop's deliberations, noted health care consultant Lynn Etheredge was commissioned to write a paper that could help set a framework for discussion for the meeting. Mr. Etheredge's paper is found in Chapter 3. The material found in Chapter 2 and Chapters 4 to 8 is based upon presentations given at the workshop and the ensuing discussion among the meeting's participants. Chapter 9, which contains the committee's findings and recommendations stemming from the workshop, was also released as a separate document in June 1998 as the *Letter Report to the Administrator of the Health Care Financing Administration.*

POLICY CONTEXT FOR THE WORKSHOP

Since the early 1970s the federal government has supported the voluntary enrollment of Medicare beneficiaries in managed care programs through a number of demonstration projects. The 1982 Tax Equity and Financial Responsibility Act, which became operational in 1985, gave Medicare beneficiaries the option to enroll in federally qualified health maintenance organizations (HMOs) and competitive medical plans, all of which offer benefits covered by Medicare and the majority of which also offer cost-sharing and supplemental service coverage that replaces the coverage obtained through Medigap policies.*

In 1995, HCFA announced its Medicare Choices demonstration program. This demonstration program had a broad goal of testing beneficiaries' responses to a range of health care delivery system options and of evaluating the suitability of these options for Medicare. The passage of the Balanced Budget Act of 1997 gave HCFA the authority to contract with an even greater variety of managed care and fee-for-service plans under its Medicare +Choice program. These include:

- coordinated care plans (HMOs [with and without point-of-service options], preferred provider organizations, and provider-sponsored organizations);
- private fee-for-service plans;
- medical savings accounts; and
- religious fraternal benefit society plans.

According to the Medicare Payment Advisory Commission, at least 72 percent of Medicare beneficiaries currently have access to a Medicare risk plan and 39 percent have five or more plans available in their local area (Medicare Payment Advisory Commission, 1998a).

The Balanced Budget Act gives HCFA until 2002 to develop a comprehensive beneficiary education and information infrastructure. Both private-and public-sector workshop participants stated that the task with which HCFA is charged is among the most challenging that any organization has faced. HCFA will be responsible not only for providing information about the traditional Medicare program but also for educating its 35 million beneficiaries and other information intermediaries about the Medicare+Choice enrollment process. Extensive research findings and workshop participants who work with the Medicare population, such as Age Wave and The Senior Network, have found that the current Medicare population lacks adequate basic knowledge about what the traditional Medicare program covers, let alone what the newer health care delivery options will add to the mix (Hibbard and Jewett, 1998; Kleimann, 1998a; U.S. Department of Health and Human Services, 1997a).

* Beneficiaries who are eligible for Medicare because of age or disability may choose to enroll in an HMO. Beneficiaries who qualify for Medicare because of end-stage renal disease are not eligible to enroll in an HMO unless they were already enrollees in a commercial plan at the time that they became Medicare eligible. In addition, as a result of the Balanced Budget Act of 1997, beneficiaries receiving hospice care may also now enroll in a Medicare+Choice plan. Beneficiaries must be enrolled in both Medicare Parts A and B to participate in Medicare+Choice.

2

HCFA's Plan of Action*

WHAT HCFA WILL DO IN 1998

The Health Care Financing Administration's (HCFA's) Center for Beneficiary Services views 1998 as an "awareness year." By effectively using the national and local media, large national organizations such as the American Association of Retired Persons, and the 10 regional HCFA offices, HCFA intends to undertake a large publicity and education campaign called the National Medicare Education Program (NMEP). NMEP has three goals:

- beneficiaries should be able to access information when they want it;
- beneficiaries should understand the information needed to make informed choices; and
- beneficiaries should perceive that NMEP, HCFA, and the federal government and its partners are trusted and credible sources of information.

Recognizing the 5–year implementation challenge that it faces under the provisions of the Balanced Budget Act of 1997 (see the box *What Must Be Done Under the Statute*), HCFA will not be able to develop cohesive, locally targeted, or elegant approaches to information dissemination in year one. Rather, HCFA is taking a long-term view of the information dissemination process and the need to develop a better understanding on the part of beneficiaries of the basic Medicare program and the Medicare+Choice program.

HCFA, however, will be striving in the first year to provide beneficiaries and intermediaries who disseminate information with accurate and timely information so that those beneficiaries who choose to participate actively in Medicare+Choice will not suffer from a lack of information designed to assist them in choosing a health plan.

* This chapter is based on a presentation by Michael McMullan, deputy director of the Health Care Financing Administration's Center for Beneficiary Services, and National Medicare Education Program documents.

BUILDING A KNOWLEDGE BASE WITH BETTER INFORMATION DISSEMINATION

HCFA states that it will take the full 5 years stipulated in the Balanced Budget Act of 1997 to attain good beneficiary understanding of the Medicare+Choice process. To achieve this goal, HCFA proposes to undertake a broad public education campaign. By layering the kind of information disseminated to the public into *basic, detailed*, and *special-case information*, HCFA hopes both to provide beneficiaries with a better sense of how the program operates and to assist them in better understanding the implications of their health plan choices. HCFA will undertake a Special Information Campaign beginning in the fall of 1998. The goal of this campaign will be to inform those eligible for Medicare+Choice of the existing plan options and the plan selection process. The 10 regional HCFA offices are charged with developing the specific action plans for their regional, state, and local information and outreach efforts.

WHAT MUST BE DONE UNDER THE STATUTE

Beginning in 1998, Congress required HCFA to provide all Medicare beneficiaries with the following information:

- the benefits covered under the basic Medicare package
- how to make a health plan choice
- an explanation of Medigap and Medicare SELECT
- beneficiary rights
- grievance and appeals procedures

For the coordinated care options (health maintenance organizations, preferred provider organizations, provider sponsored organizations, etc.), HCFA must explain each plan's:

- supplemental benefits
- cost-sharing
- limits on out-of-pocket costs
- the service area covered
- any particular rules of the plan that may be different from those of other plans
- quality and performance measures (e.g., the Health Plan Employer Data and Information Set), as available
- satisfaction measures (e.g., HCFA's Consumer Assessment of Health Plans), as available

HCFA must use the following methods to convey information to the beneficiaries:

- a print version of the general and comparative information, which must be sent to each beneficiary at the beginning of the open-enrollment month (November)
- a toll-free number will be made available for all beneficiaries who are eligible to participate in Medicare +Choice (66 percent of the Medicare population)
- a site on the World Wide Web (www.Medicare.gov)
- national publicity campaigns during the open-enrollment month

Recognizing the diversity of the Medicare population, HCFA plans to tailor its information for different communities within the Medicare population. In 1998, information tailoring will be limited to the publication of English- and Spanish-language versions of the required information because HCFA does not possess the resources to provide information in every language spoken in the United States and does not anticipate that it will have the resources to do so even at the end of the 5–year implementation period (see Chapter 7 for a discussion of language barrier issues).

By using existing private-sector call center technology, HCFA plans to develop state-of-the-art telephone call centers, toll-free telephone numbers, and information on a site on the World Wide Web in line with the Balanced Budget Act's requirements. As outlined at the workshop, HCFA plans to develop a customer-service telephone line to provide beneficiaries with information on Medicare+Choice and plan options. Beneficiaries will be able to speak directly with a customer service representative, if they so choose. The agency will supplement the customer service telephone line with printed information. As experience with the system grows and answers to questions are standardized, HCFA hopes that it will be able to automate the means of accessing more of the information and ultimately reduce the cost of maintaining the call center and toll-free telephone number. Beginning in the fall of 1998, HCFA will have 600 customer service representatives at four call center sites available to assist beneficiaries.

According to HCFA, 7 percent of all Medicare beneficiaries have access to the Internet. The agency's web site for Medicare+Choice, www.Medicare.gov, launched in the spring of 1998, includes information on program benefits, health system performance, health plan choice, and health promotion information. A valuable tool located on the web site is the Medicare Compare database. This feature enables beneficiaries to locate information on plans' benefits and premiums by zip code. HCFA expects to add to this database comparative information on health plan quality by the end of 1998. HCFA plans to update the database quarterly.

Experts on the potential of the Internet to educate consumers make the point that this medium allows consumers to access the specific information that they need within larger databases. Good Internet sites also allow consumers to link to other, related areas and sites from a central location (Cronin, 1998).

RELYING ON THE COMMUNITY FOR ASSISTANCE

In an effort to build national and community-based partnerships, HCFA is creating the Alliance Network, which consists of about 100 national, state, and local organizations that serve as channels of information on Medicare+Choice program activities and materials. By working with large employer groups that have Medicare populations, other government entities that work with this population, numerous community organizations, and information and counseling assistance programs, HCFA hopes to use each group's best practices to develop a high-quality information infrastructure. The Alliance Network will have three layers:

- a *coordinating committee* that acts as the national leadership for NMEP; the committee will provide high-level support to HCFA in the creation of educational materials;

- *task force members* who will actively disseminate NMEP materials and communicate information about the program; and
- *educational affiliates*, which will be organizations and agencies that distribute Medicare+Choice information to their members or clients.

Over the long-term, HCFA will be working closely with the Agency for Health Care Policy and Research and other groups to develop a common consumer information framework. Ideally, this collaborative effort will produce a standardized information framework that will enable health care consumers across the age spectrum to look at information in the same standardized format with identical terms and definitions. The end result of this effort will be an information framework that does not change as an individual moves from employer-based health care into Medicare.

3

HCFA as a Successful Consumer Service Agency*

Consumer service has been only a modest part of the Health Care Financing Administration's (HCFA's) functions. In administering the Medicare program, HCFA has primarily engaged in writing regulations and overseeing contractors; for beneficiaries, Medicare's bill-paying contractors have been the primary points of contact within HCFA. Since HCFA moved from a district office structure when it was formed out of the Social Security Administration, few HCFA employees actually work with Medicare beneficiaries on benefit and payment issues or help them decide on whether to enroll in health plans.

The Balanced Budget Act of 1997 creates a major new role for HCFA, that of a consumer service agency. In carrying out this role, HCFA faces an enormous challenge of managing a national process so that 39 million elderly and disabled individuals can make informed decisions about whether to stay in traditional Medicare or to select another Medicare coverage option. The fundamental importance of HCFA's new mission is reflected in its recent reorganization, in which the Center for Beneficiary Services was made one of the three major operating components of HCFA.

The Balanced Budget Act of 1997 creates a major new role for HCFA, that of a consumer service agency.

The requirements of informing and educating such a large number of individuals would be a daunting challenge even for an entity with far more resources than the U.S. Congress has provided HCFA (less than $3 per beneficiary). HCFA's administrative capacity is further constrained by a limited ability to use many of its current contractors (Blue Cross/Blue Shield plans and commercial insurers) because they are now major sponsors of competing Medicare health plans.

How can HCFA's success in this new role be measured? Two different objectives could be proposed to define success: (1) Medicare consumers are able to make choices that will produce the greatest value for themselves; and (2) health plans, health care professionals, and other providers have a well-functioning market in which they can prosper by offering better quality, service, and efficiency.

* To set the stage for the March 1998 workshop and to help provide a framework for the meeting's presentations and discussion, the committee asked noted health care expert Lynn Etheredge to write a paper describing alternate roles that the Health Care Financing Administration could assume as it moves from its primarily payer role to its role as a consumer service agency. This chapter comprises that paper.

Enabling well-informed consumer choice is fundamental. Only if consumers are armed with tools that enable them to choose health plans on the basis of greater value will health plans be motivated to compete on that basis.

These objectives, however, do not define HCFA's role with much precision. Indeed, there appear to be at least three competing views about what HCFA's appropriate role and strategies should be.

