Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

BENEFICIARY PERSPECTIVES OF MEDICARE RISK HMOs 1996

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MARCH 1998
OEI-06-95-00430

EXECUTIVESUMMARY

PURPOSE

To describe beneficiaries' experiences in their Medicare risk HMOs in 1996.

BACKGROUND AND METHODOLOGY

Medicare beneficiaries may join a risk health maintenance organization (HMO) through the Medicare program. In return for a predetermined monthly amount per enrollee, the HMO must provide all Medicare-covered services that are medically necessary, except hospice care. Once enrolled, beneficiaries are usually required to use HMO physicians and hospitals. As of October 1997, the Health Care Financing Administration (HCFA) reported 307 risk HMO plans served 5,049,296 Medicare enrollees.

Using HCFA databases, we selected a two-stage random sample of 4,065 enrollees and disenrollees from 40 Medicare risk HMOs. Since our primary focus was Medicare beneficiaries' experiences in their risk HMOs, we collected information directly from them. As in our 1993 study, we surveyed both enrollees and disenrollees to compare their responses, and thus, to gain greater insight into HMO issues. We did not attempt to validate their responses through record review or HMO contact.

FINDINGS

Overall, beneficiaries in Medicare risk HMOs gave a favorable report of good service access in 1996.

Over 85 percent of beneficiaries indicated good access to Medicare-covered services, hospital admission and specialty care. Most beneficiaries reported quick appointments when they were very ill and timely appointments for routine services.

Over 89 percent of beneficiaries attributed their improved or maintained health to HMO medical care; a large majority rated their primary doctors' and HMOs' overall performance as good to excellent.

Most enrollees (93 %) had no plans to leave their HMOs; 3 1 percent of disenrollees left their HMOs for administrative reasons only, e.g., moved from HMO service area.

Some problems we reported in 1993 have substantially improved.

Improvement is evident by statistically significant changes in reports of:

- Encountering consistently busy telephone lines when trying to make appointments for enrollees (20% to 10%) and disenrollees (37 % to 16 %).

- Doctors' failing to take beneficiaries' health complaints seriously for enrollees (12% to 7%) and disenrollees (39% to 19%).
- Doctors failing to provide Medicare-covered services to disenrollees (22% to 12%).
- Going out-of-plan for services without HMO approval by disenrollees (22% to 10%).
- Medical care received through the HMOs causing worsened health for disenrollees (23% to 11%).
- Inappropriate screening of health status at application for enrollees (43 % to 18 %) and disenrollees (48% to 20%); however, the effect of a slight word change in the 1996 survey question is unknown.

Some reported problems continued in 1996, however, and some new ones have surfaced.

Annlication procedures -- HMO screening for health status at application was reported by 18 percent of beneficiaries. While a marked reduction from the 1993 level of 43 percent, this is still a concern, as is the unimproved rate (14%) of beneficiaries' who don't understand their physicians' gatekeeper role from the beginning.

Appeal and grievance rights -- In 1996, beneficiaries' lack of awareness of appeal rights remained high, with 35 percent of disenrollees and 27 percent of enrollees being uninformed; similarly, 40 percent of disenrollees and 28 percent of enrollees were unaware of their grievance rights. Of the beneficiaries who did file formal complaints, 36 percent perceived unfair handling of their complaints; 55 percent of the uninformed said they would have filed complaints had they known their rights.

Emergency and urgent care -- In 1996, of the 39 percent of beneficiaries who said they bad used emergent and urgent services while in the sampled HMO, 10 percent said their HMOs refused to pay. Four percent of all beneficiaries said they did not seek the emergent/urgent care they believed they needed because they thought the HMO might not pay.

Gynecological services -- In 1996, of the women responding about access to gynecological services, most said either referrals from their primary physicians were required (35%) or they didn't know what was required (38%); of the remaining women, 64 percent didn't feel they needed gynecological services. Women's not being aware or not believing they need these services is of concern because national standards recommend regular gynecological care and tests for older women.

The more vulnerable Medicare beneficiaries in HMOs -- the functionally limited, disabled, and chronically ill -- experienced more service access problems.

Functionally limited and disabled beneficiaries had significantly more problems with accessing specialists, hospital care, and other Medicare-covered services, as well as with receiving full explanations of their treatment options and serious consideration of their health complaints. For example, functionally limited enrollees were more likely to report their doctors didn't take their health complaints seriously (16% vs. 5%) and failed to

provide needed services (8 % vs. 2 %). More disabled enrollees (16 % vs. 4 %) reported difficulty in obtaining referrals to specialists.

Chronically ill beneficiaries reported more problems with hospital admissions and with accessing physician services and non-routine services such as diagnostic tests and physical therapy; however, they had the same good access to other services as healthier beneficiaries.

Disenrollees, representing about 13 percent of HMO members in 1996, also reported significantly more access problems than enrollees *for some services.*

Disenrollee data have been used by researchers and program managers to detect systemic problems or trends, but, more recently, are being developed for HMO-specific consumer use. Analysis of our 1996 data revealed several areas for which disenrollees reported more problems than enrollees:

- Didn't get quick appointments when they were very ill (15% vs. 4%)
- HMO doctors didn't take their health complaints seriously (19 % vs. 7 %)
- HMOs refused to pay for emergency or urgent care (20% vs. 10%)
- Medical care through the HMO caused their health to worsen (11% vs. 3 %)
- HMO doctor failed to provide needed Medicare-covered services (12 % vs. 3 %)
- Pap tests (50% vs. 58%) or mammograms (60% vs. 71%) were offered to fewer disenrolled women in the last year

RECOMMENDATIONS

We continue to believe HCFA needs to improve its oversight of the Medicare risk HMO program in six persistent problem areas:

- Assuring HMOs properly inform beneficiaries about their appeal and grievance rights;
- Improving beneficiaries' understanding of HMO procedures and restrictions for obtaining medical services;
- Preventing inappropriate screening of beneficiaries' health status at application;
- Identifying and carefully monitoring service access problems encountered by functionally limited, disabled, and chronically ill beneficiaries;
- Systematically collecting and tracking over time HMO-specific beneficiary-reported data on access to medical services and reasons for disenrollment; and
- Distinguishing between administrative and non-administrative disenrollments, if HMO disenrolhnent rates are to be used as a performance indicator.

The 1996 survey data also suggest that HCFA needs to take steps to better inform older women about gynecological services and health.

AGENCY COMMENTS

HCFA concurred with all the report's recommendations.

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INTRODUCTION

PURPOSE

To describe beneficiaries' experiences in their Medicare risk HMOs in 1996.

