**Department of Health and Human Services**

# OFFICE OF INSPECTOR GENERAL

## HMO WITHDRAWALS

## Impact on Medicare Beneficiaries

**JUNE GIBBS BROWN**
**Inspector General**

**AUGUST 2000**
**OEI-04-00-00390**

**OFFICE OF INSPECTOR GENERAL**

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# EXECUTIVE SUMMARY

## PURPOSE

To determine the impact on beneficiaries when their health maintenance organization withdrew from Medicare or reduced its service area.

## BACKGROUND

About 6.3 million beneficiaries receive their Medicare benefits through Medicare-contracted risk health maintenance organizations (HMOs). Risk HMOs receive a fixed monthly Medicare payment per beneficiary. Such HMOs must provide a full range of Medicare services, and are at risk for any health care cost that exceeds the fixed payment.

Risk HMOs sign annual contracts with HCFA, and have an option to withdraw from the Medicare program totally or in a particular service area. At the end of 1999, 99 risk HMOs either withdrew from their Medicare contracts or reduced their service areas. At the end of 1998, 100 risk HMOs did likewise. When risk HMOs withdraw, beneficiaries enrolled with those plans must choose traditional coverage under Medicare or enroll with another HMO, if one provides coverage in their area.

This report shows the impact of the HMO withdrawals on Medicare beneficiaries.

## FINDINGS

**HMO withdrawals at the end of 1999 affected fewer beneficiaries than the 1998 withdrawals, but a much greater percentage of them were left without an HMO option**

About 300,000 beneficiaries were affected by HMO withdrawals at the end of 1999, compared to about 400,000 at the end of 1998. As a result of the 1999 withdrawals, 30 percent had no HMO available to join; only 12 percent had no HMO available to join after the 1998 withdrawals.

**About one-half of beneficiaries joined another HMO when their HMO withdrew at the end of 1999 as compared to about two-thirds after the 1998 withdrawals**

When their HMOs withdrew at the end of 1999, 55 percent of the beneficiaries joined another HMO, and 45 percent went to traditional Medicare. Statistically, this is a significant shift from the 1998 results. At that time, 66 percent joined another HMO and 34 percent went to traditional Medicare.

Affected beneficiaries seemed to prefer risk HMOs over traditional Medicare. To illustrate, of the 233 beneficiaries we interviewed who had another HMO available to join after the 1999 withdrawals, 193 joined another one.

**Most beneficiaries encountered few transition problems when their HMO withdrew at the end of 1999, but some experienced difficulty**

**Transition:** About 82 percent of beneficiaries whose HMO withdrew at the end of 1999 said their transition to alternative health care coverage was easy to somewhat easy. Of those who had no HMO available, 74 percent expressed that opinion, compared to 85 percent of those who did have an HMO available.

The remaining beneficiaries expressed some difficulty. Mostly, they cited problems of increased cost, primarily related to prescription drugs.

**Timely Information:** Eighty-seven percent of beneficiaries said they received notices in sufficient time to make decisions about their health care coverage.

**Adequate Information:** About 73 percent of beneficiaries said they received adequate information about other health care options.

About 77 percent of beneficiaries who went to traditional Medicare said they received adequate information about supplemental insurance.

**Beneficiaries characterized their health care to be about the same or better after their HMO withdrew**

Ninety-two percent of beneficiaries who went to another HMO, and 87 percent of those who went to traditional Medicare, characterized the health care they received after their HMO withdrew as about the same as, or better than, that received in their former HMO.

This may be partly attributable to beneficiary ability to keep the same medical care providers. About 90 percent of beneficiaries who went to traditional Medicare, and 69 percent of those who went to another HMO said they kept the same primary care physician. Likewise, the majority of beneficiaries also kept at least some of their specialists. Continuity of care is important to Medicare beneficiaries, and changing physicians was a major concern for those who had to do so.

**Financial impact was greater on beneficiaries who went to traditional Medicare**

**Monthly Premium:** According to information from surveyed beneficiaries, the average monthly insurance premium was $108.82 for those who went to traditional Medicare -- an increase of $84.06 after their HMO withdrew. The average new HMO premium was $20.27 -- an increase of $9.08 for beneficiaries who joined another HMO.

**Supplemental Insurance:** Seventy-five percent of beneficiaries who had no HMO available, and went to traditional Medicare, obtained supplemental insurance. Sixty-nine percent of beneficiaries who had another HMO available, but chose traditional Medicare obtained supplemental insurance. Of beneficiaries who did not, 55 percent said it was too expensive.

**Non-Covered Services:** Some HMOs provided coverage for services, such as prescription drugs, that are not covered by Medicare. Of beneficiaries who went to traditional Medicare, 63 percent said they would now have to pay for some services which had been covered by their former HMO. Of beneficiaries who joined another HMO, 19 percent said their new HMO would cover fewer services than their former HMO.

### More than one-fourth of beneficiaries expressed concern about future HMO withdrawals

Thirty-two percent of beneficiaries who went to traditional Medicare, and 24 percent of those who chose another HMO expressed concern about future HMO withdrawals. Fifteen percent said they had already experienced an HMO withdrawal at the end of 1998.

## CONCLUSION

When their HMO withdrew, more beneficiaries lost their option to join another HMO for 1999, as compared to 1998. The transition to new health care was relatively easy for most, but it was difficult for some. When they had the option, the affected beneficiaries seemed to prefer to join another HMO, rather than returning to traditional Medicare. However, beneficiaries were concerned about availability of risk HMOs in the future, obtaining information on health care options, and increasing cost -- especially for prescription drugs.

## AGENCY COMMENTS

HCFA commented on our draft report and described various actions to assist beneficiaries affected by future HMO withdrawals. For example, HCFA has released final Medicare regulations designed to broaden health care options for beneficiaries. HCFA is also enhancing outreach efforts for the fall of 2000 to better inform beneficiaries of their health care options. Appendix E contains the full text of HCFA's comments.

# INTRODUCTION

## PURPOSE

To determine the impact on beneficiaries when their health maintenance organization withdrew from Medicare or reduced its service area.

## BACKGROUND

### Medicare Health Care Options

Medicare is a Federal health program for individuals age 65 and older, and for certain categories of disabled people. In 1999, Medicare served approximately 39.3 million beneficiaries, and paid benefits totaling over $204.9 billion.

The 1997 Balanced Budget Act created Medicare+Choice to broaden beneficiary health plan options. Along with traditional Medicare and risk health maintenance organization (HMOs), new health care options may include provider-sponsored organizations, preferred provider organizations, and medical savings account plans.