- *HCFA as a neutral facilitator.* In this view, HCFA would have a limited, neutral role in facilitating consumer choice and market evolution. HCFA would send one or two mailings to each beneficiary. These mailings would explain Medicare choices and would offer a basic set of objective information and some public service announcements, as well as a toll-free number and the address of a web site that would offer similar information. For most questions, for example, whether an individual's physician is in a plan, beneficiaries would be referred to a health plan sales department.
- *HCFA as an employee benefits office.* In this view, HCFA would operate much more like the employee benefits office of a large corporation that successfully managed a rapid transition from fee-for-service to managed care offerings. There would be extensive communications about the benefits of managed care, how it differs from other options, and how to make good decisions, together with a substantial budget and resources for facilitating the transition. There would also be active contract management: Just as in an effective employee benefits office, HCFA would see that health plans took quick action to resolve problems.
- *HCFA as a consumer advocate.* In this view, HCFA would adopt a vigorous proconsumer role and would support the development of a national infrastructure for Medicare consumer information, advice, and advocacy. This view reflects concern about the potential for Medicare beneficiaries—many of whom are members of vulnerable populations—to have very bad experiences. Such concern is fueled by the consumer backlash against managed care and the documentation of the high degree of variability in the quality of managed care (National Committee for Quality Assurance, 1997; U.S. Department of Health and Human Services, Office of the Inspector General, 1998). Compared to the practice of major employers that can exclude poorer plans from the list of plans from which employees may choose (a form of leverage to promote good performance by health plans), a broader array of plans will be able to market directly to Medicare beneficiaries.

HCFA can hardly be expected to perform all of the roles described above at the same time, particularly in the absence of more legislative guidance and larger appropriations. HCFA does, however, have a range of discretion in choosing how much to blend these three roles, in setting targets and priorities, in defining its contract management philosophy, in developing relationships with a "Medicare helper" industry, and in assisting groups with special needs. HCFA has already done much preparatory work and is considering its future activities related to its new consumer service role. Some ideas and considerations that could enter into an overall HCFA management strategy for consumer service are discussed below.

THE LESSONS OF MARKET EXPERIENCE

A great deal can be learned from the more than 5 million Medicare enrollees who are already enrolled in managed care plans.

Much experience and expertise can be mined and refined for HCFA's benefit. For starters, a great deal can be learned from the more than 5 million Medicare enrollees who are already enrolled in managed care plans. In some parts of the country (e.g., California, Oregon, and Florida), 30 to 50 percent of Medicare enrollees have chosen managed care plans. Evidence indicates that many Medicare beneficiaries who are enrolled in health maintenance organizations (HMOs) are satisfied with their care, but there also are examples of practices that should not be repeated in health plan operations and in the actions that HCFA takes to correct health plan deficiencies. Health plans, marketing experts, consumer advocacy agencies, health service researchers, health care professionals, accreditation agencies, data specialists, and state insurance departments all have gained useful insights. Large employers have led the way in moving more than 80 percent of their enrollees from traditional fee-for-service plans to managed care plans over the past decade and are also a valuable source of expertise. On the basis of some inter- views that the author of this chapter conducted over a period of time, the following might be useful points for consideration.

1. *The Medicare population is highly varied. Certain identifiable subgroups are much more likely than other subgroups to shift to managed care plans over the next few years.* Marketing professionals portray the Medicare population as having a number of subgroups, so that health plans can target in their marketing efforts those individuals who are most likely to switch to a private health plan and those individuals whom a health plan should want to enroll. Some of these subgroups will consist of healthy Medicare enrollees; some may consist of individuals with moderate incomes and high health care expenses for whom financial savings are highly attractive; still others may be "dual eligibles"* or residents of counties where adjusted average per capita cost payments are particularly generous. By using such market analysis, HCFA could also target those who most need good advice and set priorities by recognizing that in the next year or two major subgroups of Medicare fee-for-service enrollees are very unlikely to choose a managed care plan.

* According to HCFA, "Some aged and/or disabled persons are covered under both the Medicaid and Medicare programs. For Medicare beneficiaries who are also fully eligible for Medicaid, Medicare coverage is supplemented by health care services that are available under the state's Medicaid program. If a person is a Medicare beneficiary, payments for any services covered by Medicare are made by the Medicare program before any payments are made by the Medicaid program. Medicaid is always 'payor of last resort.' As each state elects, services such as eyeglasses, hearing aids, and nursing facility care not covered by Medicare may be provided by the Medicaid program.

For certain poor Medicare recipients known as 'Qualified Medicare Beneficiaries' (QMBs) (those beneficiaries with incomes below the federal poverty level and with resources at or below twice the standard allowed under the SSI [Supplemental Security Income] program), the Medicaid program pays the Medicare premiums and cost-sharing expenses for Medicare [Part A and Part B]. For 'Specified Low-Income Medicare Beneficiaries' (SLMBs) (those like QMBs, but with slightly higher incomes), the Medicaid program pays only the [Part B] premiums" (Health Care Financing Administration, 1998).

2. *Most Medicare beneficiaries make limited and selective use of information in making decisions.* Although HCFA will be providing objective information on health plans, quality of care, and consumer satisfaction (e.g., Medicare Health Plan Employer Data and Information Set [HEDIS] and Consumer Assessment of Health Plans), marketing experts report that potential enrollees are most interested in having answers to the following: (1) Will I save money? and (2) Is my physician in the plan? If the answer to both questions is "yes," the prospect of enrolling the individual in the health plan is good; if the answer to either or both questions is "no," enrollment is unlikely. The reputation of a plan can also be a salient issue: As one person interviewed for this chapter remarked, "I am always asked: 'Which plan is the best one?' They get really annoyed when I tell them they have to decide and I give them lots of tables." Market research that has been done for the Federal Employees Health Benefits Plan shows that individuals key their decisions to a small number of plan features; health plans use such information to design benefits packages and marketing strategies.

   HCFA can use understanding of consumer psychology, marketing strategies, and sales tactics to make sure that beneficiaries get their questions answered and to help them become better comparison shoppers. For example, HCFA could develop a checklist of questions most frequently asked by beneficiaries. Beneficiaries could then use this checklist when querying sales personnel. Standardization of health plan options would be a great help; absent legislation, HCFA might develop certain "model" options administratively and compare plans on the basis of their differences from these model options.
3. *Medicare beneficiaries rely on multiple sources of information and advice. Some sources of information and advice are more influential than others.* Family members are often involved in discussions about joining health plans, as are physicians and friends. Media reports and other sources also provide input. A successful HCFA strategy could put a major emphasis on communicating with these advisers and potential advisers about how they can help Medicare enrollees make good decisions.
4. *The most serious mistakes made by consumers result from their lack of understanding of basic information. Beneficiaries will need more information than the amount offered by salespeople.* A great deal of discussion about informing Medicare beneficiaries and HCFA's potential roles focuses on the means of presenting sophisticated information and advancing the state of the art of information dissemination. In contrast, interviews with individuals who have observed some of the most egregious problems (e.g., in Florida) indicate that the greatest potential for people to get into serious difficulty comes from the failure of consumer service representatives to accomplish basic tasks. The following are among the real-world factors mentioned as accounting for consumers' lack of understanding of basic information about health plans:

- A failure to communicate (and for enrollees to understand) how managed care works. For example, sales presentations made in large housing complexes for elderly individuals focused their pitches on the fact that enrollees will receive many additional benefits at no cost but did not provide much other information.
- An absence of resources for advice and comparative, objective information and assistance if information or assistance is needed, or a lack of knowledge of the existence of such resources. This is particularly important for less sophisticated purchasers, including populations who have difficulty understanding the English language.

- An individual's failure to determine whether his or her physician(s) is(are) part of a plan and a failure of salespeople to mention that an individual might want to ascertain this information before signing up.
- Not knowing that there was an appeals process when payment is turned down and not knowing that there are expedited appeals processes for urgently needed medical care.
- Not being aware that under current rules one can leave a managed care plan at the end of a month.

It may be useful for HCFA to ensure that this kind of information and those cautions that can forestall the making of bad decisions are part of the marketing materials. HCFA has been working with the American Association of Health Plans to establish voluntary standards for good marketing practices.

5. *Medicare enrollees' experiences with health plans vary markedly among states and among health plans.* A recent analysis of Medicare disenrollment data by Families USA suggests that some geographic areas and health plans will have many problems (Families USA, 1997; Riley et al., 1997). In some states, the Medicare market seems to be working well: In Hawaii only 2.7 percent of Medicare HMO enrollees disenrolled in 1996, and in Minnesota only 4.2 percent disenrolled. In other states, however, Medicare enrollees disenrolled from HMOs at much higher rates in 1996:19 percent of Medicare HMO enrollees in Texas, 22 percent of Medicare HMO enrollees in Kentucky, and 25 percent of Medicare HMO enrollees in Florida. The disenrollment rates for the 10 Medicare HMOs with the highest disenrollment rates ranged from 44 to 81 percent (6 of these HMOs were in Florida), whereas the rates were 5 percent or lower for the nation's 10 Medicare HMOs with the lowest disenrollment rates. In 1996, 17 Medicare HMOs had disenrollment rates of more than 20 percent and rapid disenrollment rates (proportion of persons disenrolling in the first 3 months) of over 40 percent, figures that may be indicative of the use of misleading marketing practices.

Such statistics suggest that HCFA needs (1) the analytic capability to determine why these problems of both HMO performance and HCFA oversight occurred and how they could have been prevented, (2) to target geographic areas and HMOs that threaten to create the biggest problems for Medicare enrollees, and (3) a management orientation and strategy that ensure that such problems will not be replicated and multiplied on a national basis for 39 million Medicare enrollees. It will be unfortunate if public officials do not learn from past experience and apply those lessons to the new Medicare+Choice program.

CONSUMER ASSISTANCE ROLES

HCFA's success in helping consumers make good choices and in creating a market that rewards good performance will not depend on the agency's actions alone. Indeed, given its current resource and role limitations, HCFA will need to have both an internal management philosophy for what it will do itself and a broader strategy for fostering new roles for other actors, including the media, physicians, employers, insurance and health commissioners, accreditation organizations, advocacy and counseling groups, and disease- and disability-oriented groups.

Role of HCFA

How HCFA chooses to define its specific functions and accountabilities for consumer assistance will involve the resolution of some of the following issues.

1. *How much individual assistance will HCFA staff provide for Medicare beneficiaries? To whom will HCFA refer individuals in need of assistance?* With 35 million people in the new Medicare+Choice system, the potential demand for HCFA staff to become involved in individual assistance and to become a full-service consumer assistance agency is large. The U.S. Congress seems to want HCFA to provide basic comparative information but little individual assistance and to leave the field clear for health plan salespeople to pitch their products. HCFA, however, can collaborate with and support many other groups that want to take on a consumer assistance role. To whom should HCFA plan to refer individuals who have questions that HCFA does not have the capacity to deal with or who need assistance that HCFA as a government agency is not authorized to make available? Should HCFA seek to develop a national cadre of counselors, similar to "tax aid" programs for seniors, and offer training programs for organizations interested in sponsoring such programs?*
2. *How should HCFA use the media?* For many reasons, HCFA's ability to achieve compliance with its regulatory requirements has often fallen short of full effectiveness: Witness the $23 billion of fraud and abuse in Medicare that occurs annually and the HMO marketing problems cited earlier. With a new consumer choice market, however, HCFA has the possibility of using press releases and press conferences to generate favorable publicity for the best health plans and negative publicity for bad health plans when quality is determined by the use of objective measures. Such rewards and penalties arising from a better-informed marketplace would likely be far greater than the results that could be accomplished by letters of commendation or admonishment.
3. *How should HCFA manage health plan contracts?* There is now enough of a history with Medicare HMOs to predict what major problems lie ahead, at least with certain health plans and in some parts of the country. HCFA staff need clear policy guidance about when and how to intervene with health plans and on the use of intermediate sanctions short of dismissal from the Medicare program. The creation of new management information systems for the profiling of health plan performance data (data on appeals, grievances, and disenrollments; data from HEDIS and the Consumer Assessment of Health Plans; financial data; and date from compliance visits) merits a high priority. HCFA field offices in areas with the greatest enrollment growth and problems could also enhance the agency's rapid response and consumer service capability. HCFA's contract management capabilities, policies, and practices could be some of the most important determinants of its success as a consumer service agency.