BACKGROUND

The Medicare risk HMO program

Medicare beneficiaries may join a risk health maintenance organization (HMO) through the Medicare program. When enrolling beneficiaries, HMOs may not deny or discourage enrollment based on a beneficiary's health status except for end-stage renal disease (ESRD) or hospice care. They must also adequately inform beneficiaries about lock-in to the HMO and appeal/grievance procedures. Under a risk contract, Medicare pays the HMO a predetermined monthly amount (capitated rate) per enrolled beneficiary. In return, the HMO must provide all Medicare covered services that are medically necessary except hospice care. Once enrolled, beneficiaries are usually required to use HMO physicians and hospitals (lock-in) and to obtain prior approval from their primary care physicians for other than primary care.[1] The Health Care Financing Administration (HCFA) has oversight responsibility for Medicare risk contracts with HMOs. Effective July 1997, HCFA's internal reorganization placed many managed care functions under the new Center on Health Plan and Provider Operations. Previously, the HCFA Office of Managed Care was the responsible agency. As of October 1997, HCFA reported 307 risk-based HMO plans served 5,049,296 Medicare enrollees.[2,3]

Prior Office of Inspector General studies

The Office of Inspector General (OIG) has conducted several studies of Medicare managed care. In 1995, the OIG released two fmal reports based on 1993 survey data from 2,882 Medicare HMO enrollees and recent disenrollees randomly sampled from 45 Medicare risk HMOs.[4] While the majority of enrollees and disenrollees reported access to medical care that maintained or improved their health, the results also indicated some serious problems with enrollment procedures and service access. Further, the reports suggested how HCFA could use information from beneficiaries to guide its performance monitoring and assessments of HMOs. HCFA was generally receptive to the reports' conclusions and recommendations, and had begun to implement an improvement strategy, some features of which addressed the problems the OIG had noted.

In 1996, the OIG released final reports for two more areas of the Medicare HMO program -- HMO customer satisfaction surveys and Medicare HMO appeal and grievance processes.[5] The first found that, while virtually all Medicare risk and cost HMOs conduct customer satisfaction surveys, the surveys do not target their Medicare members, they lack uniformity, and technical weaknesses in many may mask problems and inflate satisfaction with managed care plans. The report concluded that these factors substantially

reduce the usefulness to HCFA of the customer satisfaction surveys conducted by HMOs. HCFA stated that the study provided important insights in influencing its decision to develop, its own beneficiary satisfaction survey capability. The work on appeal and grievance processes also noted several problems. While most beneficiaries were generally aware of their rights to formally complain about services and payments, they had less understanding of the particular circumstances under which these rights can be exercised. In addition, the communication between the HMO and the beneficiary regarding denials of service or payment did not work well. The study also found that HMOs did not fully comply with HCFA directives for processing appeals and grievances, and that a review of HMO marketing/enrollment materials and operating procedures showed incorrect or incomplete information on appeal and grievance rights. HCFA agreed with the conclusion that improvements were needed and was working to implement a number of the OIG's recommendations with plans for better informing beneficiaries of their appeals and grievance rights.

In 1997, HCFA has *taken* additional steps towards the improvement of their Medicare risk HMO program. In April 1997, HCFA published its final rules for an expedited review process and reconsideration when services are denied. In partnership with the Agency for Health Care Policy and Research, HCFA has launched its own survey of HMO enrollees with a survey of disenrollees under development. Ultimately, HCFA anticipates releasing comparative risk HMO data from the surveys and HEDIS measures to the public.

The results presented in this report update the 1993 OIG survey of HMO beneficiaries and address new issues, such as beneficiaries' reasons for joining an HMO and perceptions of the financial costs of HMO membership.

METHODOLOGY*

Definition of access

Beyond referencing medical necessity and an actual or likely adverse effect on the beneficiary, the law and regulations do not clearly delineate what full access to services through an HMO means. To adequately cover access to services, we adapted a definition from literature that uses five dimensions: availability, accessibility, accommodation, affordability, and acceptability. Operationally, we divided access into five areas: appointments, including waiting time and administrative processes for making them; restrictions on medical services; incidence and reasons for out-of-plan care; behavior of primary HMO doctors and other HMO personnel towards beneficiaries; and beneficiary awareness of appeal and grievance rights.

* See Appendix A for the full text of the Methodology.

Sample selection

From HCFA's Group Health Plan (GHP) data base, we selected a two-stage random sample, stratified at the second stage. At the first stage, we selected Medicare risk HMOs from those under contract with HCFA as of May 1996. We first excluded those that did not meet our parameters for length of time in the Medicare program or for number of enrollees and disenrollees. From the remaining HMOs, we randomly selected 40. At the second stage, we selected current enrollees and recent disenrollees from each sampled HMO. After excluding enrollees and disenrollees who had not been members for at least 3 months, we randomly selected 5 1 enrollees and 5 1 disenrollees from each of the 40 HMOs. Finally, using HCFA's Enrollment Data Base, we dropped beneficiaries who had died or who appeared as current enrollees, but had actually disenrolled since the last update to the GHP file. This process resulted in 2,038 enrollees and 2,027 disenrollees for a total of 4,065 beneficiaries.

Scope and data collection

Since this study's primary focus is the Medicare beneficiaries' perceptions of their risk HMO experiences, we only collected information from them. We surveyed both enrollees and disenrollees to compare their responses, and thus, to gain greater insight into HMO issues. We did not contact HMOs or their staffs, nor did we attempt to assess the quality or propriety of medical care rendered by the HMOs to these beneficiaries. We initially mailed structured survey forms to 4,065 beneficiaries in early August 1996. In mid-September 1996, we mailed a follow-up letter and second survey form to non-respondents; we closed data collection in October 1996.

With the exception of four questions on overall ratings of their HMO experiences, we did not specifically ask beneficiaries about their satisfaction with the HMOs. Instead we asked for more concrete details on beneficiaries' perceptions and experiences, such as, how long were waits for appointments, or how often, if ever, did a primary physician fail to take their health complaints seriously. Both enrollees and disenrollees provided information on sample and demographic data, enrollment experience, past and present health status and functional level, cost of HMO membership, HMO environment, and available HMO services.

A total of 3,229 survey forms were returned. Of these, 3,003 were usable yielding an unweighted return rate of 74 percent overall, 82 percent for enrollees (N= 1,665) and 66 percent for disenrollees (N=1,338).

Weighting and interpretation

We weighted the collected data to reflect a non-response bias, differences in enrollment size among the sampled HMOs, and distribution of enrollees and disenrollees in the

universe (97% vs. 3%) for the sample period.** The results are generalizable only to the 132 HMOs that met our sampling parameters.

Because of the imbalance between enrollees and disenrollees, we primarily analyzed the two groups separately. Comparisons between enrollees and disenrollees, or sub-populations of them form the basis for all tables in this report, particularly when these groups differed markedly in reporting their HMO experiences. All tables show the weighted percentages with the weighted number of respondents in parentheses. Additionally, we computed 95 % confidence intervals and statistical significance for key questions (see Appendix B).

Comparability of 1993 and 1996 data

A core set of questions on enrollment experience and access to services appears in both the 1993 and 1996 survey forms. Throughout the report, we present this comparative data for key questions. One caveat is that we selected our 1993 beneficiary sample somewhat differently. Despite the differences in sample selection, the HMOs and beneficiaries sampled in 1993 and 1996 appear to have similar characteristics in the same proportions (see Appendix C). The HMOs are predominantly independent practice associations (IPA) and for-profit. Enrollees and disenrollees are predominantly female, white, age 65 or older, and high school graduates or higher. The average length of enrollment in the sampled HMOs, calculated from HCFA data, is somewhat shorter in 1996.

