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Employer Contracting With HMOs For Medicare Retirees

by
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The Public Policy Institute, formed in 1985, is part of the Research Group of the AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to older Americans. This paper represents part of that effort.

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Foreword

Economic security, including access to affordable, comprehensive health insurance coverage during their retirement years, is of critical importance to Medicare beneficiaries. Despite the dwindling number of firms offering retiree coverage, employers remain an important source of health coverage for them.

While the Original Medicare Plan covers many of the health care needs of beneficiaries, gaps in the program and the cost of supplementing these gaps with additional insurance make Medicare HMOs an attractive option for more than 6 million Medicare beneficiaries. Most beneficiaries enroll in Medicare HMOs* as individual members (i.e., non-group); however a substantial number enroll in these plans through employer-sponsored plans.

Because Medicare HMOs are an important source of health insurance for so many beneficiaries, AARP wanted to have a better understanding of the extent and nature of HMO coverage that employers offer to their retired workers. However, current information on this topic is sparse. Therefore, we engaged Peter Fox, an expert in both managed care and retiree benefits, to conduct interviews with selected representatives of large corporations, health plans, health benefits consultants, and others with direct knowledge of these issues to explore the nature of the relationships between employers and Medicare HMOs.

Among the areas the author investigated are the circumstances under which employers decide to offer Medicare HMO coverage to their retirees; differences in the terms of the contracts that apply to active workers and retirees; and barriers that may impede these relationships, including federal regulatory relationships. It is interesting to note that the Health Care Financing Administration (HCFA) has also recognized the need to focus greater attention on this issue. In March 2000, this agency convened a meeting in Baltimore, Maryland, to explore ways to facilitate enrollment in M+C plans for beneficiaries covered by employer-sponsored retiree plans. HCFA is currently developing procedures that will streamline and simplify several of its requirements, including those concerning enrollment and disenrollment processes. Through a description of employer attitudes about these and other aspects of the “real world,” supplemented by illustrative vignettes, the author demonstrates how difficult it is to generalize about the relationships that currently exist between Medicare HMOs and employers. Nevertheless, general themes do emerge that may inform policymakers and others about the context in which enrollment in Medicare HMOs occurs when beneficiaries are covered by their former employers. To this end, AARP intends to stimulate debate and discussion with the objective of ensuring the most appropriate and accessible coverage for Medicare beneficiaries who are eligible for HMO coverage through employer-sponsored plans.

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* Medicare HMOs are “coordinated care plans” , an option authorized under the Medicare+Choice program (M+C), Part C (sections 1851-1859) of the Social Security Act.

EXECUTIVE SUMMARY

BACKGROUND

In May 2000, 6.2 million Medicare beneficiaries were enrolled in HMOs that are capitated by the Health Care Financing Administration (HCFA) under the Medicare+Choice program; another 600,000 were enrolled either in HMOs and similar organizations that were cost-reimbursed or in plans that were paid under HCFA's demonstration authority. Thus, HMOs with Medicare contracts represent an important source of supplementary coverage for retirees, as they do for other beneficiaries. Furthermore, because the cost of obtaining coverage from HMOs is generally below that associated with supplementing fee-for-service Medicare, opportunities for savings exist, whether for the retiree or the employer. Yet little has been written on how employers contract with HMOs for their Medicare retirees.

PURPOSE

The purpose of this paper is to describe a context in which employers and Taft-Hartley trust funds⁺, referred to collectively as "plan sponsors," make decisions on whether to contract with HMOs for Medicare retirees and to present the approaches that these plan sponsors have adopted and the issues they face.

METHODOLOGY

This paper principally reflects 26 interviews with purchasers, HMOs, and benefits consultants. It also includes data that are available from secondary sources. No primary data have been collected.

PRINCIPAL FINDINGS

Statistical Overview

Large employers are more likely to offer retiree health benefits than smaller ones, and firms that do offer retiree health benefits, are more likely to offer HMOs to their Medicare-age retirees than firms that do not offer retiree coverage. Various consulting firm surveys report that around 38 percent of large employers offer HMOs to their Medicare-age retirees. These firms also report that around 30 percent of these retirees who are offered the opportunity to enroll in an HMO accept it. Among Taft-Hartley trust funds, although only 29 percent offer HMOs to active workers, 41 percent offer an HMO option to retirees age 65 and over.

⁺ Taft-Hartley funds are entities organized to provide health and other benefits, such as pensions and life insurance, to unionized workers. They are governed by the Taft-Hartley Act of 1947 as well as by the Employee Retirement and Income Security Act (ERISA) of 1974. By law, the participating employers and the unions share equally in their governance. They are established under collective bargaining agreements and, in particular, serve as a vehicle to provide benefits to workers, such as those in the construction trade, who may change employers with some frequency.

Employer Efforts to Constrain Retiree Costs

Employer interest in constraining the cost of retiree coverage is driven both by the immediate cost of the benefit and by anticipated future costs. The issuance in the early 1990s by the Financial Accounting Standards Board (FASB) of Financial Accounting Statement No. 106, known as FAS 106, heightened the sensitivity to future costs by requiring that employers account for these costs on an accrual, rather than a pay-as-you go (i.e., cash), basis.

HMOs cover services that are additional to those that are part of the standard Medicare benefit package, and they usually do so at a premium that is below the cost of purchasing supplemental benefits in the fee-for-service system. As a result, they offer savings opportunities. Other options for constraining retiree health benefit costs, many of which have a greater balance sheet impact than HMOs, include:

- Shifting the manner in which retiree coverage integrates with Medicare. The major approaches are “coordination of benefits,” under which the employer’s plan in most cases covers all Medicare cost-sharing, and “carve-out,” under which the plan first calculates the normal plan benefit and then reduces this amount by the Medicare payment.
- Increasing the share of premiums paid by retirees.
- Establishing a cap on the employer’s contribution to premiums, which is in most instances not adjusted over time for inflation.

Reasons for Not Contracting with HMOs

Among firms that do not contract with HMOs for Medicare retirees, reasons for not doing so include the following:

- The desire for retiree health benefits and premium contributions to be uniform nationally, something that multistate employers have difficulty achieving.
- Difficulty in creating inducements to join an HMO, if the indemnity plan has rich benefits and little or no premium contribution is required of the retiree.
- The desire to avoid the administrative costs and hassles of dealing with multiple plans, given that no HMO has a national Medicare+Choice presence.
- In areas where Medicare+Choice growth has been recent (e.g., the East Coast), the desire to avoid the effort that would be necessary to educate retirees on the benefits and limitations of HMOs.

- The concern with biased selection, i.e., that HMOs would attract disproportionately healthy enrollees, leaving the sicker enrollees in the “base” or standard plan.