The Health Care Financing Administration (HCFA), Department of Health and Human Services, has oversight responsibility for the Medicare program, including Medicare-contracted HMOs.

Throughout this report, we use the terms health maintenance organizations or HMOs to refer to risk HMOs. We do not include Cost or Demonstration HMOs in this report.

### Medicare Risk HMOs

About 6.3 million beneficiaries receive Medicare benefits through Medicare-contracted risk HMOs. Risk HMOs sign annual contracts with HCFA. However, they can withdraw from the Medicare program totally or in a particular service area after the contract period. HMOs may decide to withdraw from service areas where they fail to realize a profit, have diminishing profits, or are unable to attract a sufficient number of beneficiaries.

Risk HMOs receive a fixed monthly Medicare payment per beneficiary. Such HMOs must provide a full range of Medicare services, and they are at risk for any health care cost that exceeds the fixed payment. In addition, many risk HMOs offer extra benefits that are not covered by Medicare. For example, some do not require beneficiaries to pay premiums and deductibles. Others provide additional health care services such as coverage for prescription drugs.

### Beneficiaries Who Lost HMO Coverage

At the end of 1999, 99 risk HMOs either withdrew from their Medicare contracts or reduced their service areas. At the end of 1998, 100 risk HMOs did likewise.

When risk HMOs withdraw, beneficiaries enrolled with those plans must choose traditional coverage under Medicare or enroll with another HMO, if one provides coverage in their area. In such instances, however, beneficiaries are inconvenienced, may incur additional costs, and may have to find different physicians and other health care providers. Further, beneficiaries who develop End-Stage Renal Disease after enrolling in an HMO may not subsequently enroll in another HMO, even if one is available. This remains true even if their HMO withdraws from Medicare.

## SCOPE AND METHODOLOGY

Our findings are based largely on beneficiary views of the impact that HMO withdrawals had on their health care. We interviewed a sample of beneficiaries who were actually disenrolled from HMOs that withdrew from Medicare. We also interviewed HCFA regional and central office officials who had oversight responsibilities for HMOs. Further, we reviewed relevant documentation, such as HCFA files on the withdrawals, Medicare+Choice regulations, and instructions on HMO responsibilities to beneficiaries.

We examined the extent that beneficiaries were informed about HMO withdrawals, the health care options available to them, the choices they made, and their opinions on the characteristics and cost of care before and after their HMO withdrew from Medicare. We did not track and compare detailed aspects of coverage for individual beneficiaries before and after the withdrawals.

### Data Collection

**Sample:** We interviewed 502 randomly selected disenrolled beneficiaries stratified by whether or not they had another HMO available to join after their HMO withdrew at the end of 1999. Table 1 shows our sample details.

**Table 1**
**Sample Selection and Results**

| | Universe | Sample | Adjustments | Adjusted Sample | Interviewed | Response Rate |
|---|---|---|---|---|---|---|
| Number of HMOs | 99 | N/A | N/A | N/A | N/A | N/A |
| Disenrolled Beneficiaries | 298,855 | 700 | -14* | 686 | 502 | 73% |
| Stratification | | | | | | |
| 1. No HMO Available | 90,211 | 350 | -6 | 344 | 242 | 70% |
| 2. Had HMO Available | 208,644 | 350 | -8 | 342 | 260 | 76% |

*13 sample members were deceased and one resides in an assisted living facility

To select our sample, we used HCFA's list of HMOs that withdrew from Medicare or reduced service areas at the end of 1999. Next, we used HCFA's Group Health Plan Master File to identify beneficiaries who had disenrolled from those HMOs between September 1, 1999 and December 31, 1999. Finally, we used HCFA's Medicare Plan Withdrawal Information File to stratify disenrolled beneficiaries by whether or not they had another HMO available to join.

**Survey:** We surveyed beneficiaries by telephone, using a standardized questionnaire. On May 16, 2000, we advised, by mail, all sampled beneficiaries, of our survey objective, and that we would call them later about their experience in obtaining health care coverage after their HMO withdrew from Medicare.

We conducted our interviews between May 22, 2000 and June 2, 2000. We completed telephone interviews with 502 of our 686 sampled beneficiaries--a response rate of 73 percent. Not all beneficiaries we interviewed responded to every question. Where fewer than all 502 beneficiaries answered a particular question, we point that out in the applicable findings of the report.

**Data Reliability:** HCFA's Medicare Plan Withdrawal Information File contained the most reliable data available on HMOs that withdrew and those which continue to operate. The file was created specifically to track and provide current information to Medicare beneficiaries and HCFA program staff on HMO withdrawals.

In July 2000, HCFA staff advised us that 326,689 beneficiaries were actually disenrolled by the 1999 HMO withdrawals rather than the 298,855 shown in Table 1. Also, HCFA's recent numbers showed that 79,000 had no other HMO available rather than the 90,211 we show in Table 1.

Two methodological factors accounted for the difference in disenrollment numbers we used in Table 1 and those reported to us by HCFA in July. First, Table 1 reflects disenrollments in HCFA's Medicare Plan Withdrawal Information File during the September - December 1999 time period. We obtained these numbers from HCFA in May 2000. HCFA's July numbers reflect disenrollments during the June - December 1999 time period.

Second, HCFA's July numbers on disenrollments included beneficiaries in five counties of one State where an HMO had reduced its service area, but excluded all beneficiaries in the remaining counties of that State who were involuntarily disenrolled because HCFA had terminated the HMO's Medicare participation. In May 2000, HCFA's Medicare Plan Withdrawal Information File that we used had included those beneficiaries who were involuntarily disenrolled when HCFA terminated the HMO.

We determined that our sample included only 33 beneficiaries who were involuntarily disenrolled from the terminated HMO. Our analysis indicated that excluding those 33 beneficiaries would not have significantly changed our findings. Furthermore, these beneficiaries were in a situation similar to those whose HMO voluntarily withdrew.

Hence, we believe it is appropriate to report our results according to the sample we used at the time we conducted the survey.

## Data Analysis

We aggregated responses to each survey question. Our results are projectable to our study's universe of 298,855 beneficiaries. To project our results to this universe, we weighted survey responses in accordance with each strata's proportion to the universe. Further, our projections are based on the number of beneficiaries who actually answered each question.