This inspection was conducted in accordance with *the Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

** Disenrollees from the sampled HMOs were about 13 percent of enrolled HMO members in 1996.

FINDINGS

SUMMARY OF BENEFICIARIES' ASSESSMENTS

In 1996, beneficiary responses about their HMO experiences present a picture of good access to care, improvements since 1993, and improvements needed. In 1996, as in 1993, the majority of HMO disenrollees and enrollees reported medical care that maintained or improved their health, timely appointments for primary and specialty care, good access to most Medicare covered services and to hospital, specialty and emergency care, and sympathetic treatment by their HMOs and HMO doctors. Since 1993, improvement is evident in the problem areas of inappropriate screening of health status at application, difficulty with making appointments by telephone, going out-of-plan for needed services, doctors' failure to take beneficiaries health complaints seriously, and disenrollees' perceptions that HMO care made their health worse. In 1996, as in 1993, screening for health status at application and beneficiaries' awareness of their formal complaint rights were problems. The 1996 data suggest access to emergency/urgent care and gynecological services is problematic for some beneficiaries.

Overall, most beneficiaries rated their primary doctors and HMOs favorably.

In 1996, the majority of disenrollees and enrollees gave favorable summative ratings, e.g., excellent and good, very easy and easy, to their doctors' care and HMOs' service access and value (see Table 1). A difference between the two groups, however, is that for every rating question, enrollees' favorable ratings were higher than disenrollees' ratings.

Table 1: Beneficiaries' Overall Ratings of the HMOs - 1996

	Enrollees				Disenrollees			
	Excell.	Good	Fair	Poor/VP	Excell.	Good	Fair	Poor/VP
Care given by primary doctor	46% (956,663)	43% (864.2681	7% (144,799)	2% (30,588)	36% (18,766)	36% (18,634)	18% (9,157)	10% (5,409)
HMO on providing needed services	46% (924,442)	46% (920,958)	7% (149,799)	1% (21.8351	29% (14,834)	40% (20,840)	18% (9,188)	14% (6,790)
	V.Easy	Easy	Neither	HardNH	V.Easy	Easy	Neither	HardNH
HMO rules make getting needed care --	26% (516,590)	41% (806,715)	28% (547,420)	5% (106,754)	22% (11,344)	30% (14,956)	29% (14.4921	20% (9,980)
	Definite Yes	Probable Yes	Not Decided	Prob/Def No	Definite Yes	Probable Yes	Not Decided	Prob/Def No
HMO worth premium costs?	57% (1,107,076)	30% (589,533)	9% (169,840)	4% (71,928	45% (23,014)	28% (14.4761	10% (5,214)	17% (8,513)

HEALTH AND FUNCTIONAL STATUS

Overall, many HMO beneficiaries appear relatively healthy based on rates of self-reported health problems and functional limitations.

► **Serious chronic medical conditions** -- Based on 1996 beneficiary-reported incidence of serious chronic medical conditions, 49 percent of disenrollees and 46 percent of enrollees had no serious chronic health problems (see Table D-l). The most frequently reported problems were heart attack/heart condition (14 %), diabetes (10 %), lung problems (7 %), broken bones (6 %), cancer, excluding skin cancer (6 %), and stroke (5 %). About one-third reported one serious chronic health problem; another 17 percent reported having 2 or 3 serious health problems. By excluding diabetes, lung problems and an "other" category, all of which were not part of our 1993 data, responding beneficiaries from 1996 and 1993 appear similar in health status based on serious chronic medical conditions.[6] In 1996, with these conditions excluded, 76 percent of disenrollees and 71 percent of enrollees reported no serious chronic health problems. Our comparable 1993 survey data showed no serious chronic health problems for 69 percent of disenrollees and 67 percent of enrollees.

► **Functional limitations** -- In 1996, disenrollee and enrollee responses on health and functional limitations, such as problems with climbing stairs or bathing, indicate that most beneficiaries were able to perform well. A substantial majority of disenrollees (71%) and enrollees (68 %) had none of these functional limitations. The most frequently reported functional limitations were problems with walking several blocks (27 %), carrying or lifting groceries (19 %), climbing one flight of stairs (16%), and bathing or showering (7%). About 10 percent had one functional limitation; another 14 percent reported two or three limitations.

► **Sickest, most functionally limited, and disabled beneficiaries** -- Of the categories of beneficiaries whose self-reported data indicated they were the most ill, functionally limited, or disabled by Medicare standards, 38 percent of disenrollees and 41 percent of enrollees were in at least one category.[7] We classified beneficiaries as the most chronically ill if they reported at least one condition from the list of heart condition, heart attack, cancer, kidney failure, stroke or diabetes, and as the most functionally limited if they reported at least one limitation from a list of most basic activities of daily living, e.g., problems with bathing or showering, or using the toilet. Many disenrollees (43 %) and enrollees (41%) said they had neither serious chronic health problems nor functional limitations.

While similar to enrollees in self-reported health status at enrollment, disenrollees' health ratings show more decline over time.

Overall, both disenrollees and enrollees reported worsened health over time, but the rate of perceived decline was greater for disenrollees (Table 2). At enrollment, disenrollees and enrollees appeared similar in health status. For example, 71 percent of disenrollees and 75 percent of enrollees rated their health as excellent to good; 5 percent and 4

percent, respectively rated their health as poor to very poor. When we surveyed them, disenrollees' (63 %) and enrollees' (69 %) reports of excellent to good health were significantly different. Also, disenrollees (11%) were more likely than enrollees (5 %) to report poor to very poor health.

Table 2: Beneficiary Self-Reported Changes in Health Status - 1996

	Enrollees			Disenrollees		
	Excellent to Good	Fair	Poor to Very Poor	Excellent to Good	Fair	Poor to Very Poor
Health at enrollment	75% (1,636,893)	21% (455,069)	4% (92,792)	71% (42,740)	24% (14,288)	5% (2,879)
Health at time of survey *	69% (1,349,839)	26% (497,630)	5% (103,983)	63% (28,344)	26% (11,800)	11% (4,760)

* In 1996, 67% of enrollees and 61% of disenrollees had been enrolled in the sampled HMOs for more than 12 months. The average enrollment length was 21 months for disenrollees and 34 months for enrollees.

Ninety percent of beneficiaries attributed their improved or maintained health to HMO medical care, but disenrollees more often blamed their HMOs for worsened health.

In 1996, nearly all enrollees (97%) and most disenrollees (89%) reported that their HMOs' medical care caused their health to improve or stay the same. Enrollees (43 %) were more likely than disenrollees (30%) to report improved health due to their HMO care. When beneficiaries said their health worsened due to their HMOs' care, both groups most frequently cited problems with timeliness of or access to treatment as the reasons for worsened health. In 1996, disenrollees (11%) were more likely than enrollees (3 %) to report worsened health. Nevertheless, compared to 1993 rates, disenrollees' responses showed marked improvement from worsened health (23 % to 11%) to maintained health (43 % to 59 %).