Additional concerns that have arisen in recent years include the following:

- Reluctance to promote HMOs to retirees in the face of the HMO backlash.
- The market instabilities resulting from the payment constraints enacted as part of the Balanced Budget Act of 1997 (BBA), which caused HMOs to, variously, leave markets, raise premiums, and reduce benefits.
- The increase in prices and decrease in benefits in many markets, especially those where no premium was charged, which together have reduced HMO attractiveness to both employers and prospective enrollees.

V. Nature of Relationship Between Employment-based Plan and HMOs

The initial criterion of most plan sponsors in choosing the HMOs with which to contract for their Medicare retirees is whether the HMOs are already offered to active workers. The decision can be made based on little or considerable information beyond that collected in administering health benefits for active workers. Some plan sponsors simply seek to offer the health plans that are available to active workers. Others independently gather extensive information on, for example, the plans’ care management programs for seniors; enrollee satisfaction levels; financial stability; accreditation status; an analysis of service availability; and various quantitative performance measures.

Premium contribution formulas vary widely. The following are the most common approaches: (1) the plan sponsor contributes the same amount of money that it spends on the base plan, and (2) the plan sponsor pays the same percentage of premiums for the HMO that is paid on behalf of enrollees in the base plan.

Finally, the benefits may be richer in the HMO, e.g., lower prescription drug copays or better coverage of preventive services.

Communicating With Retirees

Communicating with Medicare retirees can be challenging, in part because they have two sources of coverage: Medicare and the private plan sponsor. Plan sponsors communicate mostly by distributing printed materials, although they may also hold meetings for retirees. Individual questions outside of meetings are usually answered by telephone. Some companies make little or no effort to communicate information about HMO options to retirees over a certain age, e.g., 70,

reflecting their experience that individuals over that age are unlikely to join if they had no prior HMO enrollment experience.

Federal Regulatory Issues

The plan sponsors interviewed were all self-insured, and federal law largely exempts them from state regulation. As a result, federal regulatory issues were only moderately important.

Many interviewees felt that HCFA had paid insufficient attention to, and had limited understanding of, the issues surrounding employer contracting with Medicare+Choice plans. HCFA views the Medicare+Choice program as one that contracts with individual enrollees and holds that the presence of an employer does not relieve HCFA of the obligation to protect beneficiaries. The crux of the issue is how to discharge that obligation.

Plan sponsor complaints included the following:

- Confusion created by HCFA's consumer education campaign, which is perceived as not adequately distinguishing between employment-based coverage and non-group coverage, i.e., coverage that is marketed to individual enrollees.
- The mechanics of the enrollment process, which are viewed as cumbersome, including being heavily paper- rather than computer-based.
- The mismatch between the timing of Medicare's open enrollment season, as mandated in the BBA, and the open seasons of plan sponsors. Interviewees were divided regarding the significance of this issue.
- The requirement that plans include in employer-sponsored benefit packages all benefits that are in the least comprehensive benefit package offered in the individual market.

Plan Sponsor Issues with HMOs

Plan sponsors were generally pleased with the HMOs with which they contracted and, also, reported high levels of satisfaction among retirees. The most common complaint mentioned by plan sponsors was about HMOs that reduced their service areas without informing plan sponsors until late, often after the plan sponsor's open season had been concluded. Additionally, it was reported that the HMOs also changed benefit and premium levels without adequate warning to plan sponsors. The result was that the plan sponsors had to reissue materials to retirees, who were at times confused by such changes.

Other complaints were rare. One was that the HMOs were at times overly restrictive in interpreting the level of care requirements that had to be met to receive nursing facility or home health care. Finally, other enrollment problems were cited that were within the control of the HMO and not created by HCFA regulations

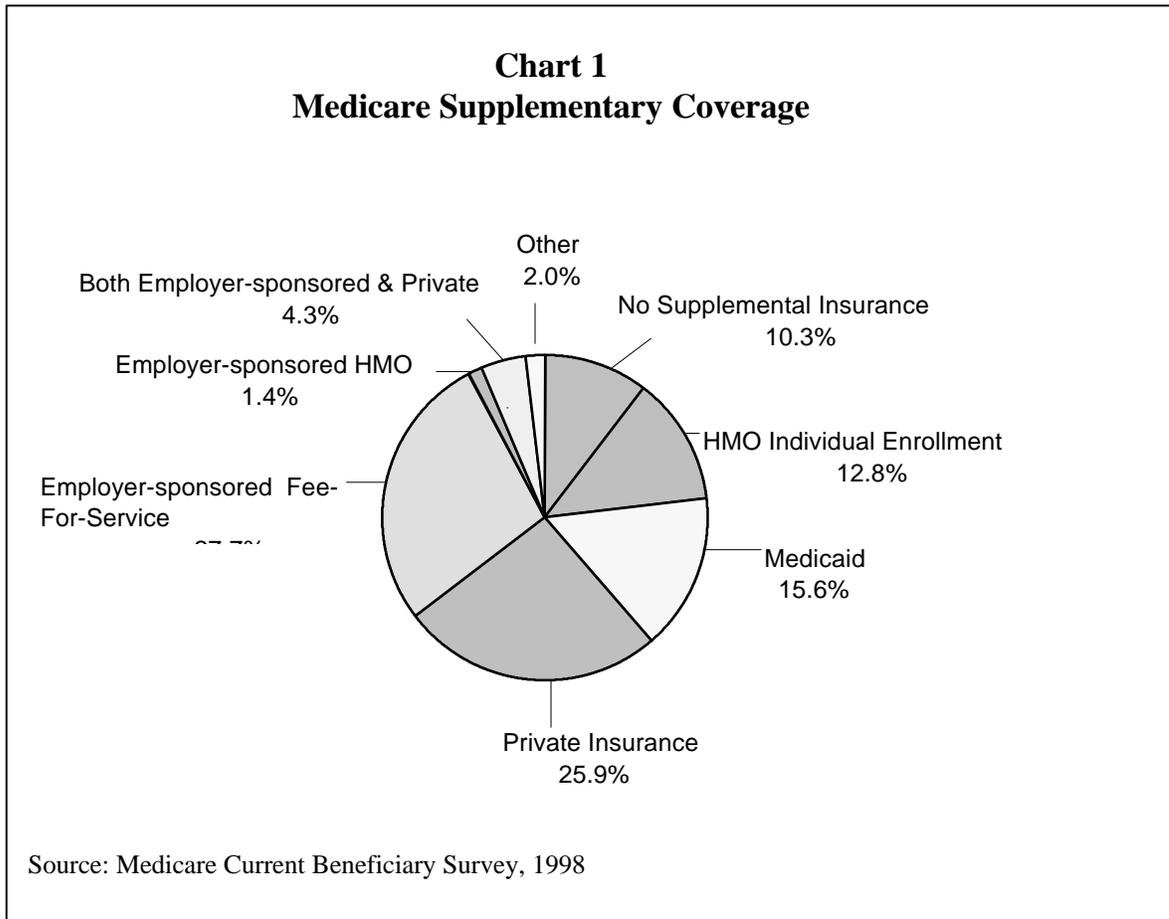
CONCLUSION

A significant reason for employers' and Taft-Hartley trust funds' contracting with HMOs for Medicare retirees was to reduce financial obligations, particularly in light of the requirement of the Financial Accounting Standards Board that anticipated future expenses be recorded as liabilities on corporate balance sheets. However, benefiting the retiree was also important, in part to keep active workers, anticipating retirement, happy in a tight labor market.