* Currently, the Health Insurance Information, Counseling and Assistance (ICA) programs operate in 50 states. ICA counselors provide beneficiaries with information about the Medicare program and other public and private health insurance options for the elderly. ICA programs differ from state to state, but most are volunteer-based service delivery programs run by paid professional staff. ICA programs are funded by HCFA, with some states providing supplementary funding. Although these programs are generally highly regarded, by themselves they may not be sufficient to respond to all the new information challenges generated by the new Medicare+Choice program.

Roles of Other Participants

A variety of other participants will play a role in helping Medicare beneficiaries determine the plan that they should select.

Media

As stated before, the media offer an important avenue for getting information to Medicare beneficiaries and for warning about potential problem plans. If it decides to use a media-oriented strategy, HCFA should consider background sessions with members of the national media supplemented with briefings in key market areas. Perhaps Health and Human Services Secretary Donna Shalala could appear in national ads announcing the best and worst plans.

Physicians

One individual with whom a prospective Medicare enrollee is likely to discuss possible enrollment in a managed care plan and from whom an opinion is likely to be valued is his or her physician. Indeed, physicians could provide a patient with important insights into whether a plan would be a good choice, how easy it is to for the physician to work with the plan, and other factors. Thus, it may be that HCFA should make special efforts to ensure that physicians are well informed about the managed care options in each area.*

Employers

Employers that offer retiree health benefits can also be a lead source of information and advice for eligible individuals. HCFA may also be able to work with some employer purchasing alliances and cooperatives so that they can assist Medicare-eligible populations.

Insurance Commissioners and Health Departments

Some of the new Medicare rules with which health plans must abide are similar to recent state patient protection laws. Part of HCFA's strategy could be to coordinate with state insurance commissioners and the National Association of Insurance Commissioners in identifying problem health plans, in providing individuals with assistance, and in using coordinated actions to bring health plans into compliance. In the past, managed care has seen fly-by-night operators and marketing firms moving from state to state as they stay "one step ahead of the sheriff." State health departments may also need to be involved with quality-of-care abuses. Joint efforts and "watch lists" might lessen future problems.

Accreditation Organizations

Under the new statute, private-sector accreditation rather than HCFA approval is the primary means of keeping poor-quality plans out of the market and protecting Medicare beneficiaries. It is important that accreditation agencies do their job well. HCFA—as well as consumer organizations—needs to scrutinize the performance of accreditation agencies and insist that they

* A further discussion of the physicians' roles in helping beneficiaries exercise choice is found in Chapter 5.

not relax their standards under pressures from health plans that are avidly pursuing the economic potentials of the Medicare market. HCFA may also be able to find ways to use accreditation agencies as a part of a rapid-response capability when problems are encountered to assess situations and remove health plan accreditation. Nevertheless, accreditation organizations do not have the resources or backing of their health plan sponsors for a more intensive role in analyzing the quality of services for the Medicare population.

Patient Advocacy and Counseling Agencies

A number of organizations are or could become involved in assisting elderly and disabled individuals eligible for Medicare to understand their choices and offer them a source of objective advice and counseling, as well as advocacy and assistance in dealing with managed care plans. Among these groups are state and local agencies on aging, chapters of the American Association of Retired Persons (AARP), and HCFA-funded state health insurance consumer advisory programs. Although AARP has conflicting interests because of its business relationships with Medigap insurance and health plans, AARP chapters may be useful purveyors of information and advice.

Disease- and Disability-Oriented Groups

The Medicare population is distinguished by variations in nearly all characteristics: from age span (disabled young adults to seniors who are more than 100 years old) to health and disability status. It also has a high concentration of individuals with chronic conditions and disabilities. Medicare enrollees with specific health problems are likely to have different and much more specific questions than senior citizens who are in good health. An individual in the former group will want to know a good deal about a plan's specialists, therapies, protocols, formularies, referral procedures, quality indicators, and outcomes that are specifically related to his or her health condition. Such information goes well beyond what is likely to be available in HCFA's general publications and databases. Thus, HCFA may want to encourage disease- and disability-oriented groups to develop their own checklists and report cards for patients with specific concerns so that such information can be readily available.

Other Special Needs Populations

The Medicare population has many individuals who have other special needs and who require attention for managed care to work well for them. Non-English-speaking populations are an example, as are patients with Alzheimer's disease, American Indians, and individuals who are deaf or blind. HCFA may be able to learn from Medicaid experiences and standards for serving the individuals who make up some of these populations. New York's Medicaid waiver, for example, requires health plan information to be available in the primary language of groups that make up more than 5 percent of the population of a service area, as well as counselors who speak languages that an individual can understand. Among the non-English-speaking languages spoken in different boroughs of New York City are Spanish, Chinese, Creole, Russian, Yiddish, Indian (Asian), Italian, Arabic, Hebrew, and Vietnamese (United Hospital Fund, 1997). Finally, some populations are vulnerable due to a diminished ability to make decisions. Outreach efforts for such people may require the use of contracted agents.

For many people who are chronically ill and have special needs, Medicare needs to supplement its customer service efforts with actions that can reduce predictable problems for them. It needs to use purchasing standards and report cards on performance to help ensure that health plans do not underserve these groups and to ensure that individuals with special health problems have valid ratings on how well health plans serve people like them. It needs to use better risk adjusters so that plans will not have strong financial incentives to demarket and discriminate against these individuals. Finally, HCFA, along with private advocacy groups, needs to watch for the problems of high cost associated with these populations.

IMPLEMENTATION

HCFA faces a challenging new future as a consumer service agency. The major tasks at hand, if they are to be performed well, exceed its current capabilities. To be successful, HCFA will need to learn rapidly, define its own role, develop effective strategies, and work closely with many partners in serving Medicare's 39 million elderly and disabled beneficiaries.

4

How to Reach Beneficiaries: Lessons from Private Industry*

As the Health Care Financing Administration (HCFA) prepares to fulfill its requirements under the Balanced Budget Act of 1997 to provide Medicare beneficiaries with information, important lessons may be learned by looking at some of the work that has been done in the private sector. Large purchasers and insurance companies have invested a great deal of time and money in obtaining a better understanding of what people want from their health plans. In light of this, the committee asked several representatives from health plans and other related organizations to discuss lessons that have been learned and best practices in marketing to that population.

HCFA's information dissemination budget for 1998 is $95 million, or less than $3 per person. This amount was whittled down from the original request for $200 million, or about $5.25 per beneficiary. By way of rough comparison, the health insurance industry has approximately $1.5 billion, or nearly $40 per beneficiary, that it can use to market to Medicare beneficiaries. Throughout the workshop, participants called on HCFA and the health plans to work together to leverage the private sector's pool of money to improve beneficiaries' understanding of the Medicare+Choice program.

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The evident self-interest of private plans and insurance companies to enter the Medicare+Choice market should not be ignored, however. Medicare+Choice presents an enormous opportunity for health plans to gain many new enrollees, enrollees who are highly "valued" by the health care system for their high levels of use of providers, hospitals, and physicians. At the same time, panelists pointed to a significant potential downside in pursuing members of the senior population, including adverse risk selection and problems associated with contracting with the federal government. The panel indicated that the benefits of dealing with the Medicare population outweigh the potential drawbacks, however.

* The material in this chapter is derived from the workshop presentations of Frederick Adler, Tom Anderson, Brace Clark, Martin Rosen, and Jack Tighe.

HOW TO TARGET THE MEDICARE POPULATION

Medicare Has a Heterogeneous Population

The Medicare population is very diverse. Forty percent are over the age of 75, and 48 percent are between the ages of 65 and 74. Fifty-one percent still live with their spouses, while 27 percent live alone and 5 percent live in a long-term-care facility. Forty-six percent have had 12 or more years of education, but 27 percent have had less than 8 years of education (U.S. Department of Health and Human Services, 1997b).

This degree of diversity contributes to the difficulty that marketing experts find in conveying a simple message to senior citizens in the United States (Lumpkin et al., 1989). Several of the panelists* indicated that in their experience only two or three factors may influence the health plan decisions made by adults who are not senior citizens. However, their work with senior citizens shows almost no consensus on the range of factors that influence that group's decisions.

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Bruce Clark and other presenters and participants at the workshop stressed that HCFA must bear in mind the local nature of health care. Different communities have different health care needs and concerns. The panel on marketing indicated that the current trend in private-sector marketing is to move away from mass marketing and toward "mass customization," in which companies reach their customers by building more personal marketing strategies. Successful private-sector marketing to the Medicare population has become more individualized. Companies and plans target potential enrollees along the lines of socioeconomic status, neighborhoods, ethnic groups, language, and religious affiliations. HCFA, however, does not have the financial or personnel resources to target its materials to every subgroup within the Medicare population, and the panelists presented a clear caution to the committee: The size and time line of HCFA's current task will compel the agency to standardize the Medicare +Choice information to the greatest extent possible. At the same time, health plans will be sending customized marketing materials to these same beneficiaries. The committee heard evidence that to help stem the confusion that will result from beneficiaries trying to understand all of the different pieces of information that they will receive, HCFA and the private sector should be encouraged to work together to build a more cohesive and useful information infrastructure.

Members of the panel suggested that the marketing dilemma might be addressed by segmenting the Medicare population into at least two groups: those over age 70 and those under age 70 or those beneficiaries who are more familiar with managed care through their former employment status and those who are of an age such that they have not had prior experience with managed care. It is worth noting that the under-70 age group tends to be more active and more Internet savvy, and tends to rely less on family members and doctors for advice on choosing a health plan. Others at the workshop suggested that segmentation by health status might be more

* Tom Anderson, Judith Hibbard, and Jack Tighe.

effective. Those suffering from existing health problems, in particular, need to receive good and impartial information regarding Medicare+Choice from sources other than the health plans. The committee heard testimony indicating that Medicare managed care plans are reluctant to market to these beneficiaries.

One of the panelists* informed the committee that it typically takes 3 to 6 months for a health plan to develop a marketing initiative for a single geographical locale—be it a county, town, or region. The challenge for HCFA to develop a national marketing strategy with local applications over the course of approximately a year is truly daunting.

Education and Marketing Should Be Done Together

Several workshop speakers and participants** spoke about the high degree of confusion among Medicare beneficiaries regarding even basic Medicare program facts. One panelist*** told of focus groups that his organization put together to look separately at issues relating to Medigap and Medicare health maintenance organizations (HMOs). Despite what the company believed were clear instructions, beneficiaries with Medigap coverage showed up at the HMO focus groups and vice versa. All groups that provide health care information to beneficiaries will face the challenge of informing beneficiaries who are not sufficiently knowledgeable about the basic Medicare program, not to mention the new Medicare+Choice options (Frederick Schneiders Research, 1998; Hibbard and Jewett, 1998; Kleimann, 1998a).

Those building the information infrastructure for the Medicare+Choice program were cautioned not to confuse marketing to beneficiaries with beneficiary education. Yet, many times these two tasks are performed simultaneously. Health plans that work with the Medicare population often spend time up front informing their plan members about the basic Medicare benefits package and how the Medicare fee-for-service system operates. Each plan, however, will tend to interpret and relay such information differently. Those who work with the beneficiaries on a day-to-day basis warned the committee that beneficiaries need to get the basic information from somebody they can trust, not somebody they know is trying to sell them something.**** HCFA should be encouraged to develop a clear list of questions and answers for beneficiaries that would address, among other issues, the differences between HMOs, point-of-service plans, and preferred provider organizations; what "network" and "capitation" mean; and clear definitions and examples of deductibles, coinsurances, and stop loss coverage.