Table 3: Effect of HMO Care on Beneficiaries' Health

	Enrollees		Disenrollees	
	1993	1996	1993	1996
Medical care received through the HMO caused their health to:				
▸ improve	53% (498,298)	43% (847,873)	34% (7,239)	36% (14,247)
▸ stay the same	45% (423,270)	54% (1,060,779)	43% (9,335)	59% (28,500)
▸ worsen	2% (17,524)	3% (50,343)	23% (4,951)	11% (5,451)

FEDERAL HMO REQUIREMENTS

Beneficiary responses indicate HMOs generally adhered to Federal standards for enrollment procedures; HMO screening for health status at application is greatly reduced, but is still a concern, as is beneficiaries' not understanding HMO rules for obtaining services.

With the exceptions of ESRD and the election of hospice care, Federal regulations prohibit HMOs from denying or discouraging enrollment based on a beneficiary's health status. HMOs must also adequately inform beneficiaries about lock-in to the HMO and other restrictions they may use for managing services, such as using primary physicians as gatekeepers for other services. The majority of beneficiaries indicate that their HMOs have followed Federal enrollment standards, but some beneficiaries' recollections and perceptions indicate weaknesses in enrollment procedures and in beneficiary understanding of lock-in and the role of primary physician as gatekeeper. Basically, the enrollment experiences of enrollees and disenrollees were similar in 1996.

Table 4: Enrollment Experience

	Disenrollees		Enrollees	
	1993	1996	1993	1996
Were asked at application about health problems, excluding kidney failure and hospice care.	48% (9,442)	20% (8,205)	43% (313,060)	18% (237,335)
Were required to have a physical examination before joining HMO.	2% (426)	1% (251)	3% (25,827)	1% (15,165)
Didn't know they could change their minds about enrolling after they applied.	15% (3,446)	15% (6,273)	8% (75,186)	9% (112,609)
Didn't know, from the beginning, they:				
► needed a referral from their primary HMO doctors to see a specialist.	17% (4,566)	14% (8,082)	10% (110,631)	14% (283,724)
► could only use HMO doctors and hospitals (except emergent care and urgent care outside the service area).	6% (1,665)	6% (3,427)	4% (38,972)	5% (104,159)

► **Screening for health status at application** -- Table 4 illustrates how HMOs may have improperly screened Medicare applicants based on their health status. [8,9] In 1996, 18 percent of all beneficiaries, who could remember, said they were asked at application about their health problems, excluding kidney failure and hospice care. However, only two beneficiaries, less than 1 percent of beneficiaries who had been asked about health problems, felt that an HMO representative tried to discourage them from joining because of their health problems. One percent of beneficiaries reported a physical examination was required before they could join the HMO, an event that is specifically prohibited.[10]

A comparison of the 1993 and 1996 survey data shows the proportion of beneficiaries that reported being asked about their health problems at application decreased significantly. We can suggest two reasons for the decrease. The first is that the HMOs reduced the frequency of these improper screenings. The second is that our slight wording change in the survey questions helped the respondents to focus better on the application process rather than on a possible post-enrollment health assessment by the HMO. [11]

▸ **Understanding of HMO rules at application** -- Another continuing problem with enrollment procedures is beneficiaries' understanding of HMO rules for obtaining services. In 1996, of the beneficiaries who could remember, 15 percent of disenrollees and 9 percent of enrollees said they didn't know they could have changed their minds about enrolling after they applied. Also within this group, 14 percent of both disenrollees and enrollees didn't know from the beginning they would need referrals from their primary HMO doctors to receive specialty care. A smaller proportion of enrollees (5%) and disenrollees (6%) reported not knowing from the beginning they were locked-in to HMO doctors and hospitals, except for emergent care and urgent care outside the service area. From 1993 to 1996, enrollees' and disenrollees' responses concerning understanding of HMO rules changed very little.

The proportions of beneficiaries unaware of their appeal rights remained high with 35 percent of disenrollees and 27 percent of enrollees uninformed. Similarly, a high proportion of beneficiaries were unaware of their grievance rights.

Federal guidelines require Medicare risk HMOs to adequately inform beneficiaries about appeal and grievance procedures, but beneficiary responses show a substantial proportion of them were unaware of their rights (see Table 5).

Table 5: Awareness of Appeal and Grievance Rights

	Enrollees		Disenrollees	
	1993	1996	1993	1996
Didn't know they had right to file formal complaint about HMO's refusal to provide or pay for services (appeal).	25% (243,871)	27% (527,146)	31% (6,753)	35% (18,778)
	Enrollees 1996		Disenrollees 1996	
Didn't know they had right to file formal complaint about other HMO problems, e.g., quality of care, waits for appointments (grievance).	28% (544,016)		40% (20,864)	
Knew about appeal or grievance rights, but not about both.	7% (125,276)		7% (3,608)	
Didn't know about appeal and grievance rights.	24% (460,052)		34% (17,506)	

Disenrollees were significantly less aware of their appeal and grievance rights than enrollees. In 1996, 35 percent of disenrollees and 27 percent of enrollees were unaware of their appeal rights. The 1996 rates are similar to those for 1993. Additionally, in 1996, 40 percent of disenrollees and 28 percent of enrollees didn't know they could make formal complaints (grievances) about HMO medical service problems, such as quality of care or long waits for appointments.[12] Finally, in 1996, a total of 41 percent of disenrollees and 31 percent of enrollees lacked complete understanding of their rights to formally complain. Thirty-four percent of disenrollees were unaware of both appeal and grievance rights compared to 24 percent of enrollees. Another 7 percent of disenrollees and enrollees didn't know about appeal or grievance rights.

A 1996 OIG report focusing specifically on 1995 HMO appeal and grievance processes provides additional insight into beneficiaries' understanding.[13] In that study, the OIG found that 86 percent of respondents were currently aware of their general right to make a formal complaint about their HMO care or services, but only 66 percent knew they could complain when they first joined the HMO. Beneficiaries were even less aware of specific instances for which they might exercise their appeal and grievance rights. For example, of beneficiaries didn't know they could formally complain about their not being provided Medicare-covered services (38%), their physicians not taking their health complaints seriously (40 %), or encountering delays in seeing a primary physician (46 %) or a specialist (43 %). While not directly comparable because of differences in survey questions,[14] this study and the OIG study referenced above together suggest that many beneficiaries don't know about their right to file formal complaints, and that this trend has not improved from 1993 to 1996.

Why beneficiaries don't know about their appeal and grievance rights is unclear. However, a related 1996 OIG review of marketing and enrollment materials from 132 Medicare risk HMOs having at least 450 enrollees found 37 (28%) HMOs included no information on either appeal or grievance processes in these materials.[15] Also, an on-site case review at 10 Medicare risk HMOs, showed that for 39 cases (27%), distributed across 8 of the 10 HMOs, the HMOs lacked evidence of informing beneficiaries about their appeal rights in initial determinations.[16] While these data are not projectable to all Medicare risk HMOs, they do indicate some reasons for beneficiaries' lack of awareness.