HCFA and plan sponsors, particularly employers, have differing perspectives on the nature of the government actions and regulations that are desirable to protect HMO enrollees. Even more, employers felt that HCFA had over the last few years paid insufficient attention to the needs of employer-sponsored plans. Finally, HCFA may be able to enhance its efforts to promote awareness of the opportunities among, particularly, small and mid-size employers as well as Taft-Hartley trust funds who may not understand the benefits of HMO contracts for their retirees.

I. INTRODUCTION

Some 90 percent of Medicare beneficiaries also have coverage that supplements Medicare, mostly from one of three sources: Medicaid, individually purchased Medicare supplemental (“Medigap”) policies, and employer-sponsored retiree health benefits. The largest single category is employer-sponsored retiree medical coverage, which accounted for an estimated 33.4 percent of all Medicare beneficiaries in 1998 (see chart 1)¹



In May 2000, 6.2 million Medicare beneficiaries were enrolled in HMOs that are capitated by the Health Care Financing Administration (HCFA) under the Medicare+Choice program; another 600,000 were enrolled either in HMOs and similar organizations that were cost-reimbursed or in plans that were paid under HCFA’s demonstration authority. Thus, HMOs with Medicare contracts represent an important source of supplementary coverage for retirees, as they do for other beneficiaries. Furthermore, because the cost of obtaining coverage from HMOs is generally below that associated with supplementing fee-for-service Medicare, significant opportunities for savings exist, whether for the retiree or the employer. Yet little has been written

¹ Unpublished data from the 1998 Medicare Current Beneficiary Survey, provided the author by HCFA staff.

on how employers contract with HMOs for their Medicare retirees.

This paper presents a qualitative picture of how employer-based plans relate to HMOs for their Medicare retirees. The term, “employer-based” encompasses both employers and Taft-Hartley trust funds. The latter are entities organized to provide health and other benefits, such as pensions and life insurance, to unionized workers. They are governed by the Taft-Hartley Act of 1947 as well as by the Employee Retirement and Income Security Act (ERISA) of 1974. By law, the participating employers and the unions share equally in their governance. They are established under collective bargaining agreements and, in particular, serve as a vehicle to provide benefits to workers, such as those in the construction trade, who may change employers with some frequency. Employers and Taft-Hartley trust funds are referred to, collectively, in this paper as “plan sponsors.”

This paper principally reflects interviews conducted in early 2000 with purchasers, HMOs, and benefits consultants. It also includes data that are available from secondary sources. However, no primary data have been collected.

Section II provides a statistical overview of retiree health benefits from various surveys. The next section discusses various approaches open to employers to constrain retiree costs. Then, in Section IV, some of the reasons why plan sponsors may elect not to contract with HMOs for Medicare retirees are presented; section V discusses the relationship between employment-based plans and HMOs on contracting decisions, premiums, and benefits. How plan sponsors communicate with retirees is briefly discussed in Section VI, followed by sections that address federal regulatory and plan sponsor issues with HMOs.

II. STATISTICAL OVERVIEW

Sources of data on retiree health benefits include: (1) the Medicare Current Beneficiary Survey (MCBS), a continuous, multipurpose survey conducted by HCFA that entails interviews with a random sample of beneficiaries; (2) surveys performed by benefits consulting firms; and (3) the employer benefits survey conducted by the Kaiser Family Foundation (KFF) and the Health Research and Education Trust (HRET). Each has its limitations:

- The MCBS has data on beneficiaries but not employers. Furthermore, some respondents may not know the type of coverage they have, e.g., whether their coverage is employer-sponsored or whether they have purchased it themselves. Confusion can arise, for example, if the employer contributes towards the cost of an individually purchased Medigap or HMO policy or, alternatively, if the retiree obtains coverage through the employer but pays 100 percent of the cost.
- The reports of the consulting firm surveys are generally unclear regarding the sampling frame. In most instances, the sample is comprised principally of the clients of the individual firms and thus is not randomly selected. One bias is that

these clients are mostly large employers, and small and medium-sized employers are largely excluded, as are Taft-Harley trust funds. Also, response rates are generally not published. Finally, the sample of employers is not necessarily the same from year-to-year, although the survey results may be broadly indicative of trends.

- The KFF/HRET survey entails a random selection of employers.² However, many retiree-related questions in the most recent survey refer only to changes since 1997, rather than inquiring about the situation at the time the survey was conducted.

Notwithstanding these limitations, the surveys do offer an overall picture of trends for retiree health benefits.

Large employers are more likely to offer retiree health benefits than smaller ones, as shown below:³

Figure 1
Percentage of Employers Offering Retiree Health Benefits by Size of Firm (1999)

3–199 workers	8 %
200–999 workers	41 %
1,000–4,999 workers	33 %
5,000+ workers	70 %

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999

According to the Hewitt Associates survey, in 1996, 38 percent of large employers offered Medicare+Choice HMOs, an increase from 7 percent in 1993.⁴ This figure is consistent with that of Mercer/Foster Higgins, which reports that, in 1999, 39 percent of plan sponsors offered an

²Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 1999 Annual Survey*, (Kaiser Family Foundation, Menlo Park, CA, Health Research and Educational Trust, Chicago, IL, 1999) p 6.

³The author cannot explain why the percentage of employers offering retiree health benefits is lower for firms with 1,000–4,999 workers than for those with 200–999 workers, a finding that is contrary to the experience of the benefit consultants interviewed.

⁴Hewitt Associates LLC, *Retiree Health Trends and Implications for Possible Medicare Reforms* (Kaiser Family Fund, Menlo Park, CA, Sept. 1997), p. 2. “Large employers” is defined as “those with usually at least 1,000 employees (sic),” reflecting the database that Hewitt Associates has available.