The ability of major national marketing campaigns to influence consumer behavior should not be underestimated. By effectively leveraging the $1.5 billion that the insurance industry spends on marketing to the Medicare population, the gap between education and marketing may be bridged. At the workshop, Robyn Stone of the International Longevity Center suggested that a portion of each marketing dollar spent by Medicare+Choice health plans be

* Frederick Adler.
** Frederick Adler, Joyce Dubow, Judith Hibbard, and Robyn Stone.
*** Frederick Adler.
**** Aileen Harper.

dedicated to disseminating HCFA's message to the beneficiaries. One of the easiest ways for HCFA to use health plans in its educational campaign is to have the plans disseminate HCFA's literature as part of any set of marketing materials sent to the Medicare population. HCFA's information enclosure would look identical from plan to plan to ensure that beneficiaries understood that the basic Medicare information was coming from a reliable source. Bruce Clark pointed out that Internal Revenue Service (IRS) forms, whether they are picked up at a neighborhood library, at a drugstore, or off the Internet, are virtually identical and are all visually recognized by the general public as IRS forms. He and others told the committee that HCFA should attempt to achieve similar visual recognition with its materials.

PARTNERING WITH EXPERT OUTSIDE GROUPS AND RESOURCES TO GET THE JOB DONE

The increased choice of health plans available to Medicare consumers will likely lead to heightened confusion among those unaccustomed to exercising choice. Health plans, HCFA, information counseling and assistance programs, and other consumer information services will need to be prepared for the number of beneficiaries wanting their questions answered in the aftermath of the planned fall 1998 mailing of the *Medicare & You* handbook and bulletins. The committee heard recommendations that HCFA should stagger the fail mailing to help alleviate some of the pressure that will be brought to bear on the fledgling information infrastructure. The tight time line mandated in the Balanced Budget Act of 1997, however, makes it difficult to stagger the mailing over more than 1 or 2 weeks. On June 18, 1998, HCFA announced that only 5.5 million beneficiaries in five states (Arizona, Florida, Ohio, Oregon, and Washington) will receive a version of the comprehensive *Medicare & You* handbook that includes comparative health plan information. HCFA explained that this pilot testing will allow it to refine the handbook before it is distributed nationwide.

The use of Industry Advisory Councils was suggested as one method of helping HCFA lean on health plans for further assistance. The committee was reminded of the Health Insurance Benefits Advisory Council implemented at the time of Medicare's establishment. A new council or set of councils could provide HCFA with senior-level advice and guidance on important issues that the agency might not have the time or resources to address carefully. The Alliance Network being implemented by HCFA and outlined by Michael McMullan earlier in this report (Chapter 2) was recognized as a good step in the direction of establishing public-private partnerships.

Relying on Traditional Medicare

The quick introduction of the Medicare+Choice program raises concerns that Medicare beneficiaries will not understand enough of the options before them to make an effective and informed choice. It is the committee's strong sense that Medicare beneficiaries should be clearly told that they do not have to make a choice at all and that remaining in the traditional Medicare program is still an option. Beneficiaries need to be assured that if they are content with their current Medicare arrangement, they do not have to change (Medicare Payment Advisory Commission, 1998b).

Beneficiaries need to be assured that if they are content with their current Medicare arrangement, they do not have to change.

However, traditional Medicare is not a flawless program, and it may not be the best alternative (either in overall costs or benefits) to be offered to beneficiaries. For example, to cover gaps in traditional Medicare coverage, most beneficiaries purchase a separate Medigap policy, usually at a significant cost. Medicare+Choice was designed to save money on two fronts: (1) by enabling the Medicare program to reap the financial benefits of the cost savings associated with managed care and (2) by helping beneficiaries save money by no longer having to purchase a Medigap policy to obtain benefits not covered by traditional Medicare. A number of workshop participants noted that the overall Medicare program has yet to realize real savings from managed care.

Cautions Concerning Private Plan Marketing

As part of its oversight responsibilities, HCFA reviews each health plan's Medicare marketing materials and assesses them for accuracy. As part of the agency's new guidelines for the Medicare+Choice program promulgated in 1997, marketing practices that could mislead or confuse beneficiaries were prohibited.

Even though only 5.5 million beneficiaries will have received the *Medicare & You* handbook initially, private plans and companies will market their services to a wider set of beneficiaries. The marketing practices of several health plans have recently been called into question (Hopkinson, 1998; Neuman et al., 1998). In addition, a recent study of four media markets (Cleveland, Los Angeles, Miami, and New York) by the Kaiser Family Foundation (1998, p. vii–viii) found that:

- lower costs and better benefits are pitched in the majority of ads across markets and media.
- Medicare HMOs appear to target physically and socially active seniors rather than beneficiaries in poor health;
- nonelderly beneficiaries are not targeted by Medicare HMO ads;
- marketing seminars are not consistently accessible to beneficiaries with physical disabilities; and
- although important information is conveyed in ads, much of it is in fine print that is difficult for older people to read.

5

Role of Third Parties in the Information Infrastructure*

The Health Care Financing Administration's (HCFA's) task of disseminating high-quality and accessible information to beneficiaries is difficult because, to a large extent, it is catch-up work. For many years, consumer advocates and information experts have urged HCFA to do a more effective job of educating its Medicare beneficiaries about the Medicare program. When the agency began to move the Medicare population into managed care arrangements starting in the mid-1980s, advocates again cautioned that better information about these plans needed to be disseminated to the beneficiaries.

As HCFA moves toward the full implementation of the provisions of the Balanced Budget Act of 1997 over the next 5 years (1998 to 2003), many third parties will need to play an integral role in facilitating the information dissemination process. Participants at the March 1998 workshop addressed the multiple roles of public- and private-sector intermediaries and information brokers and also looked at the potential liability that such groups and organizations could face because of their roles in assisting Medicare beneficiaries with choosing their health plans.

HOW CONSUMERS USE INFORMATION FOR DECISION MAKING

When learning about their health plan options, beneficiaries consult an average of three information sources.

As mentioned previously in this report, recent research has examined how well Medicare beneficiaries understand the differences between the fee-for-service and managed care forms of Medicare. The task that beneficiaries face is one of choice, but the question is how well they understand the differences and similarities between these two health care delivery systems. A recent study by the American Association of Retired Persons (Hibbard and Jewett, 1998) looked at how well beneficiaries understood the differences between the traditional Medicare program and health maintenance organizations (HMOs). For example, what is a "primary care physician" or a "network of providers," how does one obtain emergency care, and what are the grievance and appeals procedures? The research has also examined how well beneficiaries understand the implications of these concepts for cost, choice, and care.

* This chapter is based on the remarks of Aileen Harper, Judith Hibbard, and Gail Povar.

Judith Hibbard discussed with the committee her research and findings. The study surveyed Medicare beneficiaries in five markets with high levels of enrollment in managed care and used as a total sample equal numbers of beneficiaries enrolled in the traditional Medicare program and in Medicare managed care. Among all the respondents, only 11 percent were deemed to have "adequate" knowledge to make an informed health plan choice.

What Affects the Level of Knowledge?

Judith Hibbard indicated that the most significant predictors of knowledge are levels of income and education. Enrollees in HMOs were found to have lower incomes and lower levels of education than enrollees in the traditional form of Medicare. Therefore, those exercising choice are often the least well able to make the key distinctions between traditional Medicare and Medicare managed care plans.

When learning about their health plan options, beneficiaries consult an average of three information sources. Consulting with more sources results in an increased ability to differentiate between critical elements of traditional and managed care Medicare. The most common sources that beneficiaries turn to are managed care plan advertisements. Results from a series of focus groups for the National Academy of Social Insurance's Restructuring Medicare for the Long-Term project showed that beneficiaries preferred getting plan information from newspapers and print advertisements because the information seemed clearer to them. However, the beneficiaries did not distinguish a preference between advertisements and news stories (Kleimann, 1998b).

Supporting the Decision-Making Process

HCFA and all parties disseminating information to Medicare beneficiaries need to engage in active education programs that seek out beneficiaries. The tasks given to Medicare beneficiaries in the Balanced Budget Act of 1997 are highly cognitive ones and would be difficult for any population (Hibbard et al., 1997; Kleimann, 1998a). The responsibilities that Medicare beneficiaries are being asked to assume under Medicare+Choice require them to analyze several different categories of variables and then multiple variables within each category. For these tasks to be completed effectively, the committee found that good decision support counseling is necessary.

Intermediaries who disseminate information will need to be more than just information brokers. They also will need to assume the role of an educator so that they are able to help beneficiaries understand the differences between the different plans and the differences between the plans and traditional Medicare. In addition, a decision-making framework must also be developed around categories of plans (preferred provider organizations, provider-sponsored organizations, HMOs, etc.).

The committee was told that the provisions of the Medicare+Choice program will necessitate an upgrading of intermediaries' skills. Participants urged information counselors to move beyond merely describing a plan's features to explaining what a particular feature may mean for

a beneficiary's costs, treatments, and freedom of choice.* Throughout the life of the Medicare+Choice program other organizations will need to step in and provide specially tailored products and services to the intermediaries to assist them in their role of providing information to beneficiaries.

A Proposed Important First Step

Judith Hibbard articulated the need to take a concrete first step in the development of a good information infrastructure. According to consumer information experts at the workshop, the development and dissemination of a list of answers to key questions that beneficiaries must know to make an informed choice would be the best first step.

THE ROLE OF THE HICAP †

Model health insurance counseling and assistance programs (HICAPs) have multiple roles. The first is that of an impartial information disseminator. Many beneficiaries seek out HICAPs precisely because these programs are not affiliated with HCFA and because they are interested in receiving a second opinion on the information that the government sends to them. This type of information brokering needs to be accurate and unbiased. Second, model HICAPs are more than information disseminators; they also help frame the information given to beneficiaries, including (1) organizing the information in a way so that it makes sense to the beneficiary and (2) putting the information in perspective without getting into biases and decision making. The way that information is framed needs to vary by Medicare population subgroup. Third, effective HICAPs are able to empower beneficiaries by providing them with knowledge.

How to Best Provide Beneficiaries with This Information

The Center for Health Care Rights, considered a model HICAP, serves more than 15,000 Medicare beneficiaries in the Los Angeles, California, area each year and has an annual budget of $650,000. More than 30 percent of the center's constituents are currently in Medicare managed care. The center takes a three-pronged approach to disseminating information to beneficiaries:

- use of a telephone hot line;
- use of volunteers spread throughout the community; and
- use of community education programs.

* Aileen Harper.
† Aileen Harper.

These three approaches are used together. The center has found that merely giving educational materials to the senior population is not very useful, even for well-educated beneficiaries. The information becomes more meaningful when a volunteer walks the beneficiary through the information in a one-on-one situation. The volunteer network needs to be supported by a professional staff that is strong on the technical details of Medicare managed care. Even under the best circumstances, however, this three-pronged approach is not always adequate. The Center for Health Care Rights is continuously assessing how it can better reach underserved populations in particular.

Well-funded and well-staffed HICAPs like the Center for Health Care Rights also invest a good deal of money on library materials, subscriptions to journals, and manuals published by HCFA. Inadequate community support and funding can seriously hamper a HICAP's ability to provide the best and most recent information to its clients.

Liability Issues

The committee heard that it is necessary for those who provide information, counseling, and assistance to beneficiaries to develop ways to protect their organizations if a beneficiary or a beneficiary's family member determines that the counselor should be held liable for a poor health plan choice. It is incumbent on community-based organizations to provide their volunteers and staff with ongoing training in the more technical issues facing beneficiaries. Otherwise, they may easily find themselves disseminating poor or incomplete information to those they are trying to assist and leave themselves open to legal action.

Consumer counselors present at the workshop noted that HICAP employee bias could also leave an organization open to criticism. Once a third-party information broker moves beyond being a channel for comparative information and into helping beneficiaries understand what the information may mean to them, the broker's judgment becomes an issue.

THE ROLE OF PROVIDERS: AN ISSUE OF TRUST*

Of necessity, physicians and other health care providers have multiple agendas related to the practice of medicine: to carry out their definition of an effective doctor-patient or health care provider-patient relationship, to try to advance with medicine patients' visions of how they wish to live their lives, and to keep a practice viable and in business. All three of these competing agendas are operating whenever a patient enters a health care provider's office.