Most informed beneficiaries who didn't file formal complaints had no problems with their HMOs, but 36 percent of those who did file perceived unfair handling of their complaint; 55 percent of uninformed beneficiaries said they would have filed had they known their rights.

In 1996, we expanded our questions on beneficiaries' awareness of their complaint rights to include their perceptions of the fair handling of complaints, and reasons for not filing complaints (see Table 6). Respondents for these questions fell into three groups: aware of their rights, but had not filed a formal complaint (72%); aware and had filed a formal complaint (3 %); not aware of their rights (25 %).

Table 6: 1996 Complaints -- Reasons for Not Filing and HMO Fairness			
	All	Enrollees	Disenrollees
Were aware of rights, but had not filed a formal complaint about the HMO.	72% (1,466,431)	72% (1,435,821)	59% (30,610)
Of these, didn't file a complaint because:			
▸ no problems with HMO	96% (1,140,196)	96% (1,122,427)	81% (17,769)
▸ left the HMO instead	1% (8.833)	1% (5,917)	13% (2,916)
Were aware of rights and had filed a formal complaint about the HMO:	3% (62,204)	3% (58,442)	7% (3,762)
Of these, HMO did not handle formal complaint fairly.	36% (1 9,302)	36% (1 8,022)	42% (1 ,280)
Weren't aware of right to file formal complaints.	25% (521,776)	25% (503,844)	34% (17,932)
Of these, would have filed if had been aware.	55% (234,758)	55% (227,361)	55% (7,397)

In general, enrollees were less critical of their HMO experiences in these areas than disenrollees. Enrollees (72%) were more likely than disenrollees (58 %) to report they were aware of their rights, but they had not filed a formal complaint. More enrollees didn't formally complain because they said they didn't have problems with their HMOs (96%) compared to disenrollees (81%). Interestingly, 13 percent of disenrollees said they left the HMO instead of filing a formal complaint. A small proportion (1% to 2 %) of both enrollees and disenrollees mentioned they didn't know how to file a complaint, or it was too much trouble to file one.

Beneficiaries noted two other serious concerns with making formal complaints. Of the disenrollees (34%) and enrollees (25 %) who were not aware of their appeal and grievance rights, 55 percent of both groups said they would have filed a formal complaint if they had known their rights. Finally, disenrollees (7%) were more likely than enrollees (3 %) to file a formal complaint, but a sizable proportion of both enrollees (36%) and disenrollees (42%) who had filed perceived that their HMOs had not handled their complaints fairly.

ACCESS: APPOINTMENTS FOR SERVICES

Most beneficiaries reported timely doctor appointments for primary and specialty care, but a substantial number experienced noteworthy delays; disenrollees had more difficulty with timely appointments when they were ill and with longer waits at the doctor's office.

In 1996, most disenrollees and enrollees said they received timely appointments measured by days elapsed before a scheduled appointment or time spent in an office waiting to see a

doctor (see Table D-3).[17] The majority of disenrollees and enrollees reported getting appointments within 1 to 2 days when they believed they were very sick, scheduling appointments with primary care doctors and specialists within 8 days or less, and usually waiting less than a half-hour in the office and examination room before seeing the doctor. Responses about timely appointments with primary HMO doctors were similar in 1993 and 1996.

However, a sizable group of disenrollees and enrollees reported waiting from 13 to more than 20 days for scheduled appointments. Waiting this long for appointments with their primary HMO doctors were 13 percent of both disenrollees and enrollees, and 19 percent and 18 percent respectively for appointments with specialists. These data suggest that some disenrollees and enrollees had better access to physician care for more acute conditions than for health maintenance or preventive care. High percentages of both groups (85 % and 96%, respectively) reported being able to see a doctor quickly when they were very sick.

In 1996, disenrollees did not fare as well as enrollees in two categories of timely appointments -- quickly scheduled appointments for very sick beneficiaries and time spent waiting in the office and examination room to see the doctor. Of those who said they had been very sick, disenrollees (15 %) were much more likely than enrollees (4%) to say they didn't get an appointment within a day or two. Disenrollees also reported longer waits in the office and examination room to see their primary HMO doctors; disenrollees (25%) were much more likely than enrollees (13 %) to wait a half-hour to more than one hour.

Busy telephone lines continue to cause some beneficiaries to give up on trying to make appointments, but at lower rates than in 1993.

Busy telephone lines continue to hinder some beneficiaries' access to services (see Table 7). In 1996, disenrollees (16%) reported encountering consistently busy telephone lines more often than enrollees (10 %), and said they sometimes gave up trying to make appointments more often (12% vs. 6 %). However, the rates beneficiaries report for busy lines and giving up on appointments have improved substantially since 1993.

Table 7: Appointments by Telephone

	Enrollees		Disenrollees	
	1993	1996	1993	1996
Reported busy lines all to most of the time.	20% (111,691)	10% (197,804)	37% (5,093)	16% (8,491)
Sometimes gave up on making appointments due to the busy lines.	11% (65,141)	6% (73,195)	17% (2,627)	12% (4,721)

ACCESS: MEDICAL SERVICES AND OUT-OF-PLAN CARE

The great majority of beneficiaries believed they received the Medicare services they needed; however, disenrollees were more likely than enrollees to perceive problems with access to primary and specialty care.

In 1996, a large majority of enrollees and disenrollees believed their primary HMO doctors provided the necessary care (see Table 8). Their responses consistently indicated good access to Medicare covered services, hospital admission and specialty care.

Table 8: Services Through Primary HMO Doctor

	Enrollees		Disenrollees	
	1993	1996	1993	1996
Primary HMO doctor never failed to provide Medicare covered services that were needed.	97% (924,590)	97% (1,892,165)	78% (18,494)	88% (45,168)

	Enrollees 1996	Disenrollees 1996
Primary HMO doctor never failed to admit to hospital when needed.	98% (925,271)	95% (22,474)
Primary HMO doctor never failed to refer to specialist when needed.	95% (1,551,949)	86% (33,310)
Primary HMO doctor usually explained all ways health problems could be treated.	90% (1,478,238)	77% (33.286)

However, in four instances, disenrollees reported a significantly greater degree of access problems. First, disenrollees (12%) more often said than enrollees (3 %) that their primary HMO doctors failed to provide Medicare-covered services. Nevertheless, disenrollees' perception of a problem has improved since 1993. Second, of the 1996 beneficiaries who believed they needed to see a specialist, disenrollees (14%) were more likely than enrollees (5%) to report their doctors failed to make necessary referrals to specialists. Third, of the beneficiaries who had health problems, disenrollees (23 %) were much more likely than enrollees (10%) to say their primary HMO doctors didn't explain all treatment options to them. Their responses on treatment options may relate to their perceptions of their doctors' concern with costs and failure to take their health complaints seriously. They tended to say more often than other beneficiaries that their doctors didn't take their health complaints seriously and that their doctors and HMOs seemed to be more concerned with the cost of care (see Behavioral Barriers to Services on page 17).