HMO option to Medicare retirees.⁵ Hewitt also estimates that among those employers that do offer HMOs to Medicare-age retirees, 31 percent of retirees elect to enroll, a figure that is consistent with the Mercer/Foster Higgins estimate that 12 percent of all Medicare beneficiaries with retiree coverage enroll in HMOs. However, these penetration figures are considerably above the estimate from the MCBS for 1998, which reports that only 4.1 percent of all beneficiaries with retiree medical coverage are in Medicare risk HMOs. The differences between the MCBS and those of Hewitt and Mercer/Foster Higgins likely reflect the samples of these firms being heavily weighted toward the large employers that are their clients. The MCBS also reports a much higher HMO enrollment rate – 28.1 percent – among beneficiaries who are neither on Medicaid nor covered under employer-sponsored retiree health benefits.

HMO contracting is more prevalent among large employers than small or medium-sized firms. The KFF/HRET survey asks firms offering retiree health benefits whether they have introduced Medicare risk HMOs in the prior two years.⁶ What is not clear is whether respondents in fact answered the question as posed. Specifically, for a firm that introduced HMOs more than two years before the survey was undertaken, the correct answer to the question should have been “no.” In any event, 70 percent of employers with more than 5,000 workers answered in the affirmative, compared to only 11 percent for firms with 1,000–4,999 workers and 3 percent for those with 200–999 workers.

A 1998 survey conducted by the International Foundation of Employee Benefit Plans found that, among Taft-Hartley trust funds, only 29 percent offer HMOs to active workers, while 41 percent offer an HMO option to retirees over age 65. In western states (AL, CA, HI, OR, WA), 73 percent of Taft-Hartley trust funds offer HMOs to retirees over age 65, compared to 41 percent for active workers.⁷

III. EMPLOYER EFFORTS TO CONSTRAIN RETIREE HEALTH COST

Employer interest in constraining the cost of retiree health coverage is driven both by the immediate cost of the benefit and by anticipated future costs. The issuance in the early 1990s by the Financial Accounting Standards Board (FASB) of Financial Accounting Statement No. 106, known as FAS 106, heightened sensitivity to future costs by requiring that employers account for these costs on an accrual, rather than a pay-as-you go (i.e., cash), basis. Companies that did not alter their benefits would have seen the liabilities that they were required to report increase by

⁵Mercer/Foster Higgins, *National Survey of Employer-Sponsored Health Plans: 1999*, p. 45.

⁶Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 1999 Annual Survey*, p. 125.

⁷International Foundation of Employee Benefit Plans, *Managing Multi-Employer Health Fund Benefits: Survey Results*, (Brookfield, WI, Sept. 1998). The finding that many Taft-Hartley trust funds offer HMO coverage only to Medicare retirees is the reverse of the situation with employers, some of whom offer HMOs to everyone except their Medicare retirees.

factors of six to eight or more, depending on the company's plan design and demographics.⁸

HMOs typically cover services that are additional to those that are part of the standard Medicare benefit package, and they usually do so at a premium that is below the cost of purchasing supplemental benefits in the fee-for-service system. As a result, HMOs offer plan sponsors opportunities to reduce expenditures for retiree health coverage. However, employers' decisions to offer HMOs generally occur in the context of other available measures to reduce retiree health benefits liabilities. The discussion below considers options for employers only and does not take into account Taft-Hartley funds.

Retiree health costs vary by company. Firms with older workforces, such as most manufacturing firms, often have a high ratio of retirees to active workers, in some cases exceeding one retiree (Medicare and non-Medicare) to each active worker; other companies, including most of the high tech companies formed in the last decade, have few retirees. Also, some employers are more concerned with the cost of their non-Medicare retirees, who, according to the 1999 Mercer/Foster Higgins survey, had benefit costs of \$5,470, compared to \$2,160 for those on Medicare, a ratio of two-and-a-half to one.⁹

In recent years employers have responded, in some cases in dramatic ways, to the pressures to reduce their retiree health expenditures. The most forceful is to terminate retiree health benefits altogether, at least for those who have not yet reached retirement age. Among large employers, the percent offering coverage to future Medicare-eligible retirees declined from 40 percent in 1993 to 28 percent in 1999.¹⁰ Other measures to reduce employers' expenditures for retiree coverage include the following:

- **Change the manner in which retiree health coverage integrates with Medicare.** By law, Medicare is the primary payer for retiree coverage, meaning that it pays first if an individual has dual coverage. "Integration" refers to the manner in which the employer's liability for Medicare-covered services is established. The two most common forms of integration are "coordination of benefits (COB)" and "carve-out." In the 1970s, the dominant form of integration was COB. In contrast, in 1996 only 3 percent of firms used COB, whereas 64 percent used the carve-out approach.¹¹

⁸Hewitt Associates LLC, p. 11.

⁹On the other hand, most retirees are on Medicare for a considerably longer period than they are pre-Medicare. Some companies cover retirees only up to the point at which they gain Medicare eligibility. The KFF/HRET survey reports that of firms with 200 or more workers that offer retiree health benefits, 95 percent do so for non-Medicare retirees, compared with only 80 percent for Medicare retirees.

¹⁰Mercer/Foster Higgins, p. 44. The courts have generally prevented companies from terminating benefits for individuals who have already retired.

¹¹Hewitt Associates LLC, pgs. 16-17.

Under COB, the plan pays what it would have paid had the retiree not had Medicare coverage, subject to the limitation that the retiree may not be reimbursed for more than 100 percent of the medical bill. In most cases, COB plans reimburse Medicare cost-sharing in full. In contrast, under the carve-out approach, the plan first calculates the normal benefit under the employer-sponsored plan and then reduces this amount by the Medicare payment.

To illustrate the differing impacts of these two approaches, assume that Medicare and the employer's plan both have 20 percent coinsurance for a particular service. Under COB, the employer plan would pay the 20 percent Medicare coinsurance. Under a carve-out, since Medicare pays the first 80 percent of expenses, the employer plan would not pay anything, and the retiree would be responsible for the 20 percent coinsurance. The effect of shifting from COB to a carve-out is to eliminate most of the employer liability for Medicare-covered services. However, the method of integration does not affect payment for services that Medicare does not cover, notably prescription drugs, which typically amounts to around half of total employer costs under COB. Other approaches exist as well, all of which are less generous than COB.