With the advance of managed care, more health care providers are finding that their patients also expect them to be experts on health care policy, health plans, and health insurance programs. Patients often ask their providers for the provider's opinion about which managed care organization the patient should join. Patients tend to seek out their providers' advice because providers tend to be trusted figures. If, however, a patient is new to the provider's practice, he or she may question the provider's motives, particularly if the patient is seeing the provider through a managed care arrangement, because such patients have a tendency to view such a pro

* Gail Povar.

fessional's advice as a means of advancing the provider's economic agenda (Edgman-Levitan and Gerteis, 1998). In addition, providers attest that it is becoming increasingly difficult for them to establish trust with their patients.

From the information on patient-provider relationships presented above, it appears that in today's practices, patients either are overly trusting or are suspicious of the health care enterprise in general. Both ends of the spectrum interfere with a provider's attempt to create an optimal health care-related partnership between patient and provider.

THE FUTURE INFORMATION DISSEMINATION INFRASTRUCTURE

What needs to be accomplished over the next 5 years to ensure that the Medicare+Choice program works as it is intended? An initial mailing to a subset of 5.5 million of HCFA's 39 million Medicare beneficiaries was scheduled in November 1998. At the same time, public-sector groups and private-sector companies began their information and marketing campaigns targeted to beneficiaries and their families. The private-sector campaigns will be localized and customized, but to support the development of the information infrastructure adequately, the efforts of all organizations will need to be localized. In addition, to ensure that beneficiaries are getting the best and most useful information, third parties assisting beneficiaries and their families with the choice process will need to be viewed as independent.

A fledgling information dissemination infrastructure already exists in most communities. It typically consists of HICAPs, although most of these have small staffs and budgets (the U.S. Congress has allocated about $10 million to these organizations that address the myriad information dissemination problems surrounding consumer education and counseling). Protective and advocacy organizations for those people with disabilities are also part of the infrastructure. Each state and many communities have long-term-care ombudsman programs. In addition, many national organizations such as the American Association of Retired Persons and the Alzheimer's Association have active local affiliates. The committee heard that the marshaling of all of these existing local resources may be the best way to develop a viable information dissemination infrastructure.

Conditioning the Market

To prepare beneficiaries for the rush of new information regarding Medicare+Choice, beneficiaries and their families need to understand several key issues:

- the changes that are taking place in the health care market;
- the trade-offs that a beneficiary will face when switching from one health plan to another; and
- how the system is best navigated once a beneficiary chooses a health plan.

By necessity, once beneficiaries become better educated about the basic elements of managed care and traditional Medicare, information brokers will need to become more thoroughly trained to provide more refined assistance.

To implement the key components of an effective information infrastructure, additional resources will be needed. The Center for Health Care Rights, under the direction of Peter Lee, is in the process of conducting research that looks at how much effective counseling programs cost. The research, however, is still in an early stage. In the meantime, panelists stressed the need for continued and increasing public-private partnerships, such as the provision of computers to seniors centers so that beneficiaries can access HCFA's Medicare web site. Spreading the costs for funding of the information infrastructure and the development of partnerships beginning at the local level would minimize the amount of funding that would ultimately be needed.

6

Best Practices and Models for an Open-Season Enrollment Process*

According to the Balanced Budget Act of 1997, beginning in November 1998, Medicare beneficiaries eligible to participate in the Medicare+Choice program will be able to enroll in a participating plan. Beneficiaries will be able to disenroll from plans once a month through 2001, moving to disenrollment every 6 months in 2002 and finally to annual enrollment with a 3-month disenrollment period in 2003. Over the next 5 years (1998 to 2003), as the health plan choices made during an open season carry increasingly more significance due to the availability of smaller windows of time for disenrollment, the Health Care Financing Administration (HCFA) will be looking at organizations that run open-season programs for large groups of beneficiaries (be they employees or retirees). At the March 1998 workshop representatives of a major state employees' plan, the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (TSECMMP), and the Federal Employees' Health Benefits Plan (FEHBP), discussed some of the lessons that their organizations might offer HCFA. As part of the panel, General Electric, known for the effectiveness of its Answer Center, discussed how technology can best be used to convey basic information to a large, widespread population during an open season. All of these large purchasers emphasized the value of public-private partnerships and standardized benefits. They also emphasized the benefit of using retirees themselves to educate the beneficiary population.

STATE OF NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN*

North Carolina is an example of a state with an immature overall managed care market. The level of penetration into managed care outside the two major counties (Mecklenburg and Wake) is minimal. Hospital systems compete with each other only in the cities of Charlotte and Raleigh. The limited degree of competition among medical providers puts managed care organizations interested in operating in North Carolina in the position of competing with other plans using the same panel of providers and the same hospital. Of the 24 health maintenance organi

* The material in this chapter is based on presentations by David De Vries, Jim Morrison, and Guy Peterson.
* David De Vries.

zations (HMOs) licensed to do business in the state, only 12 participate in TSECMMP. The enrollment level in 4 of those 12 plans accounts for 75 percent of total enrollment in HMOs.

TSECMMP was established by general statute by the North Carolina legislature in 1982. In 1986, it began offering its first HMO options to plan members. TSECMMP covers 533,000 people, 67,000 of whom are eligible for Medicare. Only 3,000 of those 67,000 people have chosen to join 1 of the 12 HMOs (less than 5 percent penetration). There is an expectation that the level of penetration will increase as more active employees (nonretired) enrolled in managed care become eligible for Medicare. Currently, 27 percent of all TSECMMP enrollees participate in some type of managed care plan.

TSECMMP markets to all of its members, be they active or retired, with the same materials and provides them with the same benefits. All beneficiaries receive a booklet, "It's Your Choice," which is published every year and which provides basic information about the plans, including benefits and health plan telephone numbers. If a beneficiary is interested in a particular plan, it is up to him or her to call that plan and request additional information. Marketing materials are screened by TSECMMP. The state of North Carolina has attempted to make it fairly simple to compare information about different plans. The benefits are standardized, and copayments are regulated by state law. HMOs may offer additional benefits, such as vision or dental coverage; however, the benefits offered through TSECMMP tend to be more generous than those typically offered by HMOs to their other customers.

Lessons Learned

TSECMMP uses its retired employees to help pensioners and active employees with the decision-making and enrollment processes during its annual open-season enrollment period. The training of retirees across the state to become information counselors works well for TSECMMP. It has found that its beneficiaries work well with these counselors because the counselors have had practice in making the same decisions that the beneficiaries are facing.

North Carolina has found that many of the plans that initially signed up to provide care under TSECMMP dropped out after the first couple of years. The plan's administrator advised HCFA that as competition among the Medicare+Choice plans begins to take place, it is likely that quite a few of the health plans will end up leaving the federal program as well. Of the plans that remain after the initial phase of competition, only a few will have enrolled most of the market share.

To a great extent, TSECMMP relies on its participating health plans to provide detailed information on services that they provide to beneficiaries. This public-private partnership has worked well for the state, saving personnel and resources.

FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM*

FEHBP is the largest health plan in the country, with about 9 million covered lives. FEHBP currently has approximately 4 million actual contract holders, split evenly between ac

* Jim Morrison.

tive employees and retirees. The proportion of retirees to active employees is expected to increase as the government continues to downsize. The program has 350 participating health plans. Ten of these operate nationwide and are open to all enrollees, and seven operate nationwide but are open only to specific groups of retirees and employees such as employees of the Federal Bureau of Investigation, the U.S. Foreign Service, and the Secret Service. The remaining plans are managed care organizations. For the past several years, all of the plans, including those labeled as fee-for-service plans, have possessed numerous features typical of managed care plans. The Office of Personnel Management (OPM) manages FEHBP and mandates an annual open season that extends for about 5 weeks in November and December of each year. Significantly, only about 5 percent of all enrollees switch plans during any one open season.

OPM produces a plan comparison guide and approves the brochures and marketing materials used by the individual plans. Federal retirees receive their open-season enrollment materials at their address of record. Each packet is tailored to the enrollee's geographical location and contains information about all of the national plans for which the enrollee is eligible and all of the plans in the enrollee's area. Enrollees do not receive information on all 350 plans in the program. The enrollment materials that each enrollee receives indicate the plan in which he or she is currently enrolled, information on how to receive additional information about any plan in which the enrollee might have an interest, how to make an open-season selection, and how to switch health plans. Most active employee enrollees switch plans by using a Touch-Tone telephone. Retirees may use the automated telephone enrollment system unless two or more retirees reside in the same household.

There are clear distinctions between FEHBP and the Medicare program. Federal retirees have about 25 to 30 years of experience in an open-season enrollment environment. Even though they may not have changed health plans very often over those 25 or 30 years, they have had the opportunity to do so and they have had direct interactions with health plans during this period of time. Also, because they have been in this system for a number of years, the retirees already possess a great deal of knowledge about deductibles, copayments, and so forth. These two factors indicate that HCFA's task will be much more complex than FEHBP's. Presenters indicated that a heavy premium will need to be placed on the general and massive education initiative on the front end of the Medicare +Choice program. Mitigating HCFA's task is the fact that Medicare is a program that enrolls only individuals. HCFA will not have to contend with the complexities of families, dependents, and dual entitlements. Additional differences include the fact that federal employees in FEHBP basically trust that OPM has screened the health plans and that they cannot make a bad choice. Medicare+Choice, however, introduces several new types of plans such as provider-sponsored organizations and provider service networks that do not have performance histories with Medicare beneficiaries.

Lessons Learned

Jim Morrison offered the committee several lessons from FEHBP's experience. The first lesson is that HCFA must make extensive use of the private sector, most importantly, the plans participating in Medicare+Choice. Participating plans play a large role in FEHBP, and almost all of the innovation for which the program and OPM take credit has come from the plan side. However, OPM has made use of the health plans' expertise in working with enrollees for many

years. For HCFA to take on a similar relationship with the health plans would be a major change for the agency.

The second lesson that may be learned is that the enrollment process should be simplified and automated as much as possible. It is important to involve the plans in this process as well. A prominent feature of any national advisory committee should be the inclusion of officials from several of the participating plans. The plans are the organizations facing the greatest financial risk, so it is in their interest to have informed customers. In the long run, the committee heard, HCFA should assume that health plans are acting appropriately, but HCFA should also stipulate that transgressors will receive heavy penalties and punishments.

A final lesson is the need to make a reasonable allowance for Medicare beneficiaries to exercise a choice with which experts and analysts may disagree. It should be recognized that there will be anecdotal evidence and policy making as a result of horror stories, but HCFA will need to allow for the possibility that beneficiaries will exercise choices that may not be considered optimal by policy experts. Protection, however, will be needed to ensure that "poor" plan selection on the part of a beneficiary will not result in serious harm.

THE EFFECTIVE USE OF TECHNOLOGY: THE GENERAL ELECTRIC ANSWER CENTER AS A CASE STUDY*

The Balanced Budget Act of 1997 mandates that HCFA implement a toll-free telephone number to assist beneficiaries. Representatives of HCFA indicated at the workshop that the agency plans to employ about 3,000 telephone operators to handle Medicare+Choice calls, although HCFA has more recently indicated that it will only use 600 customer service representatives. For the past several years, HCFA has funded a call center demonstration project outside of Baltimore, Maryland, called *Trailblazers.* The demonstration project has received favorable reviews; however, outstanding models that exist in the private sector may provide ideas for further refinement. Hailed by many as a best practice for customer service and information, the General Electric Answer Center model was highlighted during the workshop. General Electric has more than 200,000 retirees, most of whom use an answer center modeled after the commercial Answer Center for health plan selection and information. General Electric was invited to present information on what makes a good customer service call center and how to avoid some pitfalls associated with the use of toll-free telephone numbers to provide information.

Customer Requirements

General Electric has found that customers' requirements for a good call center are clear: The phone should be answered quickly, the question asked should be answered, and that answer should be correct. If a customer is speaking with a live operator, that person should be courteous. If the customer is dealing with a voice response system, it should be easy to navigate.

* Guy Peterson.