We compared the results of our analysis of the 1999 HMO withdrawals to results of a similar analysis we did of the 1998 withdrawals. Appendix A provides a detailed comparison. However, unless otherwise noted, data analysis presented in this report refer to the 1999 withdrawals.

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We conducted a nonresponse analysis to determine whether or not significant differences exist between respondents and nonrespondents. We found no nonresponse bias based on age, gender, and whether or not beneficiaries had another HMO available to join. Appendix B shows our nonresponse analysis.

Finally, we determined confidence intervals for each key finding in the report. Appendix C shows the confidence intervals for those findings.

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We conducted our inspection between May 2000 and June 2000. We conducted the inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

## HMO withdrawals at the end of 1999 affected fewer beneficiaries than the 1998 withdrawals, but a much greater percentage of them were left without an HMO option

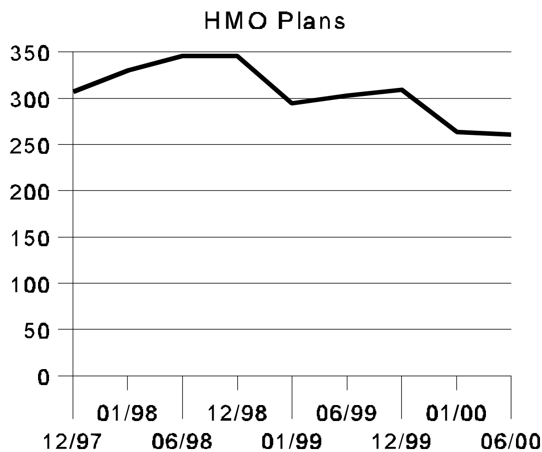
Fewer beneficiaries were affected as a result of the 1999 withdrawals, although the number of HMO withdrawals was virtually the same as in 1998. To illustrate, about 300,000 were affected by the 1999 withdrawals, compared to about 400,000 at the end of 1998.

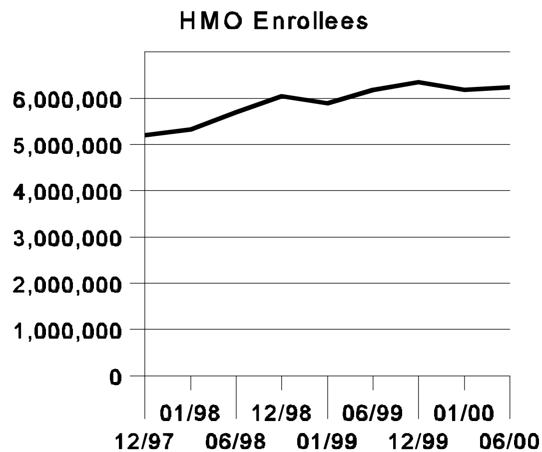
A greater number of beneficiaries, however, were left without a risk HMO option for health care after their HMO withdrew. According to HCFA managed care information system data, about 30 percent of the beneficiaries in our study population had no HMO available to join when their HMO withdrew at the end of 1999, compared to about 12 percent for 1998.

## About one-half of beneficiaries joined another HMO when their HMO withdrew at the end of 1999 as compared to about two-thirds after the 1998 withdrawals

When their HMOs withdrew at the end of 1999, 55 percent of the beneficiaries joined another HMO, and 45 percent went to traditional Medicare. After the 1998 HMO withdrawals, 66 percent of the beneficiaries joined another HMO and 34 percent went to traditional Medicare, a statistically significant difference.

The shift in beneficiary enrollment away from HMOs is mostly attributable to decreased availability of HMOs for them to join. Between December 31, 1998 and December 31, 1999, the number of risk HMOs available for serving beneficiaries decreased by 37 -- from 346 to 309. Conversely, during the same time period, beneficiary enrollment in HMOs actually increased from about 6 million to about 6.3 million. Appendix D gives additional information on the reduced number of HMOs and increase in enrollees.




Given a choice, beneficiaries seemed to prefer risk HMO coverage over traditional Medicare coverage. We obtained usable responses from 233 beneficiaries who had another HMO available to join after their HMO withdrew at the end of 1999. Of those, 193 (83 percent) joined another HMO. Only 40 (17 percent) chose traditional Medicare instead of another HMO.

The reasons cited most often for choosing another HMO over traditional Medicare were that beneficiaries did not have to purchase supplemental insurance and their overall costs were lower.

The reasons cited most often for choosing traditional Medicare over another HMO were to have more freedom of choice in services, fear of losing access to their doctors and other providers, and a dislike for HMOs.

## Most beneficiaries encountered few transition problems when their HMO withdrew at the end of 1999, but some experienced difficulty

### Transition to alternative health care coverage was relatively easy for most beneficiaries

Eighty-two percent of beneficiaries said their transition to alternative health care coverage was easy to somewhat easy. Of beneficiaries who had no HMO available to join, 74 percent expressed that opinion. Additionally, 85 percent of those who did have an HMO available expressed the same opinion. Beneficiaries frequently attributed the ease to adequate information about alternative health care coverage and former employer help in arranging for health care.

Those beneficiaries who expressed difficulty in their transition to alternative health care coverage mainly cited cost problems, particularly costs for prescription drugs. Both those beneficiaries who joined another HMO and those who went to traditional Medicare cited this problem.

### Most beneficiaries received timely information on the withdrawal of their HMO and on how to find other health care coverage

HCFA required HMOs who were withdrawing or reducing service areas to mail final non-renewal notices to affected Medicare beneficiaries by September 15, 1999.

Eighty-seven percent of beneficiaries said they received notices in sufficient time to make decisions for continuing their health care coverage under other options.

### Most beneficiaries received adequate information about other health care options

HCFA encouraged HMOs to provide beneficiaries with information to assist them in making informed decisions about other health care coverage. Such information included a list of available health care options, including how to obtain supplemental insurance. It also identified local outreach activities, such as health fairs, presentations, and public meetings.

About 73 percent of beneficiaries told us they received adequate information about other health care options. About 63 percent of beneficiaries who had no HMO available to join, and 77 percent of those who did, told us they received adequate information.

Conversely, 37 percent of beneficiaries who had no HMO available to join, and 23 percent of those who did, said they received inadequate information or none at all. They said that they wanted more detailed information about supplemental insurance and other specific health plans that were available to them.

**Table 2**
**Extent That Beneficiaries Were Informed**

| | Beneficiaries Who Did Not Have HMO Available ( n=236)* | Beneficiaries Who Did Have HMO Available (n=252)** |
|---|---|---|
| Received adequate information | 63% | 77% |
| Received inadequate information | 32% | 17% |
| Received no information | 5% | 6% |
| TOTAL | 100% | 100% |

*Six beneficiaries did not answer the question about health care information.
**Eight beneficiaries did not answer the question about health care information.

