Consumer Acceptance of HMOs

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MANY CONSUMERS of health services will be offered in the coming months the opportunity to enroll in a health maintenance orgnization (HMO). The Federal Government has made the decision that another delivery system, one that is usually more efficient in its use of health resources, is desirable (*1*).

If the HMO is what it purports to be—a more efficient way of organizing and delivering the kind of health care which people need—it is important that people learn about HMOs. We will attempt to look at some experiences in marketing HMOs and put these experiences into an educational framework in order to design an effective strategy for educating consumers about their options in health benefits. Since 85 percent of the people in the United States are covered by some form of health insurance, this paper is slanted toward educating people about their new option—the HMO.

In general, consumers do not appear knowledgeable about health insurance and usually find out about their coverage only when they use their insurance (*2*). Consumers are also not knowledgeable about health insurance premiums and lack the sophistication to determine the advantages of one health insurance plan over another. Utilization of health insurance needs attention because consumers generally are not aware of the underlying factors, such as inappropriate utilization, which push up prices of insurance.

Some unions have become highly sophisticated in negotiating health benefits for their members. A health plan grading system for labor, management, and trustee officials to use in purchasing health benefits was developed some time ago (*3*). More recently, the insurance commissioner of Pennsylvania published a "Shoppers Guide to Health Insurance." These activities are, however, somewhat isolated.

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The authors visited four health maintenance organizations in preparing this paper. The staffs of the Harvard Community Health Plan, New Haven Community Health Care Plan, Yale University Health Plan, and Georgetown University Community Health Plan reported on their experiences in discussions with the authors. Persons from other HMOs also commented on this paper.

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The experience of new HMOs in enrolling consumers in their plans has been more difficult than many health planners, HMO administrators, and government proponents had envisioned. Contrary to preliminary expectations, many plans have had a difficult time in reaching their desired enrollment (*4*). Sufficient enrollees to produce optimal monthly payments is of prime consideration in achieving the cash flow necessary to meet financial commitments. Even after reaching an optimal size, continuing attention must be paid to enrollment in order to maintain a population large enough to keep the HMO solvent.

Whether the HMO staff carries out its own marketing or uses some outside source, the administrators will need to know what an enrollment strategy entails. The staffs of the four HMOs visited in preparing this paper believe that HMOs can best "sell" their own product. Experience has shown that it is usually unproductive to have persons other than employees of a particular plan carry out enrollment activities. However, there are exceptions. Blue Cross, working for a Long Island HMO, rapidly penetrated, the market and enrolled 7,500 persons within a few months.

The staffs of most of the plans that we visited expressed a need for guides—guides that spell out precisely how to educate consumers, win consumer understanding, and enroll consumers. The staffs wanted help on specifics of getting consumers to understand and choose the HMO as their health plan.

A number of studies indicate that certain basic considerations figure in consumers' decisions about an HMO vis-a-vis their current plan. Attributes of the HMO perceived as valuable are its location and the degree to which consumers are actually informed and aware of their different benefit options. Communications seem to be essential and, even under the best of circumstances, diffusion of new knowledge about the HMO will be slow and dependent on the permeation of the HMO concept through society (*5*).

A Marketing Plan

Most HMOs develop a marketing plan for their geographic areas based on the firms employing large numbers of workers, size of union membership, and number of Federal and other public employees, Medicaid eligibles, Medicare beneficiaries, and employees in small groups. Chamber of Commerce and census reports are the sources of data on the population distribution by age, sex, family size, and income in an

HMO area. Of course, the marketing plan will include information on other health plans available to the population. The importance of having such a data base has been described (*6*).

Approaches to Acceptance and Understanding

Most HMO-type plans are using a variety of approaches to gaining consumers' attention and understanding. The response to approaches has been slow, with one exception where there was a large "captive audience" of students and faculty for whom health costs were largely underwritten.

Most plans have concentrated on employed groups who could be reached on the job. Some HMOs have marketed their plans to a geographically defined population (usually Medicaid beneficiaries) and have found that approaches within a neighborhood were both slow-going and of limited enrollment payoff.