In 1996, disenrollees also reported greater problems with being seen by only a member of the doctor's staff (see Table D-4). Sixteen percent of disenrollees who had a doctor's appointment said they were seen instead by a nurse or technician compared to only 7 percent of enrollees. Of these, sizable proportions of both disemollees (53%) and

enrollees (41%) reported not seeing the doctor at visits from 2 to more than 3 times in the last 6 months.

Compared to national goals for screening and preventive services, HMOs exceed some and fall short on others; comparisons between enrollees' and disenrollees' access to these services is also mixed.

Another measure of medical service access is the rate of access to routine preventive and screening services. In 1996, we asked beneficaries which of these services they had been offered by their HMO doctors or HMOs. We chose services offered over services received as a more liberal method of assessment. We also filtered out those beneficiaries who had not seen a doctor or had not received any services through the HMO while a member [18] We then compared the reported rates to the goals outlined *in Healthy People* 2000 (see Table D-6).[19] Because of differences between the questions we asked and the measurements for *the* goals of *Healthy People* 2000, these comparisons provide only general assessments.

According to the beneficiary-reported data, HMOs exceed several national goals for certain preventive and screening services, but fall short for others. The beneficiary-reported rates of offers for mammograms and prostate cancer screening already meet or exceed the goals. The reported rates for influenza and pneumonia immunizations, are lower than the 2000 goals, especially the pneumonia immunization. The reported rates for blood cholesterol and colon cancer screening are probably below the 2000 goal. The blood cholesterol rate is, however, higher than the 1992 interim progress rate while the colon cancer screen is lower. The reported rate for offering Pap tests appears to be lower than the 2000 goal, but we have no data on the proportion of sampled women with uterine cervix.

A small, but notable group, are the disenrollees (7%) and enrollees (5 %) who reported being offered none of the preventive or screening services. Even among those beneficiaries enrolled for over a year, 6 percent of disenrollees and 5 percent of enrollees still said none of the services were offered.

The most striking difference between disenrollees and enrollees is in their responses for the offer of Pap tests and mammograms. Overall, enrolled women were more likely than disenrolled women to say they had been offered a Pap test (58% vs. 50%) or a mammogram (7 1% vs. 60 %) in the last year of membership. The difference in rates is even wider between disenrolled and enrolled women who were members for a year or less. The reason for this difference is unknown, but the timing of the offer for these services by some HMOs, i.e., close to enrollment versus well after enrollment, may be a factor.

The rates of offering other routine preventive and screening services is closer between disenrollees and enrollees. Disenrollees and enrollees reported, at similar rates, the offer of screening for prostate cancer, blood pressure reading, blood cholesterol screening and

flu shots. Disenrollees who were members for a year or less reported the lowest rates for an offer of colon cancer screening.

Thirteen percent of beneficiaries had to wait for HMO pre-approval of some non-routine services; delays were more frequent and longer for disenrollees than for enrollees.

In 1996, of the beneficiaries who needed non-routine services in the last 6 months (73 %), 13 percent reported some problems with getting them due to the HMOs' pre-approval process (see Table D-5). Non-routine services in this category include referrals to specialists, physical therapy and the more expensive diagnostic tests, such as a CAT scan.[20] Disenrollees (24%) were more likely than enrollees (13 %) to say they had experienced delays in receiving non-routine services due to the HMO pre-approval requirement. By far, the most frequently mentioned service for which both disenrollees (69 %) and enrollees (63 %) experienced delays was a specialist referral, followed by waits for approval of physical therapy (24%) and special diagnostic tests' (17 %). Most beneficiaries who had problems getting non-routine services reported this happened 1 or 2 times in the last 6 months. Disenrollees (10%) were more likely than enrollees (2%) to say they had waited for HMO approval 5 or more times in the last 6 months. Disenrollees (27%) were also more likely than enrollees (14%) to report waiting 3 weeks or longer for approval.

Perceived unmet service needs, absence from the service area, and misunderstanding of lock-in led some beneficiaries to use out-of-plan care, but at lower rates than in 1993, particularly by disenrollees.

In 1996, excluding dental, routine eye, and emergency/urgent care, 6 percent of beneficiaries reported they had sought out-of-plan care for Medicare covered services without prior approval when required (see Table D-7). Eighty percent of beneficiaries who sought out-of-plan care in 1996 had done so 1 to 3 times in the last 6 months. Disenrollees (10%) were more likely than enrollees (6%) to go out-of-plan. For disenrollees, however, this is a notable drop from the 1993 rate of 22 percent.

In 1996, needing the care, even if the HMO would not approve it, was the motivation most frequently mentioned (32%) by beneficiaries who had gone out-of-plan. This suggests that about a third of beneficiaries going out-of-plan perceived service access problems and perhaps implies a quality of care issue. Other reasons related to going-out-of-plan but not as frequently mentioned by disenrollees and enrollees are not getting services quickly enough (11% and 15 %), not getting referrals to a specialist (10 % and 9 %) and not being helped by the primary HMO doctor (12% and 8 %). The second most frequently mentioned reason for going-out-of-plan was being temporarily out of the HMO service area which was cited by 25 percent of disenrollees and 19 percent of enrollees. Finally, disenrollees (20 %) more often than enrollees (3 %) said they went out-of-plan because they didn't think they would have to pay for it. This clearly illustrates some disenrollees' misunderstanding of lock-in.

Real or potential payment problems with emergency or urgent care affected some beneficiaries, disenrollees more often than enrollees.

Payment for emergent and urgent care is sometimes a difficult policy area for beneficiaries and HMOs. While HMOs will generally pay for any required emergency care, they will only pay for urgent care from a non-HMO provider outside the service area. Further, beneficiaries are not always able to differentiate between the need for emergency and urgent care, or between urgent and non-urgent care.[21]

Table 9: Emergent and Urgent Services - 1996

	All	Enrollees	Disenrollees
Used emergent/urgent services while an HMO member.	39% (796,742)	40% (778,465)	35% (18,277)
For those who used emergent/urgent services, HMO informed them it would not pay	10% (79,325)	10% (75,902)	20% (3,423)
Of all respondents who believed they needed emergent or urgent care, those who did not seek it because HMO might not pay.	4% (49,970)	4% (47,859)	6% (2,111)

These complexities have caused access problems for some beneficiaries (see Table 9). Of the 39 percent of beneficiaries who said they had used emergent and urgent services while a member of the sampled HMO, 10 percent encountered their HMOs' refusals to pay. Disenrollees (20%) experienced this significantly more often than enrollees (10%). Four percent of beneficiaries who believed they needed emergent or urgent care said they did not seek it because they thought the HMO might not pay.

Women responding about access to gynecological services said either their HMOs required referrals (35%) or they didn't know the HMO requirements (38%); of the remaining women, 64 percent didn't feel they needed gynecological services.

A somewhat controversial, but permissible, aspect of service access is HMOs' requiring women to have a referral to a gynecologist. Critics of this requirement would argue that gynecological services are an integral part of women's primary health care and should not require a referral. In 1996 we asked women if their HMOs allowed them to see their gynecologists without a referral (see Table 10).