The most prevalent sources of information cited by beneficiaries included former or current HMOs, insurance sales people, former or current employers, spouse's employer, media, and meetings which included HMO representatives.

### Most beneficiaries who went to traditional Medicare received adequate information on supplemental insurance

About 77 percent of beneficiaries who went to traditional Medicare said they received adequate information on supplemental insurance. However, about 18 percent of the beneficiaries told us they received inadequate information or none at all on supplemental insurance. They frequently said they wanted more detailed information. Table 3 shows what beneficiaries said about information they received on supplemental insurance.

**Table 3**
**Information on Supplemental Insurance**

| | Beneficiaries Who Had No HMO Available ( n = 225)* | Beneficiaries Who Had HMO Available (n = 35)** |
|---|---|---|
| Received adequate information | 78% | 71% |
| Received inadequate information | 10% | 6% |
| Received no information | 7% | 9% |
| Did not need information | 5% | 14% |
| TOTAL | 100% | 100% |

*Eleven beneficiaries did not answer the question on supplemental insurance.
**Five beneficiaries did not answer the question.

## Beneficiaries characterized their health care to be about the same or better after their HMO withdrew

### Rating of care remained relatively constant

The majority of beneficiaries who had used their new health plans characterized their care after their HMO withdrew to be about the same as that received in their former HMO. Table 4 shows beneficiary ratings of health care after the transition.

**Table 4**
**Beneficiaries Rating of Their Health Care**

| | Beneficiaries Who Went to Other HMOs (n = 169)* | Beneficiaries Who Went to Traditional Medicare (n = 234)** |
|---|---|---|
| Better | 8% | 19% |
| About the Same | 84% | 68% |
| Worse | 8% | 13% |

*Thirteen beneficiaries did not rate their health care.
**Nine beneficiaries did not rate their health care.

Beneficiaries who went to traditional Medicare rated their current care as better because of increased choice in physicians, ability to see specialists without referrals, shorter waits for appointments, and shorter waits at the doctor's office.

Beneficiaries who went to traditional Medicare rated their care as worse because of the increase in their costs. For example, one beneficiary said he now pays $60 per month for supplemental insurance, whereas no monthly payment was required for coverage with his former HMO.

Likewise, beneficiaries who went to another HMO said their care was better or worse depending on whether their new HMO provided more or fewer services than the former HMO. The beneficiaries noted that fewer covered services generally result in additional costs for beneficiaries who need the services.

### Most beneficiaries kept the same health care providers

Ninety percent of beneficiaries who went to traditional Medicare and 69 percent of beneficiaries who went to another HMO told us they kept the same primary care physician.

Additionally, most beneficiaries were able to keep their same specialists. To illustrate, 64 percent of beneficiaries who went to traditional Medicare said they had specialists. Of those, 95 percent were able to keep some or all of them. Further, 67 percent of beneficiaries who went to another HMO said they had specialists. Of those, 75 percent were able to keep some or all of them.

However, for beneficiaries who had to change physicians, it was a major concern. This concern was expressed by both beneficiaries who went to another HMO and those who went to traditional Medicare.

Most of the HMOs that withdrew from Medicare at the end of 1999 had contracted with local physicians, rather than operating HMO-employee clinics. This helps explain why most beneficiaries kept the same physician when they changed health care delivery systems.

## Financial impact was greater on beneficiaries who went to traditional Medicare

### Monthly premiums were greater

Beneficiaries in traditional Medicare usually purchase supplemental insurance to help pay expenses that traditional Medicare does not cover. Conversely, beneficiaries in HMOs usually do not need additional insurance. However, many beneficiaries who join HMOs pay a monthly premium to the HMO.

On average, beneficiaries who went to traditional Medicare after their HMO withdrew paid $84.06 per month more than they were paying in their former HMO. Comparatively, beneficiaries who went to another HMO experienced an average premium increase of $9.08 per month. Table 5 compares the average monthly premiums for beneficiaries who went to another HMO to that paid by beneficiaries who went to traditional Medicare.

**Table 5**
**Premiums Paid by Beneficiaries**

| | Beneficiaries Who Went to HMOs | Beneficiaries Who Went to Traditional Medicare |
|---|---|---|
| Premium in Former HMO | $11.19 | $24.76 |
| Premium in Current HMO | $20.27 | NA |
| Cost of Supplemental Insurance | NA | $108.82 |
| Difference per Month | + $9.08 | + $84.06 |

Average monthly premiums based on beneficiary self-reported data.

In computing the difference in average premiums, we included beneficiaries who said they had $0 costs. For example, about 51 percent of beneficiaries who went to traditional Medicare did not pay a monthly premium in the former HMO. Further, after their HMO withdrew and the beneficiaries went to traditional Medicare, some said they have $0 costs for supplemental insurance. Their costs for supplemental insurance was $0 because a former employer or another party paid the premium for them.

Likewise, 65 percent of beneficiaries who went to another HMO did not pay a monthly premium in the former HMO. Also, 51 percent of beneficiaries who went to another HMO after 1999 still do not have to pay a monthly premium. The HMOs do not charge a premium as means of attracting enrollees.

The average monthly premium for those beneficiaries who said they actually incurred a cost was much greater than that shown in table 5. To illustrate, for beneficiaries who joined another HMO, the average monthly premium for their former HMO is about $42.14, if we exclude those who had $0 cost. Likewise, excluding beneficiaries who had

$0 costs shows that the premium for beneficiaries who actually pay a premium in their current HMO is about $51.22.

Similarly, for beneficiaries who went to traditional Medicare, if we exclude those who had $0 cost, the average monthly premium for their former HMO was about $54.22. After their HMO withdrew, the average costs for supplemental insurance is about $110.53 for beneficiaries who actually paid a monthly premium for that insurance.

### Beneficiaries incurred supplemental insurance cost

It is important to note that our analysis does not take into consideration deductibles and copayments incurred by beneficiaries before and after the withdrawal, or in either HMO or traditional Medicare settings. However, we did examine the cost of supplemental insurance which is widely purchased by beneficiaries in the traditional Medicare program to offset some of these expenses.