A work force is generally approached by mail, telephone calls, advertising in local newspapers, and presentations to groups and in individual face-to-face conversation at the plant gate or cafeteria or at an "open house" at the HMO site. In approaching a neighborhood, the HMOs have used mailings, community meetings, and outreach education. Outreach education of consumers, conducted in door-to-door visits, has been a prime tool in enrolling a target population in neighborhoods.

Selecting the HMO — A New Behavior

The selection of an HMO as the individual's option for himself and his family in obtaining health care can be looked upon as a process of learning a new behavior. Thus, it is important to explore, step by step, how a person makes such choices—how new behavior gets established (*7*).

The elements involved in establishing behavior must be dealt with in a strategy for consumer acceptance. These elements can be identified as follows:

1. Awareness of the behavior (that an HMO exists)
2. The person must feel a need for the HMO
3. A decision to try (he enrolls)
4. His experience in the HMO
5. He is satisfied with the HMO or is dissatisfied and rejects it.

It is important to remember that HMO members who have had experience with both the fee-for-service system and the HMO will have mixed feelings. There will be some things they like best about each system. It

is necessary that members like the HMO enough to stay in it; if their experiences are not positive, they may choose to leave.

In areas where something like an HMO does not exist, the concept can hardly permeate the awareness of individual persons or be discussed in social groups. Officials of all the plans that we visited indicated that lack of knowledge or understanding of HMOs among consumers is a major problem. Most persons who comprise the potential membership of HMOs are already covered by some health insurance plan. The potential HMO member must understand the plan and believe that it offers him a better health insurance buy — he must be motivated to switch.

What aspects of the HMO appeal to potential enrollee? The answers, according to Metzner and Bashshur *(5)*:

- "One-stop medical care" where services are available for all family members and for all conditions
- 24-hour service
- Convenient location
- More benefits, including preventive services, for the same money
- A physician who is a total health care manager
- A physician who is a backed up by a range of specialists

To enable potential enrollees to make comparisons among health plan options, some HMOs have brochures which lay out the benefits of their plan compared with other choices. The Federal employees' health plan specifically forbids such comparisons in a printed brochure. In marketing plans, because of the general unfamiliarity with comprehensive prepaid group practice, it is important that some method be utilized to give employers, unions, and individuals a basis for a rational decision and enable them to see the difference between the HMO and other options.

Cost

Cost appears to be a major factor in the choice of an HMO. Some staffs of plans reported that price noncompetitiveness with existing options precludes their getting a hearing to explain what the HMO might offer, even when the benefits are much greater. Officials of one plan indicated that it can enroll and be competitive at a price up to $5 a month above the competition because of a larger scope of benefits. Another plan reported an even larger figure.

Cost to the employer is perhaps the major factor. Some employers, who pay a significant portion of the premium for their employees, are apprehensive of a change because they fear escalation of costs in future contracts, particularly where the range of benefits is wider.

Consumer Attitude Surveys

Initial enrollment activities need to identify not only the potential market for the HMO but also the level of consumer awareness. An attempt must be made to determine consumers' ideas and values about health care and to see how they relate to what the HMO offers. A consumer must be able to see how his needs would be met by the HMO. Will he get something different from his present plan? Are his expectations realistic? Consumers must be encouraged to adjust their ideas to what is reasonable to expect. HMOs must be careful not to oversell themselves, because unmet expectations produce a dissatisfied enrollee.

As a first step, the groups in which the HMO may be marketed must be identified. These will usually be large groups of workers. Each work force constitutes a different and unique audience. Gatekeepers to groups will be in the ranks of both management and labor, and both groups should be surveyed. Interviewing techniques are a basic skill for people responsible for the survey *(8)*.

Initial contacts should identify the opinion makers at various levels among both management and labor, and these persons should be among the first to be interviewed, as well as the firm's chief executive or the personnel officer, the contracting officer and his staff, the personnel committee, and union leaders. The series of interviews with representatives of management and labor should produce clues to attitudes toward the HMO concept. In addition, each person interviewed can be asked to talk with a few others and report back to the initial interviewer on the reactions he encountered. An awareness of the HMO will thus begin to permeate the organization.