Call Center Requirements

Three areas differentiate a good call center from a mediocre one: people, technology, and an inquiry management process.

People

The right staffing is the most important element, and a General Electric representative informed the committee that the company prefers to hire "thinkers" over clerks. Each thinker (almost all of whom have college degrees) costs about $3,000 to $4,000 more per year than a clerk, but the overall results are worth the up-front investment to General Electric. Once call center employees are hired, they are thoroughly trained, and that training is constantly reinforced. General Electric suggests that good call centers provide feedback to their operators, recognize good performance, and provide career paths to those not wanting to make the call center their career.

Technology

The next key component in a good call center is technology. The telecommunications industry possesses the ability to create a toll-free telephone system with highly flexible capabilities. A good call center will use the latest technological advancements to the utmost degree possible. The technology used by a call center should at least include a basic call-monitoring system, an inquiry tracking system, the proper capacity and switching technology, a voice response system, an information system for operators to obtain quick and accurate answers to questions, and Internet access that provides the same information as the voice response system. Throughout the workshop participants provided testimony regarding the reluctance of senior citizens to use voice response systems. Several testified that when Medicare beneficiaries contact health plans, they spend an average of 25 minutes on the telephone with the operator. To the contrary, General Electric has found that 50 percent of its pensioners use the voice response system, thereby circumventing an operator interface for this segment of the retired population.

Table 1 Typical Costs Incurred by General Electric for Information Requests

Method of Contact	*Cost per Contact ($)*
Face-to-face counseling	20.00
Letters and forms	10.00
Live operator telephone call	3.00
Voice response telephone call	1.00
Internet	0.40
No contact	0

Inquiry Management Process

The third element in a good call center is an inquiry management process. When dealing with a large volume of calls, it is important for the system to manage those calls and not let the calls manage the system. General Electric logs in each call received and dissects the information in a variety of ways to determine better methods of operation. The overall objective of a call center is to reduce the overall number of calls or to drive more of the inquiries to a voice response system or the Internet. Each phone call, particularly one handled by a live operator, is

viewed as a defect in the information infrastructure. Once a particular question is asked several times, General Electric determines a way to get the correct or more clear information to its retirees either on the voice response system, on the Internet, or by altering its printed materials to be more specific.

Research indicates that there are wide variations in the cost of an inquiry. Table 1 presents the typical costs incurred by General Electric for different types of information requests.

7

Special Needs Populations: Helping Those Most in Need of Assistance*

Throughout the workshop presenters indicated that the first group on which informational efforts need to be concentrated is the more vulnerable members of the Medicare population. Thl Health Care Financing Administration's (HCFA's) current paradigm of frail elderly includes those with low levels of education, African Americans, those who live in rural settings, those with impaired hearing or vision, Hispanics, and dually eligible individuals (those beneficiaries with both Medicare and Medicaid). The committee acknowledges that there are many population subgroups within the overall Medicare population for which special sensitivity is required. During the workshop, presentations on the special needs of chronically ill individuals within managed care plans, beneficiaries for whom English is not a first language or who have low levels of literacy, and beneficiaries with Alzheimer's disease and other cognitive impairments were given.

CHRONIC ILLNESS IN MANAGED CARE

Chronic illness is highly prevalent among members of the Medicare population. Some would argue that it is the norm and not a special need. The Current Beneficiary Survey indicates that 65 percent of all elderly people have two or more chronic conditions. Thirty-four percent of seniors report limitations in mobility or activities of daily living, and 35 percent report limitations in social activities. Those people who are chronically or socially isolated use health care services at disproportionately higher levels than the rest of the senior population.

65 percent of all elderly people have two or more chronic conditions.

Presenters told the committee of criticism that has been leveled at the managed care industry regarding its treatment of chronically ill individuals and its tendency toward favorable risk selection. Current research suggests, however, that managed care organizations (MCOs) generally treat the same proportion of chronically ill patients as indemnity plans (Fama et al., 1995). Some research shows that MCOs do a poorer job than fee-for-service health care of maintaining the health status of older Americans (Ware et al., 1996).

* Presentations by Peter Fox, Francesca Gany, and Katie Maslow provided the material for this chapter.

Looking at the general population, testimony at the workshop indicated wide variations across plans in terms of how MCOs treat chronically ill individuals. On the one hand, the committee heard that many plans do not recognize that elderly people have different health care needs. On the other hand, a number of plans have major programs and special interventions that are not typically seen in fee-for-service systems. Those MCOs tend to have in place more sophisticated systems that identify elderly people with higher levels of risk and that do a better job of case managing. Such MCOs also are more disposed to developing systematic ways of interacting with community-based social services to assist individuals in gaining access to the health care system (i.e., rehabilitation programs and diabetes, hypertension, and disease management programs) (Fox et al., 1998).

It is important for researchers to develop for the chronically ill population satisfaction measures that are separate from those developed for the general population receiving care for acute illnesses. The committee was told that chronically ill individuals tend to be happier with their primary care provider if they feel comfortable with that person and that they also rate their satisfaction with a health plan higher if they do not use it very much.

It is probably not possible for HCFA to provide information on each health plan's programs that address the special needs of the many subpopulations within Medicare. Beneficiaries and their family members are often concerned with rather subjective, very specific information that the federal government cannot easily provide. Here, private affinity groups or an organization similar to the one that publishes *Consumer Reports* can step in and indicate not only which plans have a disease management program in place but also which ones are the best.

CHALLENGES FOR THE IMMIGRANT POPULATION

In 1965, the immigration policy in the United States changed, loosening quotas and substantially increasing the number of immigrants. The immigrants who arrive in this country are typically between 20 and 45 years of age, so many of those first immigrants that arrived in the 1960s are now Medicare beneficiaries. What special consideration should be given to this group?

12 percent of Americans over the age of 65 primarily speak a language other than English. The largest subset, 30 percent, speaks Spanish.

Immigrants over the age of 65 have come from diverse areas of the world and speak many different languages. According to HCFA, 12 percent of Americans over the age of 65 primarily speak a language other than English. The largest subset, 30 percent, speak Spanish. These beneficiaries were raised in many different cultures and often favor different methods of health care. Over the past 33 years the largest numbers of immigrants have come from China, Mexico, the Dominican Republic, Jamaica, and India, which are very different from the United States in terms of language and culture. In addition to language barriers, immigrants face the same barriers to understanding and choosing from among the various options under Medicare+Choice as native-born beneficiaries, as well as economic and legal barriers to care. Another concern is that over the past 33 years many immigrants have come from countries with governments that are oppressive or not trustworthy. Therefore, additional complications arise when they are forced to deal with a large program administered by the federal government. Furthermore, even though these

beneficiaries may have resided in the United States for many years, significant numbers of immigrants still cling to their home country's favored methods of health care.

Reaching the Immigrant Population

For the November 1998 mailing to its Medicare beneficiaries, HCFA planned to prepare information in both English and Spanish. For the large numbers of non-English and non-Spanish speakers in the Medicare population (about 3.3 million people), the question is whether they will be able to use the standard information sources being developed for Medicare+Choice. Will they use the toll-free telephone number? If so, will interpreters be available? How will they read the materials sent to them? Will the burden of information dissemination fall largely on the extended families? What other resources exist for them? Participants emphasized to the committee that one of the most important issues that should be kept in mind when developing information resources for the immigrant communities is their lower level of literacy, particularly with written English.

Alternative Methods of Reaching the Immigrant Populations

It is also important for HCFA and other groups reaching out to the beneficiaries to work with those in the ethnic communities whom the elderly people in those communities trust. Perhaps the most effective resource will be the media used by the various ethnic communities, particularly radio, because radio circumvents the problems of literacy and trust. Churches and seniors centers also are valuable resources that will need to be used more fully.

HOW TO HELP COGNITIVELY IMPAIRED INDIVIDUALS MAKE INFORMED DECISIONS

According to data from the Medicare Current Beneficiary Survey, 5 percent of Medicare beneficiaries have Alzheimer's disease and 2 percent are mentally retarded (Eppig and Poisal, 1997). However, Katie Maslow of the Alzheimer's Association estimates that those figures are too low and that approximately 10 to 15 percent of the Medicare population have Alzheimer's disease or some form of dementia and that another 4 to 6 percent are mentally retarded.

For most cognitively impaired beneficiaries, the extended family will be the decision maker for the beneficiary. Evidence indicates that just as non-cognitively impaired beneficiaries generally do not understand the basic provisions of Medicare, the same is true for the family members of cognitively impaired individuals. Many family members are unable to distinguish between the Medicare and Medicaid programs and fail to understand basic elements of fee-for-service and managed care plans. When dealing with cognitively impaired individuals, it is critical to make sure that the family members are also provided with good information.

Even though HCFA had not begun to publicize the Medicare+Choice program at the time of this workshop, health plans were already sending patients information. At this time of major change and confusion, the committee heard, it is important for family members to understand

that the person for whom they care does not have to choose a different health plan. Several workshop participants* indicated that advocacy groups working with the families of beneficiaries who are cognitively impaired are advising them to wait before making a decision. Anxiety among the family members is very high because they bear the responsibility for making a critical decision for a loved one who clearly needs their assistance.

Decision Making by Cognitively Impaired Individuals

How does a person with cognitive impairment exercise Medicare beneficiaries' rights in the areas of enrollment, treatment, appeals, grievances, and disenrollment? The American Bar Association Commission on Legal Problems of the Elderly, the American Association of Retired Persons, and the Alzheimer's Association are working with HCFA to develop a set of rules governing decision making in managed care for people with cognitive impairments.

Current HCFA materials indicate that state laws in the area of decision making have precedence over federal regulations. States specify who is eligible to make a health care decision for a cognitively impaired person. However, only Florida's law includes selection of a health plan in the health care decision definition. The existing laws in 49 states do not cover health plan enrollment.

* Joyce Dubow and Katie Maslow.

8

Implementation Issues*

Two major activities need to take place before the Health Care Financing Administration's (HCFA's) November 1998 mailing: (1) Several different types of plans (health maintenance organization, point-of-service, provider-sponsored organization, provider service network, medical savings account, and private fee-for-service) need to be defined and (2) during the fall of 1998, 39 million beneficiaries must be reached and educated about Medicare+Choice before they receive HCFA's mailing. November 1998 will mark the largest open-enrollment season ever attempted, although the first true open enrollment will take place in 2002, when the beneficiaries will be locked in to the choices that they have made until the next open-enrollment season a year later. Presentations over the course of the workshop indicated that the chances of getting the information infrastructure in place by the fall of 1998 is very low, not because those implementing the program are not competent but because the task is so cumbersome.

To move from operational theory to implementation, the development of information in six areas should be examined.

1. *The conflict between making something understandable and accessible to the public and to various subgroups versus making something legally and technically correct and complete.* There has been a traditional emphasis on making information as legally and technically correct as possible, often sacrificing the information's accessibility to the public. Experts need to learn that more information is not necessarily better information. Also, the visual presentation of the information is almost as important as the content.
2. *There is a difference between making people aware of information and helping them understand it.* Helping people understand information and providing a context and creating an infrastructure that assists people in making informed choices involve more time and money and greater human resources. If a clear understanding of the Medicare+Choice and traditional Medicare programs does not exist, beneficiaries will be afraid and anxious.
3. *The presentation of data is key.* The first round of data available to beneficiaries will focus on benefits and costs. However, more data on quality will need to be included as time progresses. The key issue becomes how to present the data so that it is usable. Organizations are moving beyond just including Health Plan Employer Data and Information Set (HEDIS) data and

* This chapter is based upon remarks by Carol Cronin, Helen Darling, Lynn Etheredge, Vicki Gregg, and Leonard Schaeffer.

are beginning to organize information in terms of groups of information, for example, including all data on women's health indicators (e.g., mammography rates) together. Eventually, organizations will be presenting qualitative data using an evaluative approach in which algorithms and weighting systems will be applied to the data. These systems will allow some plans to be favored over others. This final way of presenting information is being developed by the Foundation for Accountability and other similar organizations.