Sixty-one percent of women respondents provided information indicating their awareness of their HMOs' policy for referral to gynecological services. Within this group, the smallest proportion of 28 percent said their HMOs did not require a referral. Thirty-five percent of the women said a referral was required, but disenrolled women (61%) were much more likely than enrolled women (35 %) to report this. Finally, 38 percent of women didn't know their HMOs' referral requirements for gynecological services, with enrolled women (37%) much less aware than disenrolled women (16%).

Table IO: Referrals for Gynecological Services - 1996			
	All	Enrollees	Disenrollees
Women who answered regarding their awareness of the HMOs' requiring a referral for gynecological services.	61% (665,386)	61% (615,819)	51% (1 3,667)
Of these, women who said:			
▸ referral not required	28% (185,050)	28% (181,843)	23% (3,207)
▸ referral required	35% (230,439)	35% (222,131)	61% (8,308)
▸ don't know	38% (249,897)	38% (247,745)	16% (2.152)
Women for whom a referral for gynecological services was not pertinent:	39% (420,165)	38% (407,202)	49% (12,963)
▸ primary doctor is a gynecologist	3% (10,684)	3% (10,239)	3% (445)
▸ uses primary doctor for all health care	33% (137,087)	33% (134,993)	16% (2,094)
▸ didn't need to see a gynecologist	64% (272,394)	65% (261,970)	80% (10,424)

For the remaining women respondents (39%), referral for gynecological services was apparently not an issue.[22] Of these women, 64 percent said they didn't need to see a gynecologist. Interestingly, disenrolled women (80%) were much more likely than enrolled women (64%) to believe that. These women's answer is a serious health concern because both the National Cancer Institute and the Healthy People 2000 project recommend regular gynecological care and tests for older women.[23] Thirty-one percent of these women used their primary doctors for all health care, and a few (3 %) had a gynecologist for a primary HMO doctor.

ACCESS: BEHAVIORAL BARRIERS TO SERVICES

Unsympathetic behavior of primary HMO doctors, their staffs and HMO office staff can subtly or directly restrict beneficiaries' access to medical services. Examples of this behavior are not taking health complaints seriously, showing undue concern about treatment costs, or encouraging a beneficiary to leave the HMO. As mentioned previously, some beneficiaries seemed to relate problems with full explanations of treatment options to their perceptions of their doctors' concern with costs and failure to take their health complaints seriously (see page 13).

In 1996, rates improved for beneficiaries believing their health complaints were taken seriously; when they perceived problems, they most often cited their doctor's apparent lack of interest or blaming health problems on their age.

In 1996, disenrollees (19%) were more likely than enrollees (7%) to believe their primary HMO doctors did not take their health complaints seriously (see Table 11).[24] Substantial proportions of both disenrollees (40%) and enrollees (28 %), who didn't feel they were taken seriously, said they encountered this attitude all to most of the time. From 1993 to 1996, the proportions of disenrollees and enrollees believing they were not being taken seriously declined significantly. However, the rates of those experiencing this problem all to most of the time remained high. In 1996, the two behaviors reported most often by both disenrollees and enrollees as indicative of their doctors' attitudes were their seeming not to listen and blaming the beneficiaries' health problems on their age. About a third of disenrollees and a fourth of enrollees also mentioned their doctors seemed to be impatient with them, not letting the beneficiaries fully explain their concerns, and not examining them.

Table 11: Doctor's Behavior Regarding Health Complaints

	Enrollees		Disenrollees	
	1993	1996	1993	1996
Primary HMO doctor did not take health complaints seriously.	12% (108,855)	7% (13,874)	39% (8,868)	19% (9,383)
Didn't take complaints seriously all to most of the time.	36% (32,760)	28% (33,049)	44% (3,675)	40% (3,318)
	Enrollees 1996		Disenrollees 1996	
When primary HMO doctor didn't take complaints seriously, s(he):[25]				
▸ seemed not to listen	45% (51,449)		50% (4,327)	
▸ blamed health problems on beneficiary's age	36% (41,788)		47% (4,104)	
▸ seemed impatient	25% (28,388)		36% (3,104)	
▸ wouldn't let beneficiary fully explain concerns	26% (29,832)		33% (2,856)	
▸ didn't examine beneficiary	23% (26,885)		31% (2,729)	

Most enrollees continued to believe providing the best medical care was more important to their HMOs and doctors than holding down costs; disenrollees believing this about their doctors increased, but overall, they were still more likely to say cost was emphasized.

The majority of beneficiaries reported they believed their primary HMO doctors and HMOs emphasized providing the best medical care over holding down the cost of care (see Table 12). However, a substantial minority perceived an emphasis on containing costs. In 1996, disenrollees were more likely than enrollees to say that holding down the costs was most important to their primary doctors (15 % vs. 7 %) and HMOs (27 % vs. 15 %). Both disenrollees and enrollees seemed to believe that cost concerns were more important to their HMOs than to their primary HMO doctors. Between 1993 and 1996, beneficiaries' beliefs about what was important to their HMOs and doctors changed little (see Table B-2).

Table 12: Cost of Care vs. Best Care Possible

	Enrollees		Disenrollees	
	1993	1996	1993	1996
Most important to your primary HMO doctor is: *				
► holding down cost of care	10% (94,695)	7% (142,064)	28% (6,460)	15% (7,655)
► giving best medical care possible	73% (7 16,623)	74% (1,484,817)	47% (1 0,927)	57% (29,309)
► don't know	12% (120,819)	16% (312,089)	24% (5,564)	25% (12,876)
Most important to your HMO is:*				
► holding down cost of care	11% (108,364)	15% (300,595)	35% (8,071)	27% (13,689)
► giving best medical care possible	67% (667,057)	62% (1,232,924)	39% (9.016)	43% (22,369)
► don't know	12% (120,709)	16% (318,857)	20% (4,609)	24% (12,384)

* The column does not total 100% as a small proportion of beneficiaries answered that both holding down cost of care and giving best medical care possible were most important.

A few beneficiaries felt they had been encouraged to leave their HMOs.

A small group of beneficiaries reported having felt at sometime during their membership that their HMOs or primary HMO doctors wanted them to leave. Disenrollees (7%) reported encouragement to leave more often than enrollees (1%). Interestingly, disenrollees (4%) most often said they were being encouraged to leave because they would probably receive better care outside the HMO. Disenrollees also felt their HMOs or HMO doctors wanted them to leave because they were too sick to be in the HMO (1 %), the medical care they needed was too expensive (2 %), or they asked for too many services

or appointments (2%). Of the beneficiaries who felt they had been encouraged to leave, 39 percent said someone, nearly always their doctors, had actually told them they should leave their HMOs.