The interviews should cover the following questions or areas of information:

- Benefits and costs of existing health plans
- What people like and dislike about the plans
- Additional coverage which might be desirable if the cost is not too great
- What the interviewee knows about a health maintenance organization
- What conditions will cause an employee to switch
- Obstacles to switching to the HMO
- Who does the interviewee respect and like at work and whose opinion does he value (for further individual contact).

Data generated by the individual interviews will guide the HMO strategy-makers as they move next to contacts with groups of employees. The motivation, needs, and the vocabulary generated from the individual discussions should serve as the basis for explaining the HMO option to groups.

A sample of wives from each group should be contacted. In most cultures women have a health function assigned to them *(9)*. Wives, therefore, usually exercise prime control over the choice of a health plan. They are also usually more firmly attached to their present medical arrangements than are men.

The objective of all initial contacts should be to identify existing perceptions and to open people's minds to the HMO as an option to their existing health plan. They may wish to consider all their health plan options in the light of what they feel they need and select the one which offers them the best health care.

Employer Awareness of the HMO

Those who interview employers should ask them what they consider to be benefits of an HMO. The benefits named can then be used in the enrollment strategy. The following advantages are usually identified by employers *(10)*:

1. HMOs offer a benefit package which is economically competitive with that of indemnity plans covering similar benefits.
2. HMOs can offer more benefits for the same costs as some indemnity plans.
3. All health services can be obtained through one source. Shopping for health care is not necessary.
4. An HMO member initially chooses his physician and can easily change to another plan physician if he wishes.
5. Employers sometimes find the option of another health care delivery system an attractive alternative for their employees and, in a business perspective, view "managed health care" as desirable.

Employer members of the health plan board of one HMO not only offered the HMO option to their own employees but also assisted the plan through contacting their business peers and encouraging the peers to offer their employees the HMO option. The use of peer contacts on all levels is important; peers can legitimize that which is new and unknown *(11)*.

HMOs' Values to the Patient

Some benefits to the patient, although clear to the economist, are certainly not well understood by the public or even by the members of existing plans, In HMO-type health care, benefits per prepaid dollar are higher; use of hospitals is lower; and certain end results of care, such as lower perinatal mortality, have been shown to be better than care given by individual practitioners.

In a study 1 month before the opening of one plan, the following assets were identified by enrollees as their reasons for enrolling *(12)*:

1. Extensive coverage—for both family members and a range of conditions or ailments;
2. Cost—the actual cost was subsidized by the employer for faculty as well as students, the availability of extras such as drugs and eyeglasses at a reduced rate, the general comfort of knowing health expenses were largely paid for;
3. Convenience—"one-stop medical care" with all services in one building as well as the convenient location of that building (while not every HMO has consolidated services, the psychological convenience of not having to secure medical care on one's own or handle the red tape of claims or bills for services rendered is a factor);
4. The philosophy of the plan—comprehensive care plus preventive services; and
5. Quality of care—the staff members were well-known and respected physicians in the community. (Not all HMOs will have well-known physicians, but they will have well-qualified physicians.)

Decision to Try the HMO

What appears to be an individual decision to enroll in an HMO is usually a group-influenced decision *(7)*. Economic vulnerability is a primary basis on which a group makes such a decision *(10)*. Individual behavior gets established through the behavior of groups in which people find themselves. The economics get sorted out by the group. Initially, a person learns to handle his health and medical care needs in the way his parents did. Throughout life an individual's behavior is influenced by peer interaction — at school, at work, at home, and in social settings. If all the groups with which potential enrollees are associated discussed the HMO option — comparing it to other options, considering what they dislike about present health arrangements, other coverage they would like to have, the prime assets of the HMO, and the obstacles to changing to the HMO, it would be predictable that significant numbers of people participating in such groups would choose to enroll. Even those who feel they are taking a risk, for example, by severing an existing tie to a physician, are more likely to do so after a group discussion of the pros and cons *(13,14)*.