The Balanced Budget Act guaranteed beneficiaries a right to buy certain Medigap insurance policies if available in their State. When a beneficiary applies for the Medigap insurance within 63 days of HMO disenrollment, insurance companies cannot (1) place preexisting conditions on the policies such as exclusion of benefits, and (2) discriminate in policy cost based on health status, claims experience, medical condition, or amount of health care services used.

About 75 percent of beneficiaries who had no HMO available, and went to traditional Medicare, told us they had obtained supplemental insurance to cover expenses that traditional Medicare does not cover. Also, 69 percent of beneficiaries who had another HMO available, but chose traditional Medicare, said they obtained supplemental insurance.

Beneficiaries who did not purchase supplemental insurance typically gave the reasons shown in table 6.

**Table 6**
**Reasons Beneficiaries Did Not Purchase Supplemental Insurance**

| | Beneficiaries Who Had No HMO Available* | Beneficiaries Who Had HMO Available |
|---|---|---|
| Too Expensive | 31 (69%) | 6 (55%) |
| On Medicaid | 1 (2%) | 0 (0%) |
| Other** | 13 (29%) | 5 (45%) |
| TOTAL | 45 (100%) | 11 (100%) |

*Four beneficiaries did not answer the question about reasons for not purchasing supplemental insurance.

**There was no consistent pattern for responses in the "other" category. Responses ranged from personal preference for not purchasing supplemental insurance to lack of understanding and lack of information about supplemental insurance.

Most beneficiaries who had supplemental insurance coverage obtained it on their own. Table 7 shows how beneficiaries who went to traditional Medicare obtained supplemental insurance.

**Table 7**
**How Beneficiaries Who Went to Traditional Medicare Obtained Supplemental Insurance**

| | Beneficiaries Who Had No HMO Available* | Beneficiaries Who Had HMO Available |
|---|---|---|
| Purchased Themselves | 158 (90%) | 21 (88%) |
| Through Former Employment | 12 (7%) | 2 (8%) |
| Medicaid, Union or Other | 5 (3%) | 1 (4%) |
| TOTAL | 175 (100%) | 24 (100%) |

*Thirty-four beneficiaries did not answer the question about reasons for not purchasing supplemental insurance.

### Costs for noncovered services were greater

About 63 percent of beneficiaries who went to traditional Medicare said they would now have to pay for services which had been covered by their former HMO. Some HMOs provided coverage for services, such as prescription drugs, that are not covered by Medicare. They did so to enhance their ability to compete for enrollees. About 11 percent of beneficiaries said they did not know if they would have to pay for services previously provided by their HMO because they had not yet needed the services.

Conversely, only 19 percent of beneficiaries who joined another HMO said their new HMO would cover fewer services than their former HMO. Another 10 percent did not know yet if they would have to pay for previously covered services.

## More than one-fourth of beneficiaries expressed concern about future HMO withdrawals

Fifteen percent of the beneficiaries told us that their 1999 HMO withdrawal was not their first experience with an HMO withdrawing from Medicare. Of those beneficiaries, 71 percent said their first experience was at the end of 1998.

### About 30 percent of beneficiaries who went to traditional Medicare were concerned

Thirty-two percent of beneficiaries who went to traditional Medicare said the fact that HMOs could withdraw from Medicare would keep them from joining another one. However, another 41 percent of beneficiaries who went to traditional Medicare told us that this would not keep them from joining another HMO.

The remaining 27 percent of beneficiaries who went to traditional Medicare said they did not know if the fact that  can withdraw from Medicare would keep them from joining one. Some beneficiaries told us it would depend on the services offered by the HMO.  If it would be less costly to be in an HMO, they said they would join it, even if they knew the HMO could withdraw a year later.

### Almost one-fourth of beneficiaries who went to another HMO were concerned

Twenty-four percent of beneficiaries who went to another HMO told us they were very concerned about their new HMO canceling its contract with Medicare.  Thirty-six percent were slightly concerned.  Forty percent said they were not concerned at all.

# CONCLUSION

When their HMO withdrew, more beneficiaries lost their option to join another HMO for 1999, as compared to 1998. The transition to new health care was relatively easy for most, but it was difficult for some. However, when they had the option, the affected beneficiaries seemed to prefer another HMO, rather than returning to traditional Medicare. Beneficiaries were concerned about availability of risk HMOs in the future, obtaining information on health care options, and increasing cost -- particularly for prescription drugs.

## AGENCY COMMENTS

HCFA commented on our draft report and described various actions to assist beneficiaries affected by future HMO withdrawals. For example, HCFA has released final Medicare regulations designed to broaden health care options for beneficiaries. HCFA is also enhancing outreach efforts for the fall of 2000 to better inform beneficiaries of their health care options. Appendix E contains the full text of HCFA's comments.

**APPENDIX A**

# COMPARISON OF 1999 AND 1998 FINDINGS ON HMO WITHDRAWALS

Statistics in Section I are based on population data. The remaining statistics in Sections II -VI are based on sample data.

| KEY FINDINGS | 1998 | 1999 | Difference |
|---|---|---|---|
| **I. Affected Beneficiaries** | | | |
| Risk HMOs available @ 12/98 and 99 | 346 | 309 | -37 |
| Beneficiaries served | 6 million | 6.3 million | .3 million |
| HMO withdrawals | 100 | 99 | -1 |
| Beneficiaries displaced | 404,417 | 298,855 | -105,562 |
| Beneficiaries with no available HMO | 50,015 (12%) | 90,211 (30%) | 40,196 |
| **II. Replacement Coverage** | | | |
| Beneficiaries joined another HMO | 66% | 55% | -11% [a] |
| Beneficiaries went to regular Medicare | 34% | 45% | 11% [a] |
| Beneficiaries had a choice and chose regular Medicare over another HMO | 20% | 17% | -3% |
| Beneficiaries had a choice and chose another HMO | 80% | 83% | 3% |
| **III. Transition Problems** | | | |
| Transition easy | | | |
| All Beneficiaries | 86% | 82% | -4% |
| Beneficiaries with no available HMO | N/A | 74% | N/A |
| Beneficiaries with an available HMO | N/A | 85% | N/A |
| Received timely information | | | |
| All Beneficiaries | 82% | 87% | 5% |
| Beneficiaries with no available HMO | N/A | 86% | N/A |
| Beneficiaries with available HMO | N/A | 87% | N/A |
| Received adequate information | | | |
| All Beneficiaries | 70% | 73% | 3% |
| Beneficiaries with no available HMO | N/A | 63% | N/A |
| Beneficiaries with available HMO | N/A | 77% | N/A |