- **Increase the share of the premium paid by retirees.** Data collected by the benefits consulting firms of Foster Higgins and William M. Mercer (now merged companies) report that the average percent of premium paid by retirees aged 65 and older (for themselves and their dependents) rose from 38 percent in 1993 to 60 percent in 1998.¹²
- **Cap the employer's premium contribution.** Although the way in which the caps are structured varies, a typical approach is for the employer to limit its premium contribution to one-and-a-half to two times its dollar contribution at the time the cap is promulgated. Once the cap is reached due to rising health care costs, the retiree is responsible for the full amount of subsequent premium increases. Although the cap on the employer's contribution does not usually affect expenditures for several years after being announced, the estimated reduction in out-year payments has an immediate, and often large, effect on the amount that a firm must accrue on its balance sheet. Although caps may reduce or remove the ability of firms to achieve savings by contracting with HMOs, a powerful incentive to contract, as discussed below, is to reduce the financial impact of the caps on the retirees.
- **Contract with HMOs for retiree coverage.** Few employers have been willing to

¹²Employee Benefits Research Institute (EBRI), *EBRI Health Data Book*, 1st ed., p. 144, based on data from surveys conducted by William M. Mercer, Inc., and A. Foster Higgins and Co., Inc.

mandate enrollment in HMOs for Medicare retirees. Rather, the norm is to create incentives for beneficiaries to join. The potential savings, which are shared between employers and employees, amount to the difference between what the employer pays to supplement standard Medicare and what the HMO charges. This difference can be significant, although under some circumstances it is exceeded by the impact of any of the other measures described above. It is also a more conjectural approach to constraining expenditures, since HMO penetration is forecasted only with great uncertainty. Thus, the other measures have in many instances become top priority for employers wishing to limit the effect of FAS 106. However, short of terminating retiree health coverage altogether, which is generally done only for future retirees, the various approaches are not mutually exclusive. Furthermore, some employers that have capped their future contributions contract with HMOs as a vehicle to delay or otherwise soften the effect of the higher premium contributions that retirees would otherwise pay.

IV. REASONS FOR NOT CONTRACTING WITH HMOs

Lack of interest is particularly prevalent in areas, largely outside of western states, that have neither a long-standing history of HMO enrollment among the commercial population nor substantial Medicare+Choice presence.

Long-standing reasons for not contracting should be distinguished from more recent ones that result from the impact of the federal Balanced Budget Act (BBA) of 1997, which constrained Medicare reimbursement to health plans and imposed new administrative requirements on the plans. Long-standing reasons include the following:

- HMOs differ by market area in the richness of the benefits and the premiums they charge. The policy of some plan sponsors is to have uniform benefits and premiums nationally, which these disparities militate against.
- For some plan sponsors, the base plan is as comprehensive as that of the HMOs, which, combined with low premium contributions, can militate against creating inducements for retirees to join.
- Having to deal with multiple plans entails administrative costs and hassle. Some large employers are accustomed to contracting with multiple plans for their active workers. For example, they may have a base plan with a national company and also offer various HMOs with Medicare contracts in the areas in which they are available. Other employers contract with a single carrier that provides nationwide coverage, e.g., CIGNA, Aetna, United. Those that contract with a single carrier for their active workers are particularly likely to be reluctant to contract with additional health plans for retirees because of the administrative effort required.

Even those that contract with multiple health plans for active workers may be reluctant to do so for Medicare retirees because a separate set of negotiations is involved (e.g., broadening prescription drug benefits beyond what the HMO offers in the nongroup market).

- In geographic areas where Medicare+Choice growth has been recent, a major effort would be necessary to educate retirees on the benefits and limitations of HMOs, e.g., the lock-in. One large employer interviewed as part of this project conducted a pilot, which has been subsequently discontinued, that entailed encouraging Medicare retirees to enroll in an HMO with which the company contracted for its active workers; the administrative burden was judged to be high. For example, the benefits department had to answer retiree questions that the employer felt should have been addressed to the health plan.
- The employer may be concerned that disproportionately healthy retirees will enroll in the HMO, leaving the sicker ones in the self-funded base plan, thereby increasing employer costs. Some employers negotiate a payment structure that approximates experience rating, thereby removing the effect on premiums if a disproportionately healthy group were to enroll in the HMO option. However, doing so is feasible only in areas with sufficient numbers of retirees so that there is a reasonably stable experience base. Some employers find that their Medicare retirees, however many of them there might be nationally, are too dispersed to support experience rating by individual plans.

Additional concerns that have arisen in recent years include: (1) a reluctance to promote HMOs to retirees in the face of the “HMO backlash” and (2) the market instabilities, caused largely by the payment reductions enacted as part of the BBA, resulting in HMOs’, variously, leaving markets, raising premiums, and/or reducing benefits. Employer sensitivity to the unstable market environment may have been heightened by HMO industry efforts to bring attention to the problems created by the BBA and the regulations implementing it.

Overall, most employers with a history of contracting with HMOs for their retiree health benefits will continue to do so for the foreseeable future; those that might have considered doing so are holding off for now. Moreover, some retirees may be reluctant to join an HMO for the first time because of the lack of predictability regarding benefits, premiums, or even the availability of the health plan in future years.

V. NATURE OF RELATIONSHIP BETWEEN EMPLOYMENT-BASED PLAN AND HMOs

Most plan sponsors require that workers, upon retirement, decide whether to accept health benefits. The retiree can, at a later date, drop these benefits but is then precluded from re-

enrolling. Once a retiree has elected health benefits and enrolls in an HMO, he/she is in most instances allowed to switch to the base plan, either at-will or at the next open season.¹³

HMO offerings generally occur as part of a dual or multiple choice structure, with the retiree being able to join an HMO or stay in a base plan, which may be indemnity, point-of-service, or PPO. In rare instances, mostly among a few Taft-Hartley trust funds, there is no base plan as such, and benefits are available only through one or more Medicare+Choice plans. In these situations, special arrangements may be made for retirees who move out of service areas of the health plans, such as making indemnity coverage available.

Plan Contracting Decisions

The primary criterion of most plan sponsors in choosing the HMOs with which to contract for their Medicare retirees is whether the HMOs are already offered to active workers and non-Medicare retirees. Some plan sponsors will not consider contracting with HMOs that are not available to active workers, whereas others are willing to offer other options. One large employer that contracts with 50 HMOs for its nonunionized workers nationwide (15 for members of its largest union, which wanted to limit choice) does so largely independently of its choices for active workers; however, this employer is an exception.

The decision regarding the health plans with which to contract for Medicare retirees can reflect little or considerable information beyond that collected in administering health benefits for active workers. Some plan sponsors simply seek to offer the health plans that are available to active workers. Others independently gather extensive information, such as: whether the HMO has care management programs designed to serve older persons, Health Plan Employer Data Information Set (HEDIS) scores that are relevant to the Medicare population, financial stability, accreditation status, and an analysis of service availability. Plan sponsors may also perform satisfaction surveys of retirees who enroll in HMOs for use in contract renewal decisions.