The interaction that occurs during a group discussion is the major means of sorting out options as a basis for decision making. Metzner and Bashshur *(5)* report that discussion with peers, family, and friends are the major influences on the choice of a plan. The directors of enrollment for the HMO need to find both formal and informal methods of promoting discussion. As a part of enrollment strategy, many HMOs arrange discussions for small units at work. As a second choice, mass meetings are held with presentations and discussion in the cafeteria. Buttonholing of employees in the cafeteria or at the entrance is a necessary approach when no time can be taken during the workday for such meetings.

Group sessions should be held on as many levels as possible, from top administrators on down to workers, and they should cover the issues derived from the initial surveys or interviews. The objective of these contacts is to get people at each level to consider and discuss — to verbalize — the advantages of an HMO-type plan. People cannot understand what they cannot discuss and explain.

When behavior change is sought in the People's Republic of China, problems and opposite points of view are deliberately brought out, thoroughly discussed, and rebutted in group discussions. This process is an important step in building group consensus and commitment to a particular behavior ("Motivating the Masses for Family Planning in the People's Republic of China," an unpublished manuscript by Virginia Li Wang, Johns Hopkins University School of Hygiene and Public Health, and Victor H. Li, Stanford University Law School).

The advantages of the HMO must be clear from these discussions and must outweigh the employee's normal tendency to keep his present coverage. Encouraging employers to have employees sign up annual-

ly is an aid to enrollment, since it can force people to consider periodically the wisdom of their choice.

The staffs of existing HMOs emphasize the importance of an accurate presentation and understanding of the plan. Misconceptions or unrealistic expectations lead to dissatisfied members. One unhappy member deters additional enrollments. Generally, there are few dropouts, and these are primarily occasioned by a change of residence or job. Happy enrollees were recognized as diffusers of the HMO concept to others. All plans expect growth within employee groups.

Some decisions are viewed as more important than others. Obviously, those with long-term implications for jobs, careers, and family have important consequences. The choice of a health plan is treated as a low-level decision in many employment situations. The new employee is frequently given a health plan form along with many others to fill out and turn in to a clerical worker. In many instances, no attempt is made to do other than hand the employee a piece of literature to read at his leisure. Every attempt should be made to raise the level of importance of this decision in the eyes of the employer and the employee. Some plans do this by written invitations to join from an officer, key union official, or middle-management personnel. Reference group theory suggests those closest to the decision maker (that is, the immediate peer group) have a greater impact on attitude change *(7)*.

Reducing Resistance to the HMO

Research on how behavior is changed suggests the importance of identifying the points of resistance and trying to reduce the level of their importance. Reducing resistance can change attitudes more rapidly than a hard sell *(15)*. Donabedian identified factors which operate against the choice of an HMO-type organization *(10)*. The arguments against HMOs and some answers to these objections follow:

- Enrollment decreases as distance to a health facility increases. Satellite health centers may be an answer.
- The free choice of a physician and sometimes a hospital is limited. Emphasize the enrollee's initial choice of physician and the opportunity to change. Staff of one plan reported that the lack of affiliation with more than one hospital is a problem. Because of the composition of their target population, an affiliation with a Catholic hospital would be useful. Representation of various ethnic and racial groups on the HMO's staff was also of importance.
- A perception that clinic-type medicine, or something less than quality medicine, is offered. All plans tried various means to encourage a personal feeling about the health plan, its employees, and its physical surroundings. All plans identify those factors which contribute to quality medicine, such as qualification of personnel, a full range of "back-up consultants," continuity of medical records, and so forth.
- Some prospective enrollees perceive gaps in coverage. The interlocking relationships which exist for a range of health services add to the feeling of broad coverage. Many plans use comparative analysis of existing coverage and the HMO-type coverage to demonstrate broad coverage.
- The established relationships of wives and children with obstetricians, gynecologists, and pediatricians are a deterrent to changing health arrangements. To reduce the importance of this deterrent, some plans emphasize the range of services desired by many prospective enrollees and provided by the plan as part of the package. One plan reported that some perceived relationships with physicians are not real; people identify a physician in the neighborhood to whom they would go if sickness occurred.
- Some people see prepayment as diminishing their control over their health care dollar because payment is not directly to the physician. Medicaid recipients particularly, as reported by one plan's staff, felt that "giving up their Medicaid card even to receive a new one" diminished their control. Plans deal with this issue in various ways. One plan has a "consumer satisfaction" card available at each service center. Such an approach, however, gets only to the user. Some plans have consumer participation in various elements of the operation of the plan. Grievance procedures are usually explained.