4. *The issue of using standardized information versus customized information.* Throughout the workshop the notion of "mass customization" was mentioned. With mass customization, information is tailored to appeal to the interests and concerns of different groups of Medicare beneficiaries. Information experts argued that this type of information dissemination is easier to do over the Internet than in print. The senior population at present, however, favors print materials over the Internet's resources. The committee was advised to tell HCFA to establish prototypes for displaying and disseminating information that would encourage private-sector creativity but that would still enable plans to let beneficiaries know that "we are standard in these ways, but not in these."
5. *Targeting of the correct audience is important.* The Medicare population is very heterogeneous. When disseminating information it is critical to avoid stereotyping, particularly by age, dependency status, and health status. Research indicates that those with technically poor health status sometimes perceive their own health to be better than it really is.
6. *Developing information for the short term versus the longer term.* Creating information for the immediate deadline of November 1998 is a first step. The real issues will be played out over the next 5 years. It is critical not to do anything in the short term that must be undone in order to do it right in the long-term. Some information experts encouraged the committee to look at the development of information in generational terms. The expectations of the generation currently in or just entering Medicare will be vastly different from those of the baby boomers and younger generations when they enter the Medicare program.*

ACCOUNTABILITY

Contract management is a critical issue for HCFA. Under Medicare+Choice, many new plans (and types of plans) will be entering the Medicare marketplace. Several of these plans will be small and largely untested. The potential for error is great. Presenters examining the implementation issues for Medicare+Choice encouraged HCFA to tighten its contract management procedures so that it could quickly step into a bad situation. HCFA was also encouraged to follow the example of the Office of Personnel Management and the Federal Employees' Health Benefits Plan and put more of the burden for good performance and conduct on the health plans themselves.

The plans need to be accountable for providing good and complete information to beneficiaries. If people are not getting the medical care they need, the language translation services promised to them, or the disease management program advertised to them, it should be the plan's responsibility to correct these errors before HCFA steps in with severe punitive measures. The committee heard that it is unreasonable to expect a government agency to manage with a slim

* Carol Cronin.

$95 million budget an industry with a $1.5 billion marketing budget and to manage effectively the enrollment features of the Medicare+Choice program.

IMPLEMENTATION LESSONS FROM TENNCARE

Tennessee's Medicaid program, TennCare, offers some valuable implementation lessons for HCFA's Medicare+Choice program. Like Medicare+Choice, TennCare was a 5-year phased-in program that moved large numbers of people into managed care programs. Twenty-five percent of Tennessee's population of 5 million people is enrolled in TennCare, including one-quarter of the elderly population.

A presenter familiar with TennCare* offered HCFA four pieces of advice. First, identify the most vulnerable among the Medicare population and offer them as much personal assistance as possible. In Tennessee, case managers were assigned to the at-risk population. TennCare's use of case managers during the transition period was highly effective.

Second, use simple information. Whereas experts may understand and use HEDIS information, for example, the general public does not want to deal with that level of detail. It is more important to synthesize this information effectively and to reproduce it in a way that is easily accessible and understandable.

Third, recognize the limited lifetime of educational information. TennCare found that the educational information shared with their beneficiaries had a lifetime of 90 days. If participants in Medicare+Choice do not use their health plan every 3 months or so, they need to be reminded of the basic tenets of the program.

Fourth, involve the states and local advocacy groups. It is critical to effectively use people at the state level who understand the senior population. Throughout the workshop, the committee heard that health care is local and that information should be tailored to the community level, if possible. HCFA should not limit its partnerships to community advocacy groups, however. Although these groups are proficient in solving an individual's problems or in sounding any alarms that may be needed, through its regulatory powers the state government ultimately has more power over a health plan.

USE OF AN ADVISORY COUNCIL

Over the course of the workshop, presenters referred back to the Health Insurance Benefits Advisory Council which was established at the time of Medicare's establishment. The council involved senior officials committed to making Medicare work. The council was able to provide advice and counsel to HCFA on important issues that the agency might not have the time or resources to examine carefully. The establishment of a new advisory council that would assist HCFA with the Medicare+Choice program would be a positive step in creating good public-private partnerships.

* Vicki Gregg.

POLITICAL CONSIDERATIONS

The Balanced Budget Act of 1997 stipulates that materials from HCFA be sent to beneficiaries in October 1998, one month before a general election. Presenters felt that congressional phone lines would be overwhelmed by confused and anxious beneficiaries and their family members. Speakers cautioned that political rhetoric emanating from any beneficiary confusion might mitigate long-term efforts. HCFA was urged to consider dedicating additional personnel to working with congressional offices.

9

Letter Report to the Administrator of the Health Care Financing Administration on Developing an Information Infrastructure for the Medicare+Choice Program*

Committee on Choice and Managed Care Office of Health Policy Programs and Fellowships Institute of Medicine June 22, 1998 Nancy-Ann Min DeParle Administrator Health Care Financing Administration Washington, D.C. Dear Ms. Min DeParle:

In March 1998, the Institute of Medicine (IOM) Committee on Choice and Managed Care held a one-and-one-half-day workshop on "Developing an Information Infrastructure for Medicare Beneficiaries." This workshop followed in the footsteps of the Committee's 1996 report, *Improving the Medicare Market: Adding Choice and Protections.* One of the 1996 report's seven major recommendations was the following:

> 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. (p. 89)

* The text included in this chapter is a copy of the committee's original letter, dated June 22, 1998.

The March workshop focused on the information and dissemination requirements established in the Balanced Budget Act of 1997 (BBA), as they pertain to instituting an open-season enrollment process by the year 2002 for Medicare beneficiaries and implementing the Medicare+Choice (Part C) program. As part of the BBA mandate, HCFA is required to mail an announcement of the new Medicare+Choice options to all 39 million Medicare recipients by November 1998. Approximately 50 people from the public and private sectors were invited to the workshop. They were selected for their special expertise on information needs and information technologies as they relate to exercising health plan choice in a competitive, managed care environment, especially among senior citizens.

We want to share some of the committee's findings and recommendations based on the presentations and discussions at the workshop, and on the committee's 1996 report. The committee supports the major provisions of the BBA pertaining to increasing Medicare beneficiaries' health plan choices and providing beneficiaries with better information about the options available to them. However, the committee would like to underscore the following findings and concerns:

- The introduction of Medicare+Choice brings with it new rules and procedures that will be totally unfamiliar to most beneficiaries. In addition, the scope and speed of the proposed changes are likely to cause confusion and anxiety among many elderly beneficiaries.

  Medicare beneficiaries have had much less exposure to managed care than have people who are insured through their employers. While managed care enrollment for the over-65 population is increasing rapidly, according to May 1998 HCFA data only about 16 percent of people eligible for Medicare are enrolled in a managed care plan, compared to over 70 percent in the under-65 insured population. In addition, unlike most employed people—particularly those working in larger firms—whose employers help screen and evaluate their health plan options, most Medicare beneficiaries must rely on their own knowledge and judgment to select a plan wisely. In its 1996 report, the committee noted that the elderly need more time and require more outside help to make health care decisions. In addition, findings of a study presented at the workshop indicate that the information processing tasks that would be required of Medicare beneficiaries under the BBA are highly cognitive and would be difficult for *any* population to address successfully (Hibbard et al., 1997).
- The new system scheduled to be introduced by November 1998 will give many elderly people a broader array of health plan options from which to choose. However, although HCFA will present comparative information about the plans in a standardized format, most of the marketing materials available from individual plans themselves will not be standardized or presented in a way that would be conducive to helping elderly people make informed decisions they could feel comfortable with.

  The 1996 IOM study and experts at the workshop addressed the value of standardized packaging, pricing, and marketing of benefit options to allow beneficiaries to more easily compare the benefits offered by different plans. Representatives from the plans, however, told the committee that the current trend in private-sector marketing is to move toward "mass customization," whereby materials are tailored to an individual's demographic characteristics, socioeconomic status, neighborhood, ethnic group, language, and religious belief. To help decrease

confusion and to make it easier for beneficiaries to make informed choices, the committee refers to the findings of its 1996 report to underscore the advisability of the government developing a common terminology that would be used by all plans to describe their benefits, as well as common formats for presenting the information; both efforts should draw on the best practices used by employers and by private and public organizations.

- Many beneficiaries do not understand how basic Medicare and Medigap coverage works. Far fewer elderly persons have even a rudimentary understanding of how managed care works or of how to choose among managed care plans, traditional Medicare, and Medigap.

  Research over the past 12 years has documented how poorly Medicare beneficiaries understand the differences between traditional and managed care Medicare (Cunningham and Williams, 1997; Davidson, 1988; Hibbard et al., 1997; McCall et al., 1986; Sofaer, 1993). Beneficiaries now face the daunting challenge of having to choose between two systems they do not understand, and, for many elderly persons, having to compare and to select from among many more plan options than employed populations face. In an examination of current survey research, the committee heard evidence at the workshop that 30 percent of beneficiaries in high-penetration managed care markets "know nothing" about managed care organizations, even though half of this group is currently enrolled in a managed care plan (Hibbard and Jewett, 1998).
- Despite HCFA's best efforts, a fall health plan marketing campaign is likely to produce, at the very least, a high level of confusion and anxiety among Medicare recipients—perhaps a backlash—and a host of questions about the impending changes.

  Several presenters at the workshop commented that the increased range of health plan choices available to Medicare recipients under Medicare+Choice will likely spawn a great deal of anxiety and confusion among those unaccustomed to having to make such choices. The 1996 IOM report and testimony given at the March workshop spoke to the benefits of allowing sufficient time for beneficiaries to learn about and understand the new system. The potentially daunting scope and speed of the transition to what, for most beneficiaries, remain uncharted waters underscores the need for building trust and familiarity in this arena. Trust and confidence can be greatly enhanced through the development and dissemination of reliable, objective, and understandable information. Efforts to build trust and a level of comfort with Medicare Part C are particularly important given the ongoing negative public perception and attitude about managed care in general.
- Compounding the likelihood of raised anxiety and confusion among the elderly will be a concurrent flood of mailings marketing existing plans as well as a number of new Medicare products. Despite current rules designed to monitor and control marketing materials sent to Medicare beneficiaries, such mailings can too easily include misleading or incomplete information. Most materials sent to the elderly lack a clear, understandable explanation of what it means to be part of a managed care plan and what coverage or cost trade-offs need to be considered by beneficiaries in order to make a good health plan choice. Such information must be part of the marketing materials to minimize dissatisfaction among beneficiaries that could subsequently lead to excessive, costly rates of plan disenrollment.

Many health plans understand the importance of spending time with Medicare beneficiaries up front to provide them with reliable information about the plan and how it differs from traditional Medicare. The committee, however, heard ample evidence that plans tend to interpret and relay information differently from each other. Experts who work with beneficiaries provided extensive evidence at the workshop that all too frequently, the information that plans provide is incomplete and confusing. A recent report published by the Kaiser Family Foundation also points to evidence that HMOs, particularly those using aggressive sales tactics, rarely include explanations of how they differ from traditional Medicare or detailed explanations of their benefits and coverage limits (Frederick Schneiders Research, 1998).

- Whereas HCFA is making Herculean efforts to prepare for Medicare+Choice, the information infrastructure and resources available for this daunting task appear inadequate, particularly in terms of the capacity to answer both the volume and content of the inquiries that will surely result from HCFA's mailing and from the marketing materials sent out by the health plans themselves. A major upsurge in the number of constituent calls to members of Congress should be anticipated as one consequence of the sweeping nature of implementing Medicare+Choice as it is now scheduled.