One employer varies its premium contribution based on the performance of the health plans, with the contribution being higher to plans that are judged to be of particularly high quality, measured, for example, by HEDIS scores and enrollee satisfaction surveys. Also, a California business coalition whose members include some 40,000 Medicare retirees, 10,000 of whom are in HMOs, has agreements under which the health plans set aside a small percent of their administrative fees, which they are allowed to retain only if certain objectives are met (e.g., predetermined rates on HEDIS measures, telephone abandonment rates, and turnaround time for enrollment card renewals).

The following are two examples of employers that have adopted extensive review processes:

¹³Employers typically hold an annual “open season” of four-to-six weeks, during which period, enrollees are allowed to switch among plans. Such switching is generally not allowed outside of open seasons.

Employer A issues a Request for Proposal (RFP) specifically for Medicare retirees and assesses such factors as: care management programs available for older persons, customer service, and complaints filed with state insurance offices. The selection process includes a site visit to the plan and reference checks with other employers.

Employer B makes a fixed contribution to a base plan of \$72 per capita. In most cases, this amount approximates or exceeds the premium levels of the HMOs with which it contracts. The motivation for HMO contracting is, principally, to expand choice and achieve savings for the retiree rather than to reduce company costs, although savings result in areas where the HMO premium is below the company's contribution. The HMOs offered to Medicare-eligible retirees are in most cases the same as for active workers. However, the company does offer some additional HMOs in areas with significant numbers of retirees. The company issues an RFP each year and asks that the health plan approximate the company's preferred benefit package; however, variations are accepted. In areas of high enrollment concentrations, the company, with the help of consultants, meets with the HMOs prior to making a selection. Selection and retention of HMOs, for both actives and retirees, is based heavily on HEDIS scores and enrollee satisfaction levels. The company has had occasion to drop HMOs with which it had previously contracted.

Although not common, some plan sponsors encourage retirees to consider joining HMOs with which they do not contract. This can be accomplished in several ways:

- The plan sponsor contracts with one or more HMOs but allows the enrollee to join other, i.e., non-contracted, HMOs.
- The plan sponsor does not contract with any HMOs but allows the retiree to join a Medicare+Choice contractor of his or her choosing. Under this and the approach described above, enrollees typically receive a premium contribution up to the per capita cost of the employer's base plan and are guaranteed the right to revert to the base plan should they elect to drop HMO coverage.
- The plan sponsor may not make arrangements for any retiree health benefits but, instead, makes a contribution that can be applied to either an individual Medicare supplement ("Medigap") policy of his or her choosing or an HMO.

Premium Contributions and Benefit Packages

The level of the premium contributions required along with the benefits offered relative to those in the base plan are central to the retiree's decision to join an HMO. Premium contribution formulas vary widely. One commonly used approach is to make available to the retiree who joins an HMO the estimated amount that would have been spent had he or she remained in the base

plan. If the HMO premium exceeds the employer's contribution to the base plan, the retiree pays the difference; if it is lower, the employer usually keeps the savings.

Another common approach is for the plan sponsor to pay HMOs a percent of the premium. For example, if the plan sponsor contributes 50 percent to the base plan, the same percentage would be contributed to HMOs, regardless of their premiums. Paying an HMO a percent of its premium rather than a set amount that is tied to the cost of the base plan mutes the incentive for retirees to join.¹⁴

In the base plan, most plan sponsors do not have annual or other limits on benefit payments for prescription drugs, although some are doing so in response to rising drug costs. They generally contract with HMOs for drug benefits that roughly match those in their base plan, although HMO benefits may have lower copays. Plan sponsors may also contract for office visit cost-sharing that is lower (e.g., copays of \$5 rather than \$10) than what the base plan or the HMO markets to individuals. Also, selected preventive services and limited eye and hearing care may be covered only in the HMO.

Most employers that contract with multiple HMOs strive for near-commonality among the benefit packages for the health plans with which they contract but accept some variations. In contrast, the Pacific Business Group on Health standardized the benefit package for its members, primarily to make it easier for retirees to compare benefit packages.

Illustrations of Premiums and Benefit Structures

This section presents examples of the premium and benefit structures that plan sponsors have adopted.

***Employer A** has broad benefits in its base plan, and retirees pay a minimal share of premiums. However, benefits in the HMO are more comprehensive. Specifically, HMO enrollees face copays of \$3 to 5 per prescription compared to \$8 to 20 in the base plan. Also, for some of the unionized employees, office visits are covered with no copay in the HMOs, whereas there is no coverage of office visits in the base plan. Some 19 percent of all Medicare retirees have joined HMOs as a result of the improved benefits. This figure would be higher if it included only individuals who lived within a service area of contracted HMOs, a statistic that the company does not calculate.*

***Employer B** has almost 40,000 Medicare retirees and contracts with 30 to 40 HMOs*

¹⁴As illustration of the impact on the decision to join an HMO, assume a base plan costing \$2,000 a year of which the employer pays \$1,000, leaving the retiree responsible for the balance. Assume, further, that an HMO is also offered having an annual premium of \$1,600 per retiree. If the employer paid a fixed amount that reflected the contribution to the base plan, the retiree would face an annual premium contribution of \$600. On the other hand, if the employer contribution was set at 50 percent of whatever plan was elected, the employer and the retiree would each pay \$800 a year, creating a weaker incentive to enroll in the HMO.

nationwide. Its maximum premium contribution to the HMO is set at the contribution level for the base plan. The base plan is a “carve-out” plan, i.e., it pays only up to the maximum of the company plan, which has a \$350 annual deductible and 20 percent coinsurance on most services.¹⁵ The drug benefit has a separate \$25 annual deductible plus 20 percent coinsurance for drugs purchased from retail drug stores; for mail order drugs, the deductible is waived, and the copay is \$6. In contrast, the HMOs have only small copays on physician visits and drugs.¹⁶ In many cases, the employer contribution to the base plan exceeds the HMO premium, in which case, the retiree is able to obtain coverage at no cost, and the company retains any balance. Also, for a period of time after it first contracted with Medicare+Choice plans, the company offered each retiree a cash payment of \$550 for joining and remaining in the plan for a year. HMO penetration, company-wide, is around 20 percent.¹⁷ The company saves about \$10,000 in FAS 106 liability for each retiree who joins an HMO.

Employer C insures 50,000 retirees and dependents nationwide. In areas where it has contracts with a single HMO, the enrollee pays a percent of the premium (10 percent for the retiree and 20 percent for the spouse) to either the HMO or the base plan, resulting in only a mild incentive to join an HMO. However, in areas where it offers retirees two or more HMOs, the contribution reflects HMO premiums, with retirees paying the difference if they elect the base plan. The company attempts to conform the benefit packages for the HMOs with which it deals but does not insist on complete uniformity. Since HMO premiums average about \$800 a person annually, compared to \$1,500 for the base plan, there is a strong incentive to join an HMO, and in the affected areas, almost 60 percent of eligible retirees have done so. Also, the company classifies geographic areas into three categories, based on average premium levels. Within a category, it pays the full premium if the HMO is close to the average; if not, the enrollee pays the difference.