Seeing the Health Plan

A number of new plans have found that the personal familiarity gained through a visit to the HMO is important. If prospective enrollees can tour the facility, if they can meet some of the people who work there, if they can ask questions which this experience engenders, if they can share this experience with others, the unknown plan will begin to have reality. A number of plans have found that a regular open house, with a tour and an explanation of the medical care being offered, helps to increase familiarity with the physical facilities of the plan and its people. The type of energy commitment such a visit entails seems psychologically important *(16)*. While most HMO staffs feel this activity is important, no plans have compiled factual data to support their assumptions.

Who Joins the HMO First

Researchers point out that workers who are closely integrated into a plant and whose jobs have influence are more likely to choose the HMO if management and labor are behind the plan *(7)*. One HMO which had considerable labor support in the planning stage drew its early membership from such workers.

If intercommunication is a factor in acceptance of new ideas, it is easy to see why relatively isolated persons lag in the adoption of new ways. One plan had the slowest growth in small work groups where individuals worked in the field and had little opportunity to talk with each other.

New ideas tend to be diffused through groups by the adoption of a practice by a few members *(17)*. It becomes important to try to identify those in a group who may be susceptible to adopting new ideas and

practices. Such innovators tend to have some of the following characteristics:

- More highly educated than most of the group
- Have more outside contacts or have traveled widely and hence are familiar with a range of ideas
- Emancipated (not dependent on the immediate society) either because they are economically more independent or because they are not integrated into it (perhaps are new members)
- Members of a society which places a value on efficiency and science
- Represent sources of information to the group on the results of their adoption of a practice
- Are likely to be viewed as leaders by other members of the group.

The person who is most likely to select an HMO, based on experience of existing HMOs, resembles the "early adopter." He tends to be older, to have an above average income, to have no established relationships with physicians, and to be better educated. In addition, HMO enrollees tend to be members of larger than average families, usually young families. New employees who have recently moved to the area are prime targets, since they have no local medical connections *(17)*.

In its early days, the Group Health Cooperative of Puget Sound, Wash., sought a means of getting to new employee groups and looked closely at its members. It was discovered that persons in key leadership positions in a number of employee groups were among the early joiners of the plan. Each of these was contacted as a beginning strategy for that employee group. The initial leader was of assistance in establishing contacts for the plan in which he believed and in encouraging its acceptance.

Existing plans do not appear to be using diffusion by working with early joiners as a method of furthering enrollment. That diffusion occurs naturally seems inherent in the growth of existing plans.

Diffusion seems to occur also on an organizational base. The leaders of one plan reported that when prestigious organizations affiliate with the plan, there is a domino effect, and other, similar organizations in the area begin to affiliate rapidly. This effect was noted particularly among professional firms and educational institutions.

Wives

As mentioned earlier, wives are important in making a health plan choice. HMO staffs have identified the following as concerns of women: prenatal and postnatal care, family planning services, preventive services, well-baby care, inoculations, 24-hour service, and one personal physician backed up by a range of specialists.

HMOs are presently using three approaches to wives: *(a)* encouraging a discussion between employee and spouse around the HMO option vis-a-vis present health plan; *(b)* discussions which husband and wives attend together, either at the place of business or preferably at the health plan facility, and *(c)* a telephone information service to discuss and answer questions about the plan.

Enrolling the Poor

Experiences reported in enrolling the poor and the working poor have varied, but generally they have been less than successful (unpublished study by the Department of Health Care Administration, George Washington University, Washington, D.C.). The staff of one plan we visited reported that they had little difficulty in a locale where a strong and interested community board has been actively engaged in all phases of offering the HMO option and in some aspects of designing the services. Local groups can be brought into a close relationship, thus performing a legitimizing function to the benefit of providers and consumers *(7)*. By contrast, another plan having enrollment difficulty had a community board whose members did not know a single enrollee and who were not themselves members of the plan.