  At its March workshop, the committee invited a representative of General Electric to discuss that company's Answer Center as a model for handling large volumes of toll-free telephone calls. The GE representative noted that out of a 6-million-person customer base, the Answer Center receives 8 million calls annually. He also informed the committee that GE places a high value on recruiting and training its Answer Center employees and prefers to employ college graduates rather than less well-educated clerks. The committee also received testimony from the California Public Employees' Retirement System (CalPERS), which reported that during its annual 1-month open-enrollment period, about 15 percent of its over 1 million members call its customer service center (Stanley, 1997). The timing of HCFA's fall mass mailing, as outlined in the BBA, will roughly coincide with the congressional elections. Presenters and congressional health staff members at the workshop both indicated that any likely surge in telephone calls would thus take place during a time when many members of Congress are in their home districts campaigning for reelection.
- If the current timetable and choice process hold, many elderly people are likely to make ill-considered choices that will ultimately undermine Congress' efforts to restructure Medicare.

  Congress is moving the major federal entitlement programs that deal with health (Medicare and Medicaid) into managed care with the purported goal of saving money. This committee has previously found that "[b]eneficiaries who make misinformed choices can be hurt financially or clinically, or both" (Institute of Medicine, 1996, p. 85). Speakers at the workshop cautioned that any political rhetoric emanating from the beneficiaries' confusion may complicate Congress' long-term efforts in the managed care arena.
- Medicare+Choice is quite different from the Federal Employee Health Benefits Program (FEHBP), a program that many people are holding up as a model. The Medicare market consists of 39 million people, more than 3 times the size of FEHBP's membership. Further,

FEHBP has involved the option to chose among plans for 35 years. Federal workers are very familiar with the options open to them, and many of them have a detailed understanding of how the various plans work. The opposite is true for Medicare beneficiaries. Furthermore, most federal workers have ready access to professional counselors in their benefits offices or to peers who can readily assist them with their questions

There are other clear distinctions between FEHBP and the Medicare program as well. Federal retirees have about 25–30 years' experience with an open-season enrollment environment. Even though the retirees may not have changed their health plan often over the past 25 or 30 years, they have had the opportunity to do so, and they have had direct interactions with health plans during this period. In addition, because they have been in this system for a number of years, the retirees already possess a great deal of knowledge about deductibles, copies, and so on. This level of familiarity and experience among beneficiaries indicates that HCFA's task will be much more complex than FEHBP's. Jim Morrison, past director of FEHBP, indicated at the March workshop that federal employees in FEHBP trust that the Office of Personnel Management has adequately screened the health plans, thus limiting the likelihood of their making a poor health plan choice. Medicare+Choice introduces several new types of plans, such as preferred provider organizations (PPOs) and provider-sponsored organizations (PSOs), that do not have a performance history that HCFA or beneficiaries can evaluate.

In light of the preceding findings and concerns, and keeping in mind this committee's prior work in the areas of beneficiary information and the development of a sound information infrastructure, the committee makes the following recommendations:

- **HCFA should stagger its mailings over a period of several months, both to reduce and spread out the certain upsurge in the volume of inquiries and to allow some level of market-testing of the material.**

  HCFA should urgently request more time from Congress for additional educational efforts among beneficiaries and infrastructure development at the front end of the process.
- **HCFA should delay the initial mailing until market-testing demonstrates that the differences among the various health plan choices and benefit packages will be presented in a standardized, easily understandable way.**
- **HCFA should focus on conveying a few key messages and the answers to a few select questions on topics about which the elderly most need assurance. For example: (1) Will I be able to continue seeing my current physician? (2) Will I be able to see a specialist if I think I need one? (3) Will the plan save me money, and if so, how? (4) How will my pharmacy costs be covered? (5) Can I leave the plan if I am unhappy? and (6) If I have a complaint, how will it be addressed?**

- **All the major groups that the elderly reach out to for help (e.g., HCFA, Congress, and local Health Insurance Counseling and Assistance Programs [HICAPs] among others) need to be enlisted in the effort and well prepared to respond to both the volume and content of the inquiries that will certainly result.**
- **Given that the vast majority of people eligible for Medicare have not had to change plans, and bearing in mind the anger and opposition that resulted from an earlier attempt to substantially change the program (i.e., the 1988 Medicare Catastrophic Coverage Act), beneficiaries should be reassured that: (1) They are not in any danger of losing traditional Medicare coverage if they prefer to keep it, and (2) they can delay making any choice at all indefinitely, in which case they would continue to be covered by traditional Medicare.**

We appreciate your consideration of our views. We will make this letter public on June 22, 1998. If you have any questions about the issues raised in this letter, please contact Marion Ein Lewin, Study Director.

Sincerely,

Harry P. Cain II, Ph.D., *Co-chair* Stanley B. Jones, *Co-chair* Helen B. Darling, M.A. Allen Feezor, M.A. James P. Firman, M.B.A., Ed.D. Sandra Harmon-Weiss, M.D. Risa J. Lavizzo-Mourey, M.D., M.B.A. Mark V. Pauly, Ph.D. Shoshanna Sofaer, Dr.P.H.

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The Honorable Tom Bliley
The Honorable Barbara Boxer
The Honorable John B. Breaux
The Honorable Tom Campbell
The Honorable John H. Chafee
The Honorable Dan Coats
The Honorable Susan Collins
The Honorable Kent Conrad
The Honorable Alfonse M. D'Amato
The Honorable Thomas Daschle

The Honorable John D. Dingell
The Honorable Christopher J. Dodd
The Honorable Richard Durbin
The Honorable Mike Enzi
The Honorable William H. Frist
The Honorable Greg Ganske
The Honorable Richard Gephardt
The Honorable Newt Gingrich
The Honorable Bob Graham
The Honorable Phil Gramm
The Honorable Charles Grassley
The Honorable Judd Gregg
The Honorable Tom Harkin
The Honorable Orri G. Hatch
The Honorable Tim Hutchinson
The Honorable Ernest J. Istook, Jr.
The Honorable James M. Jeffords
The Honorable John R. Kasich
The Honorable Edward M. Kennedy
The Honorable J. Robert Kerrey
The Honorable Jon Kyl
The Honorable Joseph Lieberman
The Honorable Trent Lott
The Honorable Connie Mack
The Honorable John McCain
The Honorable Jim McDermott
The Honorable Daniel Patrick Moynihan
The Honorable Don Nickles
The Honorable Nancy Pelosi
The Honorable John Edward Porter
The Honorable Jack Reed
The Honorable John D. Rockefeller, IV
The Honorable William V. Roth, Jr.
The Honorable Olympia J. Snowe
The Honorable Arlen Specter
The Honorable Fortney Pete Stark
The Honorable William M. Thomas
The Honorable Henry A. Waxman
The Honorable Paul D. Wellstone
The Honorable Ron Wyden

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A

Workshop Agenda

CHOICE AND MANAGED CARE:
Developing the Information Infrastructure for Medicare Beneficiaries
Workshop
March 4–5, 1998
March 4

8:30 a.m. ***Welcome and Introductions***

Harry P. Cain II, Ph.D. (Co-Chair)
Executive Vice President, Business Alliances
Blue Cross and Blue Shield Association
Chicago, Illinois

Stanley B. Jones (Co-Chair)
Director
Health Insurance Reform Project
George Washington University
Washington, D.C.

8:45 a.m. ***Setting the Stage: Critical Issues and Questions***

Lynn Etheredge, Ph.D.
Consultant (commissioned paper author)
Chevy Chase, Maryland

9:10 a.m. ***A Status Report from HCFA***

Michael McMullan
Director, Center for Beneficiary Services
Health Care Financing Administration
Baltimore, Maryland

Additional Perspective: *W. Doug Davidson*
Director of Communications
Foundation for Accountability
Portland, Oregon

9:45 a.m. ***Panel: Issues in Marketing to Medicare Beneficiaries***

Who is likely to "change" and take advantage of the new options? How will the private sector market to these groups? How should you market to subgroups of the elderly? What are or will be the likely segmentation strategies? What influences "choice" from a marketing perspective?

Moderator: *Harry P. Cain II, Ph.D.*
Executive Vice President, Business Alliances
Blue Cross and Blue Shield Association
Chicago, Illinois

Frederick S. Adler
President and CEO
The Senior Network, Inc.
Stamford, Connecticut

Tom L. Anderson
Vice President, Medicare
United HealthCare
Edina, Minnesota

Bruce Clark, Dr.P.H.
Senior Vice President/Co-founder
Age Wave Health Services
Emeryville, California

Martin Rosen
Senior Vice President
NYLCare
New York, New York

Jack Tighe
Senior Vice President for Government Programs
Independence Blue Cross
Philadelphia, Pennsylvania

11:15 a.m. ***Panel: Roles of the Public and Private Sectors,Information Brokers, and Potential Liability***

This session will discuss the potential roles and responsibilities of information brokers, community-based organizations, physicians/health care providers, etc. This panel also will discuss the issues of potential liability related to different sources of advice and what happens when beneficiaries choose poorly.

Moderator: *Shoshanna Sofaer, Dr.P.H.*

Schering Plough Professor of Health Policy

Baruch College

New York, New York

Aileen Harper

Director, Direct Service Programs

Center for Health Care Rights

Los Angeles, California

Judith Hibbard, Dr.P.H.

Professor of Health Policy

Department of Planning, Public Policy & Management

University of Oregon

Eugene, Oregon

Gail Povar, M.D.

Private Practice Physician

Cameron Medical Group, LLP

Silver Spring, Maryland

Robyn Stone, Dr.P.H

Executive Director

International Longevity Center

New York Academy of Medicine

New York, New York

12:45 p.m. ***Lunch: Highlights of a Recent Report from the California Managed Health Care Improvement Task Force***

Sara Singer

Director, Health Care Management

Graduate School of Business

Stanford University

Palo Alto, California

2:15 p.m. ***Panel: Best Practices and Potential Models for an Open Season Health Plan Enrollment Process***

This session will showcase representatives from model programs in the public and private sectors that may offer lessons (as well as cautions) on how to develop an effective health benefit information infrastructure targeted to a large and diverse population group.

Moderator: *Allen Feezor, M.A.*

Vice President for Insurance and Managed Care

East Carolina University Medical Center

Pitt County Memorial Hospital

Greenville, North Carolina

David G. De Vries

Executive Administrator

State of North Carolina Teachers' and State

Employees' Comprehensive Major Medical Plan

Raleigh, North Carolina

James W. Morrison, Jr., M.P.A.

President

Morrison Associates

Washington, DC

Guy Peterson

Leader, Corporate Benefits Delivery

General Electric

Schenectady, New York

3:45 p.m. ***Adjourn for the Day***

March 5

8:30 a.m. ***Panel: Special Needs Populations: Helping Those Most in Need of Help***

This session will explore how any information infrastructure put in place may have to be adapted to meet the needs of those with chronic conditions, physical or mental impairments, or low literacy levels.

Moderators: *Sandra Harmon-Weiss, M.D.*
Vice President and Head of Government Programs
Aetna US Healthcare
Blue Bell, Pennsylvania

Risa Lavizzo-Mourey, M.D.
Director, Institute on Aging
Chief, Division of Geriatric Medicine
Associate Executive Vice President for Health Policy
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Katie Maslow
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10:00 a.m. **Getting from Here to There: Implementation and Unresolved Issues**

This panel will discuss the issues of scale and administrative feasibility, the role of government and

regulation, and the role of federal versus state government. Panelists will also address from their professional experience how the information infrastructure should be organized and financed, and how the information infrastructure should be assessed in terms of its success and shortcomings. The panel also will take up issues left unresolved in earlier sessions.

Moderator: *Leonard D. Schaeffer, A.B.*
Chairman and CEO
Wellpoint Health Networks
Woodland Hills, California

Carol Cronin
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Health Pages
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Helen B. Darling
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Lynn Etheredge, Ph.D.
Consultant
Chevy Chase, Maryland

Vicky B. Gregg
Senior Vice President
Blue Cross and Blue Shield of Tennessee
Chattanooga, Tennessee

12:00 noon **Summary and Concluding Remarks**

Harry P. Cain II, Ph.D.
Executive Vice President, Business Alliances
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Chicago, Illinois

Stanley B. Jones
Director
Health Insurance Reform Project
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12:30 p.m.	**Adjourn**

B

Workshop Participants

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