| KEY FINDINGS | 1998 | 1999 | Difference |
|---|---|---|---|
| Received adequate information on supplemental insurance | | | |
| All Beneficiaries | 69% | 77% | 8% [a] |
| Beneficiaries with no available HMO | N/A | 78% | N/A |
| Beneficiaries with HMO available | N/A | 71% | N/A |
| Did not need information | 13% | 5% | -8% |
| **IV. Characterization of Health Care** | | | |
| Characterization of care the same or better than former HMO | | | |
| Beneficiaries went to another HMO | | | |
| About the same | 82% | 84% | 2% |
| Better | 12% | 8% | -4% |
| Beneficiaries went to regular Medicare | | | |
| About the same | 69% | 68% | -1% |
| Better | 21% | 19% | -2% |
| Kept the same primary physician | | | |
| Beneficiaries went to regular Medicare | 84% | 90% | 6% |
| Beneficiaries went to another HMO | 77% | 69% | -8% |
| Kept the same specialist | | | |
| Beneficiaries went to regular Medicare | 87% | 95% | 8% |
| Beneficiaries went to another HMO | 80% | 75% | -5% |
| **V. Financial Impact** | | | |
| New monthly premiums after HMO withdrew | | | |
| Supplemental insurance | N/A | $108.82 | N/A |
| HMO premium | N/A | $ 20.27 | N/A |
| No monthly premium in former HMO | | | |
| Beneficiaries went to regular Medicare | 52% | 51% | -1% |
| Beneficiaries went to another HMO | 79% | 65% | -14% [a] |
| No monthly premium after HMO withdrew | | | |
| Beneficiaries went to another HMO | 72% | 51% | -21% |
| Obtained supplemental insurance | | | |
| All Beneficiaries | N/A | 75% | N/A |
| Beneficiaries had no available HMO | N/A | 78% | N/A |
| Beneficiaries had available HMO | N/A | 69% | N/A |
| Costs for noncovered services | | | |
| Beneficiaries went to regular Medicare | 62% | 63% | 1% |
| Beneficiaries went to another HMO | 13% | 19% | 6% |

| KEY FINDINGS | 1998 | 1999 | Difference |
|---|---|---|---|
| Don’t know if services are covered after transition | | | |
| Beneficiaries went to regular Medicare | 19% | 11% | -8% |
| Beneficiaries went to another HMO | 16% | 10% | -6% |
| **VI. Future HMO Withdrawals** | | | |
| Beneficiaries went to regular Medicare | | | |
| Would not join another HMO | 34% | 32% | -2% |
| Would still consider another HMO | 43% | 41% | -2% |
| Undecided | 23% | 27% | 4% |
| Beneficiaries went to another HMO | | | |
| Very concerned | 26% | 24% | -2% |
| Slightly concerned | 36% | 36% | 0% |
| Not concerned | 38% | 40% | 2% |

[a] **The differences between 1998 and 1999 are statistically significant at the 95 percent confidence level.**

APPENDIX B

## ANALYSIS OF RESPONDENTS VS. NON-RESPONDENTS

A consideration in surveys of this type is whether the results may be biased by significant differences between respondents and non-respondents. To determine whether significant differences exist in this survey, we compared age, gender, and whether or not beneficiaries had another HMO to join. Although we had 502 respondents to our telephone calls, some of the beneficiaries responses were not usable. As a result, we had 463 responses and 223 non-responses to use for this analysis. The analysis suggests that our survey results were not biased with regard to these factors.

**Analysis by Age**

A t-test was used to compare the average age of respondents and non-respondents. This difference was not statistically significant.

**AGE**

| Sample (n=686) | Average Age |
|---|---|
| Respondents (n=463) | 72.64 |
| Non-respondents (n=223) | 73.19 |

t=-.8104 (not significant)

**Analysis by Gender**

A chi-square test showed no relationship between respondents and non-respondents with respect to gender.

| | **Males** | | **Females** | |
|---|---|---|---|---|
| | **Number** | **Percent** | **Number** | **Percent** |
| Sample(n=686) | 326 | 48% | 360 | 52% |
| Respondents (n=463) | 221 | 48% | 242 | 52% |
| Non-respondents (n=223) | 105 | 47% | 118 | 53% |

Chi-square=.025 (not significant)

**Analysis by Whether or Not Beneficiaries Had Another HMO Available to Join**
A chi-square test was performed to determine if there was a relationship between the availability of another HMO to join and response to the survey. The chi-square test showed no significant difference.

| | **HMO Not Available** | | **HMO Available** | |
|---|---|---|---|---|
| | **Number** | **Percent** | **Number** | **Percent** |
| Sample (n=686) | 338 | 49% | 348 | 51% |
| Respondents (n=463) | 225 | 49% | 238 | 51% |
| Non-respondents (n=223) | 113 | 51% | 110 | 49% |

Chi-square= .260 (not significant)

APPENDIX C

# CONFIDENCE INTERVALS

| KEY FINDINGS | POINT ESTIMATE | 95% CONFIDENCE INTERVALS AND BOUNDARIES |
|---|---|---|
| Beneficiaries who went to another HMO when former HMO withdrew. | 55% | +/- 3.7%<br>51.3% - 58.7% |
| Beneficiaries who went to traditional Medicare when former HMO withdrew. | 45% | +/- 3.7%<br>41.3% - 48.7% |
| Beneficiaries who had no HMO available to join said their transition to another health care delivery system was easy to somewhat easy. | 74% | +/- 4.7%<br>69.3% - 78.7% |
| Beneficiaries who had another HMO available to join said their transition to another health care delivery system was easy to somewhat easy. | 85% | +/- 4.5%<br>80.5% - 89.5% |
| Beneficiaries who went to another HMO said they kept same primary doctor they had in former HMO. | 69% | +/- 6.6%<br>62.4% - 75.6% |
| Beneficiaries who went to traditional Medicare said they kept same primary doctor they had in former HMO. | 90% | +/- 3.7<br>86.3% - 93.7% |
| Beneficiaries who had specialists and went to another HMO said they kept some or all specialists they had in former HMO. | 75% | +/- 7.6%<br>67.4% - 82.6% |
| Beneficiaries who had specialists and went to traditional Medicare said they kept some or all specialists they had in former HMO. | 95% | +/- 3.2%<br>91.8% - 98.2% |
| Beneficiaries who went to another HMO said their health care is better than that received in former HMO. | 8% | +/- 4.1%<br>3.9% - 12.1% |