One of the plans' great difficulties has been in negotiating with government agencies. A number of plans have been unable, after long negotiations to make a title XIX contract. Staff of one plan reported that title XIX agency workers continually discouraged potential enrollees. There are reported instances of Medicaid eligibles being enrolled in HMOs with no choice in the decision.

Contacts in behalf of the plan by informed and interested community leaders with other community leaders and agencies appear to have been an important ingredient in successful enrollment. Outreach workers who have been trained to function as communicators in a highly personal and individual way between potential enrollees and the plan have been an important method of enrollment. One plan official mentioned the necessity for the outreach worker to do followup work to maintain or increase enrollment of the nonemployed.

Other than house calls to enroll the "poor," plans have not generally tried a neighborhood approach. Many plans, however, provide speakers for community groups.

None of the HMOs reported attempting to identify neighborhoods where a significant number of enrolled employees live and trying to saturate them through the organized civic, social, religious, and recreational groups with information and discussion about the HMO option. Similarly, no one seems to have tried to reach women's groups in the fashion of voluntary agencies such as the American Cancer Society, the American Heart Association, and the American Lung Association.

Staffs of plans we visited reported that women (and men) called to inquire how those in groups that do not have an HMO option could enroll. No attempt has been made to see if such people could represent a beginning approach to the successful penetration of a neighborhood. "Network theory" suggests that this technique would be useful *(11)*. Metzner and Bashshur *(5)* report that women talk with neighbors about health (their own and their children's) and about the choice of

a health plan or physician. It would be useful to see if neighborhood approaches to women in different areas might be successful. Such an approach must be carefully planned and confined to areas where eligible employees reside in order to warrant the costs of such efforts.

Mass Media Approaches

Some plans are utilizing advertising and public service announcements in radio, TV, and newspapers. Several HMO-type organizations have been written up in the Sunday supplements of newspapers. Mass media seem more likely to reinforce existing predispositions and norms of the group to which the individual may belong (*18*). However, mass media appear to increase the individual's information on a subject, and may have value as a supplement to interpersonal communication in HMO marketing. Studies of communication and research suggest that changes occur among those who are not completely devoted to group norms. Additionally, there is evidence to show that communication on a completely new subject — and an HMO is a new subject — may have value. Difficulties in advertising an HMO because of the sensitivity of medical groups may create a barrier to the use of media approaches. Increasingly, however, health insurance and Blue Cross plans are using the mass media to inform and advertise.

Experience with the HMO

Once a person is enrolled, it is important that he be satisfied with his experiences with the plan. The physicians in one HMO try, in encounters with new enrollees, to help them to understand what to expect — how to use the plan, when to call them, the facility's coverage in off-hours, and so forth. It would appear that education on utilization of the HMO would be of value to all plans, but it is not a presently planned activity in most of them. Printed descriptions of services offered are usually made available.

Officials of one plan report that suggestions and comments regarding the services offered are sought through a suggestion box prominently placed in each area of the facility. In this plan, employees are encouraged to deal with any problem as it arises to the best of their ability and, if it is beyond their scope, to bring the problem to the attention of their supervisor.

Administrators of a number of HMOs stress the importance of the commitment of plan employees to the HMO concept. They recognize that all employee contacts with enrollees affect perceptions of the HMO. However, officials of one new plan reported that their own employees are really unfamiliar with the HMO concept and are more accustomed to crisis medicine themselves. Informed employees who understand the plan and who also understand their enrollees are needed.

It seems important that every HMO have an enrollees' retention and extension plan, based on some of the ideas already set forth.

In summary, it would appear useful to incorporate what we know about how behavior is developed into present recruiting plans to make people more knowledgeable about a second choice open to them in health care delivery — health maintenance organizations. It would be helpful if the move to educate people about HMOs also improved their decisionmaking about health insurance in general.

This paper has set forth some of the issues involved. We suggest that those responsible for enrollment need to become more knowledgeable about behavior development and change. Also, the skills of enrollment personnel need improvement in such areas as interviewing, analysis of resistance factors, small-group discussion, leadership identification, and other factors which underlie diffusion and communications theory.

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