Employer D in its base plan imposes a retiree contribution to premiums that is as low as 10 percent of premiums, a percentage that is attained after 20 years or more of service. Retirees who join HMOs have their required dollar contribution frozen at the time of enrollment, i.e., the contribution stays flat as premiums increase over time. In addition, the drug benefits are better in the HMO; retirees enrolled in the base plan pay 40 percent coinsurance for brand-name drugs (zero for generics), whereas in the HMO, the copays are: \$5 per prescription for generic drugs and, depending on the HMO, either \$10 or \$15 for brand name drugs. The company has also negotiated with unions in its headquarters area the right to terminate the base plan once 50 percent of retirees elect the HMO; however, it does not expect this threshold to be reached in the foreseeable future,

¹⁵Cost-sharing is subject to a catastrophic limit of \$2,500 a year, above which the plan pays in full.

¹⁶The copay for prescription drugs is \$1.

¹⁷The company does not calculate the penetration rate among only retirees who live within the service area of the HMOs that are offered.

particularly as HMO enrollment has declined in recent years because of benefit reductions and premium increases as a consequence of the reimbursement changes in the BBA.

Employer E has 71,000 Medicare-eligible retirees and contracts with 85 HMOs, including nine that have cost contracts or other forms of non-risk arrangements with Medicare.¹⁸ The employer pays the full premium towards both the base plan and the HMOs, except that the enrollee must pay the difference if the cost of the HMO exceeds that of the base plan, which is true with many of the non-risk HMOs. There is a modest benefit package advantage in joining an HMO. The base plan has a deductible of 1 percent per year of the annual pension payment, with a minimum of \$75 and a maximum of \$200. Retirees also pay a 20 percent coinsurance on office visits; most other services are paid in full once the deductible is met. In contrast, in the HMO there are only small office visit copays. Prescription drug benefits have copays of \$5 for generic fills and \$10 for brand name drugs in both the base plan and the HMOs. Some 10 percent of Medicare retirees have joined HMOs.

Taft Hartley Trust Fund A participants are mostly truck-drivers. Its base plan reimburses Medicare cost-sharing in full but does not cover prescription drugs, although it does pay for drugs for active employees. Retirees in the base plan make a premium contribution of \$27 a month. The trust fund has entered into a contract with an HMO that includes unlimited coverage of prescription drugs (with copays). Also, the premium contribution is waived for HMO enrollees. The combination of the expanded coverage, particularly for prescription drugs, and the elimination of premium contributions resulted in first-year penetration rate of 30 percent in a population that has little experience with HMOs, since HMOs are not offered to active workers.

Taft Hartley Trust Fund B does not cover dental services in its base plan. However, Medicare retirees who join the contracted HMO receive limited dental coverage, for which the trust fund pays the HMO \$15 a month per enrollee. Another incentive to join is that the base plan covers Medicare Part A cost-sharing but not Part B cost-sharing, whereas the HMO has a \$10 office visit copay on physician services and covers most other services in full.¹⁹ The motivation for contracting with the HMO was not to achieve cost savings. Rather, it was to help retirees since a significant numbers of Medicare retirees purchase individual Medicare supplement (“Medigap”) policies, largely to obtain coverage for Part B cost-sharing. The purchase of Medigap policies results in duplicate coverage for many services and, thus, represents an inefficient use of retiree income. HMO enrollment has been small, reflecting that improvement in coverage has been modest.

¹⁸HCFA has historically offered HMOs the option of contracting on a cost-basis, i.e., the HMOs are paid based on actual costs incurred. These contracts can either be for all Medicare services or for a subset of Medicare services, typically Part B services. Cost contracting is being discontinued.

¹⁹Both the base plan and the HMO provide comprehensive prescription drug coverage.

VI. COMMUNICATING WITH RETIREES

Communicating with Medicare retirees can be challenging, even more so than with active workers, because these retirees have coverage from two sources: Medicare and the private plan sponsor. Plan sponsors communicate mostly by distributing printed materials, although they may also hold meetings for retirees. Individual questions outside of meetings are usually handled by telephone, and some employers complain about having to solve problems that the retirees should address to the HMO. Prior to open season, some employers send retirees booklets that describe the choices available to them based on their ZIP code.

Some benefits managers interviewed as part of this project stated that they made little or no effort to communicate information about HMO options to retirees over a certain age, e.g., 70, reflecting their experience that these individuals were unlikely to join if they had no prior HMO experience.

VII. FEDERAL REGULATORY ISSUES

The plan sponsors interviewed were all self-insured, and ERISA largely exempts them from state regulation. The federal statute is silent on group or employment-based coverage, leaving regulation largely to HCFA's discretion.²⁰ Federal regulatory issues were only moderately important to plan sponsors. Several employer representatives interviewed said they felt that HMOs at times blamed HCFA inappropriately. For example, one employer reported contracting with an HMO that did not offer drug coverage in its basic package. The interviewee stated that the HMO reported that federal regulations precluded it from contracting with the company if it contracted separately, e.g., with a pharmacy benefits manager (PBM) for the administration of prescription drug coverage, when, in fact, there is no such prohibition.

Some expressed the perspective that HCFA had paid insufficient attention to, and had limited understanding of, the issues surrounding employer contracting with Medicare+Choice plans; HCFA views the Medicare+Choice program as one that contracts with individual enrollees and holds that the presence of an employer does not relieve it of the obligation to protect beneficiaries. The crux of the issue is how HCFA's obligation is discharged.

A frequently expressed complaint relates to confusion created by HCFA's consumer

²⁰The regulatory provisions are largely contained in a series of Operational Policy Letters (OPLs): (1) OPL 95 -- Capacity Limit / "Age-In" Reserved Vacancy Guidelines and Open / Closed Enrollment Rules for an M+CO's Plans (issued 6/21/99); (2) OPL 87 -- Use of Special Election Periods for Medicare Beneficiaries in Employer Group Health Plans (4/20/99); (3) OPL 52 -- FEHBP Members Enrollment in Medicare Risk Plans (4/14/97); (4) OPL 28 -- Administrative Fee Charged to Employer Group Retirees; (5) OPL 27 -- Employer Group Premium When a Flexible Benefit is Involved (11/28/95); and (6) OPL 25 -- Plan Maintenance of Disenrollment Forms for Employer Groups (8/01/95).

education campaign, which is perceived as insensitive to employment-based coverage despite its being the most prevalent form of coverage that supplements Medicare. HCFA sends beneficiaries information on Medicare and on their health plan options. Although “employer and union-sponsored” benefits are discussed, several interviewees felt that the information was not prominently displayed in, for example, the *Medicare and You* handbook that is distributed to beneficiaries and, thus, could easily be missed. One large employer, who expressed annoyance at HCFA’s limited attention to retiree benefits, reported feeling compelled to mount a campaign to tell its Medicare retirees to disregard the materials that HCFA distributes.