| KEY FINDINGS | POINT ESTIMATE | 95% CONFIDENCE INTERVALS AND BOUNDARIES |
|---|---|---|
| Beneficiaries who went to traditional Medicare said their health care was better after their HMO withdrew from Medicare. | 19% | +/- 5.0%<br><br>14% - 24% |
| Beneficiaries who went to another HMO said their health care is about the same as that received in former HMO. | 84% | +/- 5.5%<br><br>78.5% - 89.5% |
| Beneficiaries who went to traditional Medicare said their health care is about the same as that received in former HMO. | 68% | +/- 6.3%<br><br>61.7% - 74.3% |
| Beneficiaries who went to another HMO said their health care is worse than that received in former HMO. | 8% | +/- 4.1%<br><br>3.9% - 12.1% |
| Beneficiaries who went to traditional Medicare said their health care was worse after their HMO withdrew from Medicare. | 13% | +/- 4.4%<br><br>8.6% - 17.4% |
| Beneficiaries who had no HMO available to join had sufficient time to make a decision about their health care. | 86% | +/- 4.5%<br><br>81.5% - 90.5% |
| Beneficiaries who had another HMO available to join had sufficient time to make a decision about their health care. | 87% | +/- 4.2%<br><br>82.8% - 91.2% |
| Beneficiaries who had no HMO available received adequate information about other health care coverage. | 63% | +/- 6.2%<br><br>56.8% - 69.2% |
| Beneficiaries who had another HMO available received adequate information about other health care coverage. | 77% | +/- 5.2%<br><br>71.8% - 82.2% |
| Beneficiaries who had no HMO available said they did not receive adequate information about other health care coverage. | 32% | +/- 6.0%<br><br>26% - 38% |
| Beneficiaries who had another HMO available said they did not receive adequate information about other health care coverage. | 17% | +/- 4.6%<br><br>12.5% - 21.6% |
| Beneficiaries who had no HMO available said they did not receive any information about other health care coverage. | 5% | +/- 4.0%<br><br>1% - 9% |

| KEY FINDINGS | POINT ESTIMATE | 95% CONFIDENCE INTERVALS AND BOUNDARIES |
|---|---|---|
| Beneficiaries who had another HMO available said they did not receive any information about other health care coverage. | 6% | +/- 4.4%<br><br>1.6% - 10.4% |
| Beneficiaries who had no HMO available said they received adequate information about supplemental insurance. | 78% | +/- 5.4%<br><br>72.6% - 83.4% |
| Beneficiaries who had no HMO available said they did not receive adequate information about supplemental insurance. | 10% | +/- 3.9%<br><br>6.1% - 13.9% |
| Beneficiaries who had no HMO available said they did not receive any information about supplemental insurance. | 7% | +/- 3.3%<br><br>3.7% - 10.3% |
| Beneficiaries who had no HMO available said they did not need any information about supplemental insurance. | 5% | +/- 2.8%<br><br>2.2% - 7.8% |
| Beneficiaries who went to another HMO did not have to pay a monthly HMO premium in the former HMO. | 65% | +/- 6.8%<br><br>58.2% - 71.8% |
| Beneficiaries who went to traditional Medicare did not have to pay a monthly HMO premium in the former HMO. | 51% | +/- 6.4%<br><br>44.6% - 57.4% |
| Beneficiaries who went to another HMO said their new HMO would cover fewer services than their former HMO. | 19% | +/- 5.6%<br><br>13.4% - 24.6% |
| Beneficiaries who went to traditional Medicare said they would now have to pay for some services not covered by traditional Medicare. | 63% | +/- 6.2<br><br>56.8% - 69.2% |
| Beneficiaries who went to another HMO said they did not know yet if they would have to pay for previously covered services. | 10% | +/- 4.3%<br><br>5.7% - 14.3% |
| Beneficiaries who went to traditional Medicare said they did not know if they would have to pay for services previously provided by their former HMO. | 11% | +/- 3.9%<br><br>7.1% - 14.9% |

| KEY FINDINGS | POINT ESTIMATE | 95% CONFIDENCE INTERVALS AND BOUNDARIES |
|---|---|---|
| Beneficiaries who went to traditional Medicare had supplemental insurance to cover expenses that traditional Medicare does not cover. | 75% | +/- 5.2%<br><br>69.8% - 80.2% |
| Beneficiaries who went to another HMO said they were very concerned that the new HMO would withdraw from Medicare. | 24% | +/- 6.1%<br><br>17.9% - 30.1% |
| Beneficiaries who went to another HMO said they were slightly concerned that the new HMO would withdraw from Medicare. | 36% | +/- 6.8%<br><br>29.2% - 42.8% |
| Beneficiaries who went to another HMO said they were not concerned at all that the new HMO would withdraw from Medicare. | 40% | +/- 7.0%<br><br>33% - 47% |
| Beneficiaries who went to traditional Medicare said the fact that HMOs can withdraw from Medicare would keep them from joining another HMO. | 32% | +/- 5.6%<br><br>26.4% - 37.6% |
| Beneficiaries who went to traditional Medicare said the fact that HMOs can withdraw from Medicare would not keep them from joining another HMO. | 41% | +/- 6.2%<br><br>34.8% - 47.2% |
| Beneficiaries who went to traditional Medicare said they did not know if the fact that HMOs can withdraw from Medicare would keep them from joining another HMO. | 27% | +/- 5.5%<br><br>21.5% - 32.5% |

APPENDIX D

# MEDICARE RISK HMOs AND ENROLLMENT

**DECEMBER 1997 TO JUNE 2000**

| MONTH/YEAR | # PLANS | # ENROLLEES | % CHANGE |
|---|---|---|---|
| 12/97 | 307 | 5,211,339 | |
| 01/98 | 330 | 5,328,308 | 2.2% |
| 06/98 | 346 | 5,710,550 | 7.2% |
| 12/98 | 346 | 6,055,546 | 6.0% |
| 01/99 | 295 | 5,901,853 | -2.5% |
| 06/99 | 303 | 6,192,892 | 4.9% |
| 12/99 | 309 | 6,347,434 | 2.5% |
| 01/00 | 264 | 6,189,971 | -2.5% |
| 06/00 | 261 | 6,238,549 | 0.8% |

APPENDIX E

# AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

**DATE:** AUG 11 2000

**TO:** June Gibbs Brown
Inspector General

**FROM:** Nancy-Ann Min DeParle
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "HMO Withdrawals: December 1999 – Impact on Medicare Beneficiaries," (OEI-04-00-00390)

Thank you for the opportunity to review and comment on the above-referenced draft report, which examines the impact on beneficiaries whose health maintenance organization (HMO) either withdrew from the Medicare program or reduced its service area in 1999 and 1998.

The Medicare+Choice program was created by the Balanced Budget Act of 1997. Since 1998, most HMO contracts with the federal Health Care Financing Administration (HCFA) have operated under Medicare+Choice to provide health care coverage for beneficiaries in certain areas. About 70 percent of Medicare beneficiaries live in areas served by at least one HMO; only about 6.2 million, or 16 percent of all Medicare beneficiaries, have enrolled in a Medicare HMO.

HCFA is continuing to do all that it can to ease the transition for beneficiaries affected by HMO withdrawals and ensure that they receive the rights and protections guaranteed by law. We realize how frustrating and disruptive it can be for beneficiaries when their private health plan makes a business decision to leave Medicare. HCFA is committed to providing information to beneficiaries affected by these plan decisions as well as their caregivers and our partner organizations, such as the State Health Insurance Assistance Programs.

We noted with interest your finding that the over 80 percent of beneficiaries in a health plan that withdrew felt their transition was easy to somewhat easy. Also, your study found that over 70 percent of beneficiaries felt that they had adequate information to make their health care decisions. We are pleased that the majority of beneficiaries did not have a difficult transition and had access to the information they needed. We have been proud of our efforts to conduct an extensive information and outreach campaign to help beneficiaries. Of course, there is more work to do as we continue to improve our

operations to help make the transition for beneficiaries after a plan withdrawals as easy as possible.

HCFA is committed to ensuring that all beneficiaries, whether in Medicare+Choice or traditional Medicare, have a strong Medicare program available to them. As the OIG notes in its conclusion, "Beneficiaries were particularly concerned about continued availability of risk HMOs in the future, information on health care options, and increasing cost." This finding underscores the need for enactment of the President's proposal to modernize and strengthen Medicare, which is the best way to stabilize the Medicare+Choice program. The prescription drug proposal proposed by the President would provide an estimated $2 billion in 2001 and $25 billion over five years to HMOs for the cost of providing prescription drugs. The President's broader plan also proposes to change the way HMOs are paid by creating a competitive defined benefit program, which would use market-based rates determined through a bidding process. Beneficiaries could get reduced premiums by choosing low-cost benefit plans or supplemental benefits by paying more.

We very much appreciate all the work that went into this report and your efforts to understand how beneficiaries are affected by significant changes in the Medicare+Choice program.

Enclosure

**Response of the Health Care Financing Administration**
**Regarding Office of the Inspector General Draft Report:**
**"HMO Withdrawals: December 1999 –**
**Impact on Medicare Beneficiaries," (OEI-04-00-00390)**

Since the Medicare+Choice program was created, HCFA has been working continuously to make sure that there is a wide range of health care options and information available to Medicare beneficiaries and to improve the operation of the Medicare+Choice program.

**Information Campaign**

The report found that over 80 percent of beneficiaries in a health plan that withdrew felt their transition was easy to somewhat easy. Also, the study found that over 70 percent of beneficiaries felt that they had adequate information to make their health care decisions. We are pleased that the majority of beneficiaries did not have a difficult transition and had access to the information they needed. We have been proud of our efforts to conduct an extensive information and outreach campaign to help beneficiaries. Of course, there is more work to do as we continue to improve our operations to help make the transition for beneficiaries after a plan withdrawals as easy as possible.

As part of our efforts, HCFA strongly encourages withdrawing Medicare+Choice plans to send a letter to beneficiaries (usually in July or August) that explains their basic rights and lets them know when they will receive more detailed information about their options soon. HCFA also requires all nonrenewing plans to send affected beneficiaries an information package by October 2 that explains their options to return to traditional Medicare or to enroll in another Medicare+Choice plan, if available.

HCFA will continue to work diligently to provide information to its partners at the national and local level about beneficiaries' rights and protections. Along with help from our partners (outside Medicare support groups), HCFA will be hosting numerous local outreach events across the nation this fall to help beneficiaries make informed decisions about their health care options. We intend to have an even more aggressive outreach campaign than in previous years. Detailed information on these local events is available at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227).

In the Fall, HCFA will also update its health plan database at the website and toll-free line, so that beneficiaries will know what options are available for them. All of these efforts are part of HCFA's ongoing National Medicare Education Program, whose purpose is to provide beneficiaries with the necessary information to make knowledgeable health care decisions. As part of this, we publish the *Medicare&You Handbook* that provides beneficiaries with detailed information on their health care options.

**Financial Impact on Beneficiaries**
Also of interest were OIG's findings on the financial impact on beneficiaries affected by plan withdrawals and how this impact varied between beneficiaries enrolling in another Medicare+Choice plan and those returning to fee-for-service Medigap. Several concerns, including financial concerns, were noted in the conclusion to the report: "Beneficiaries were particularly concerned about continued availability of risk HMOs in the future, information on health care options, and increasing cost."

Outside experts have reported this financial impact as well. A study funded by the Kaiser Foundation published in the November-December 1999 issue of Health Affairs, reported that, "A major share of beneficiaries affected by the HMO withdrawals - while fortunatc to have Medicare as a "safety net"- experienced a decline in their supplemental benefits, an increase in their premiums, and some disruption in their care arrangements." The study went on to say that, "[B]eneficiaries most adversely affected. . . were more likely to have no supplemental coverage, the under age 65, disabled, those 85 and older, racial and ethnic minorities, poor and near-poor, and beneficiaries reporting fair or poor health. . . ."

**Improving Medicare+Choice**
We are also working hard to improve the administration of Medicare+Choice for the health plans that choose to participate. We have been consulting with the managed care industry and have tried to address their concerns. Furthermore, we are continuing to focus on reducing regulatory burden without sacrificing any opportunities to improve the quality of care provided to beneficiaries.

Ultimately, the best way to stabilize Medicare+Choice is to enact the President's proposal to modernize and strengthen Medicare. The prescription drug proposal proposed by the President would provide an estimated $2 billion in 2001 and $25 billion over five years to HMOs for the cost of providing prescription drugs. The President's broader plan also proposes to change the way HMOs are paid by creating a competitive defined benefit program, which would use market-based rates determined through a bidding process. Beneficiaries could get reduced premiums by choosing low-cost benefit plans or supplemental benefits by paying more.

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