A related concern about HCFA’s beneficiary information practices is that retirees are overwhelmed with information from a variety of sources, much of which is considered irrelevant by those who were interviewed for this study. As a result, some retirees apply to enroll directly to the HMO without informing the employer. Also, any information that the HMO makes available to retirees, including the enrollment forms, must be HCFA-approved, creating paperwork for the HMOs and delays for them and employers; some interviewees suggested that the employers should, instead, be trusted to be scrupulous about the information that HMOs provide enrollees with retiree benefits, which HCFA could review retrospectively.

HCFA’s enrollment procedures are commonly viewed as less than optimal. Employers are accustomed to providing HMOs with computerized enrollment listings. However, HCFA makes each enrollee sign an HMO application form, resulting in more paper transfer than occurs in most private sector transactions. Currently, either the employer or the retiree sends both the employer and the health plan enrollment papers form to the health plan, which in turn retransmits them to HCFA.

Another issue relates to the mismatch in open enrollment seasons. The BBA phases in an open enrollment process over several years. Starting in November 2002, each November will be an open enrollment period for the subsequent year, with beneficiaries being allowed to reconsider their decision the following January through March. Many plan sponsors hold their open seasons at other times, often in the fall. Interviewees were divided regarding whether restricting open enrollment for Medicare retirees to the mandated BBA period was problematic. Some regard the mismatch as a significant administrative problem. Others believe that having Medicare retirees make health plan choices at a different time from active workers has the advantage of better distributing the employer’s administrative workload; they also believe that it may reduce enrollee confusion by decreasing the likelihood that Medicare retirees will review the wrong employer-provided materials. For these reasons, many employers already hold their open seasons for Medicare retirees at a different time than for active workers.

Some interviewees find awkward the requirement that for an HMO’s employment-based group coverage, each and every benefit must be at least as generous as the least comprehensive benefit offered in the non-group market, i.e., individual market. In its basic plan offered in the individual market, one HMO covered drugs with a \$7 copay and an annual maximum of \$1,000. A large employer wanted to offer unlimited coverage with a \$10 copay. HCFA suggested that the

HMO charge a \$7 copay on the first \$1,000 in benefits in a year and \$10 thereafter; both the health plan and the employer considered this proposal confusing and administratively cumbersome. Instead, the health plan went through the mechanics in the non-group market of offering a \$10 copay plan with a \$1,000 limit but pricing it identically to the more generous \$7 copay plan in order to discourage participation in the \$10 copay plan. In addition, the HMO did not actively market the \$10 copay plan.

Another HMO offered limited dental coverage in its basic plan and, thus, is required to include such coverage in any employer offering, even though the employer had carved-out the dental benefit and offered it to its retirees separately. The result was that the retiree who enrolled in the HMO had duplicate coverage for this benefit.

HCFA also requires that the premium charged retirees enrolled in the employer-sponsored plan should be no higher on an actuarial basis than that charged in the individual market. HCFA does not generally review premiums charged individual employers but has asserted the right to audit premiums after-the-fact to verify compliance with this requirement. Many employers hold that they are quite capable of negotiating premiums and benefits without added HCFA “protection,” which creates time delays and adds administrative costs.

VIII. PLAN SPONSOR ISSUES WITH HMOs

Overall, plan sponsors were pleased with the HMOs with which they contracted and also reported high levels of satisfaction among retirees who had enrolled. The most common complaint among interviewees was about HMOs that reduced their service areas and did not inform plan sponsors until late, often after the open season had concluded. Some HMOs also sought to change premium levels without adequate warning to plan sponsors. The result was that the plan sponsors had to reissue materials to retirees, who were at times confused by such changes. The plan sponsors recognized that health plans must make reasoned business decisions and that the BBA changed many of the ground-rules under which the plans operate. However, they felt that the HMOs with which they contracted must have known beforehand that they were considering leaving selected markets, and some expressed annoyance at reading about the pull-outs in the press rather than being informed directly by the health plan. They also felt that the HMOs knew in advance that the benefits and premiums changes were likely, even if the HMOs did not know the full magnitude of the adjustments.

Several plan sponsors commented that plans dropping out of selected markets was not, by itself, a major problem because it affected only a small number of retirees. Also, in many parts of the country those that were affected could join other plans while retaining their physicians.

Some plan sponsors also reported problems with the HMOs’ interpretation of benefits. For example, one employer complained about HMOs being at times overly restrictive in interpreting the level of care requirements that had to be met for enrollees to receive nursing facility or home health care.

Although many of the reported problems associated with enrollment processes stem from HCFA's administration of the program, interviewees attributed others to the HMO. Some employers would like HMOs to agree on a standardized enrollment form so that a multistate employer does not have to deal with multiple forms.²¹ Another problem is that many HMOs do not link the enrollment records of a Medicare retiree with his or her non-Medicare dependents (e.g., spouse or disabled child) who are also enrolled in the health plan. Thus, if the retiree calls with questions about the dependent, he or she may be informed that the dependent is not covered because there is not an adequate cross-walk between Medicare and non-Medicare enrollees.

IX. CONCLUSION

Plan sponsors interviewed in the process of preparing this report contracted with Medicare+Choice plans for their retirees for several reasons. As expected, a significant reason was to reduce financial obligations, particularly in light of the requirement of the Financial Accounting Standards Board that estimated future expenses be recorded as liabilities on corporate balance sheets. However, a desire to benefit the retiree was also important and took several forms. First, for employers that had capped their contribution to retiree health benefits, HMOs were a vehicle to pay for benefits within the cap, thereby diffusing retiree resentment as well as pressures to raise the cap. Second, many plan sponsors wanted retirees to have access, to the extent feasible, to the same health plans that they could join prior to becoming eligible for Medicare. Third, some employers felt that retiree satisfaction was important to them, whether in its own right or as a way of keeping active workers anticipating retirement happy in a tight labor market.

HCFA and plan sponsors, particularly employers, have different perspectives on the nature of the government actions and regulations that are desirable to protect HMO enrollees. In addition, employers felt that HCFA had over the last few years paid insufficient attention to the needs of employer-sponsored plans. Finally, HCFA may be able to do more to promote awareness of the opportunities among, particularly, small and mid-size employers as well as Taft Hartley trust funds, entities that may not understand the benefits of HMO contracting for their retirees.

²¹One problem is that employers have not reached agreement among themselves about a uniform form.

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