FUNCTIONALLY LIMITED, DISABLED AND CHRONICALLY ILL HMO BENEFICIARIES

A review of recent literature strongly indicates that a separate analysis of seriously or chronically ill and disabled HMO members is required for a complete understanding of HMO medical care. Because they use the health care system more often and cost more to care for, the less healthy members have a more experienced view of that system than healthy members and are more vulnerable to cost saving strategies employed in managed care.[26,27] Further, a recent medical outcomes study found patients with chronic illnesses had worse outcomes in HMOs than in fee-for-service, but, similar differences did not exist between HMO and fee-for-service outcomes for a healthier population.[28] Also of concern is the tendency for Medicare HMO enrollees to be healthier than beneficiaries in fee-for-service and for less healthy beneficiaries to be over-represented in the HMO disenrollee population.[29]

We classified disenrollees and enrollees as functionally limited or chronically ill by using their self-reported health and functional status.[30] Disabled beneficiaries met the Medicare disability criteria and were younger than age 65. The sub-populations of functionally limited and disabled beneficiaries are not the same, although some overlap exists.[31] The sub-population of the chronically ill, as we have defined them, is very broad in terms of their illnesses. More significant differences in access to services may appear when we analyze the data by individual illnesses or conditions. We plan to release a separate, more detailed report illustrating differences between these three groups and healthier beneficiaries.

We found statistically significant differences when comparing the experiences of healthier beneficiaries with those of functionally limited, disabled and chronically ill beneficiaries. In general, functionally limited and disabled beneficiaries reported more service access problems than the chronically ill and the healthier beneficiaries. Compared to healthier beneficiaries, however, functionally limited and disabled beneficiaries reported no significant differences in quick appointments when they were very sick, delays in receiving non-routine services (e.g., referrals to specialists, special diagnostic tests), and the belief that containing cost was most important to their primary HMO doctors.

Functionally limited and disabled beneficiaries experienced significantly more problems in accessing specialists, hospital care, and other Medicare-covered services, and in receiving full explanations of their treatment options and serious consideration of their health complaints.

► **Functionally limited** -- Functionally limited beneficiaries, i.e., had problems with basic daily activities, reported more problems in accessing medical services through their HMOs and their primary HMO doctors than healthier beneficiaries (see Tables E-l and E-

4). Functionally limited enrollees (11%) and disenrollees (3 1%) were more likely than healthier enrollees (5 %) and disenrollees (16%) to say that HMO rules and procedures made it hard or very hard for them to get the health care they needed. Concerning their primary doctor's care of them, functionally limited enrollees were more likely than healthier enrollees to say their doctors didn't take their health complaints seriously (16% vs. 5 %) and failed to provide needed Medicare-covered services (8 % vs. 2 %). Functionally limited enrollees were also less likely to feel their primary HMO doctors had explained all treatment options to them (85% vs. 91%).

Functionally limited disenrollees reported the same significant access problems when compared to healthier disenrollees -- health complaints not taken seriously (24% vs. 17 %), needed Medicare-covered services not provided (20% vs. 1 1 %), and all treatment options explained less often (69% vs. 79%). In addition, functionally limited disenrollees said more often than healthier disenrollees that their primary HMO doctors failed to refer them to specialists when needed (25 % vs. 12%). Functionally limited beneficiaries reported no significant differences for hospital admissions.

► **Disabled** -- Disabled beneficiaries reported more problems with accessing medical services than aged beneficiaries (see Tables E-2 and E-5). Like functionally limited beneficiaries, disabled enrollees (24%) and disenrollees (37%) were much more likely than aged enrollees (5%) and disenrollees (18%) to say that HMO rules and procedures made it hard or very hard for them to get the health care they needed. Disabled enrollees (16 %) and disenrollees (36%) were also more likely than aged enrollees (4%) and disenrollees (13 %) to report their primary HMO doctors failed to refer them to needed specialist services. Disabled disenrollees also stated more often that their primary HMO doctors failed to hospitalize them when needed (19 % vs. 4 %) Disabled disenrollees reported other significant access problems -- health complaints not taken seriously (39% vs. 17 %), needed Medicare-covered services not provided (27 % vs. 11%), and all treatment options explained less often (61% vs. 78 %).

As a group, most chronically ill beneficiaries had the same good access to medical services as healthier beneficiaries with the exception of more problems with hospital admissions and receiving non-routine and physician services.

Chronically ill disenrollees and enrollees fared as well as their more healthy counterparts in accessing medical services through their Medicare HMOs with three exceptions (see Tables E-3 and E-6). They reported experiences similar to healthier beneficiaries' for quick appointments when they were very sick, full explanations of treatment options, referrals to specialists, having their health complaints taken seriously, and the effect of HMO rules and procedures on the ease of obtaining needed health care. The exceptions involved access to physician, hospital and non-routine (e.g., referrals to specialists, special diagnostic tests) services. Chronically ill disenrollees were more likely than healthier disenrollees to report that their primary HMO doctors failed to hospitalize them when the beneficiaries believed they needed to be admitted (8 % vs. 3 %). Also, chronically ill disenrollees were more likely to say they experienced delays in receiving non-routine services (32 % vs. 20 %). Finally, chronically ill enrollees (5 %) were more likely than

healthier enrollees (3 %) to report their primary HMO doctors failed to provide them needed Medicare-covered physician services.

REASONS FOR JOINING AND LEAVING AN HMO

During a period of rapid growth, 75 percent of Medicare risk HMOs faced greatly increased market competition; many lowered premiums and added drug coverage.

An important aspect of beneficiaries' reasons for joining and leaving Medicare risk HMOs is the effect of market competition. As mentioned, the Medicare risk HMO program has grown rapidly, increasing from 90 Medicare risk HMOs in February 1993 to 307 in October 1997. In addition, Medicare beneficiaries can enroll or disenroll from their HMOs at any time. Medicare HMOs often attract new beneficiaries through enhanced benefits, such as offering prescription drug coverage, or reducing the amount of extra premiums charged to beneficiaries.

Analysis of our sampled Medicare risk HMOs confiis increased program growth and competition in their geographic areas during 1995 and 1996. During 1995 and 1996, 43 percent of the sampled HMOs experienced competition from one new Medicare risk HMO, 32 percent from two or more. Overall, the growth of the Medicare HMO program resulted in 48 percent of our sampled HMOs competing with four or more other Medicare risk HMOs offering services within the same market area.

During the 1995-96 growth period, Medicare risk HMOs did offer more attractive cost and benefit packages. In December 1994, half of all Medicare risk HMOs charged enrollees a premium averaging $32.00 per month, but, by December 1996, only one-third of all Medicare risk HMOs were charging an additional premium averaging $13.52 per month.[32] In the same two-year period, the proportion of Medicare risk HMOs offering prescription drug coverage increased dramatically from 38 to 60 percent.[33] Of the 40 Medicare risk HMOs in our 1996 sample, 31 plans offered a prescription drug benefit, and 29 plans did not charge a monthly premium. Of the HMOs charging a premium, four plans charged under $40 a month, six plans charged between $40 to $65 a month, and one plan had a monthly premium of over $100.

Securing more affordable health care was, by far, the most important reason why beneficiaries joined their HMOs; the majority paid no, or low cost, monthly premiums.

Disenrollees and enrollees agreed on the reasons for joining an HMO. Wanting more affordable health care was the most frequently mentioned and most important reason for over half of both groups. Together with affordable health care, three other reasons account for over 80 percent of beneficiaries' reasons for joining, i.e., HMO coverage of services that Medicare doesn't cover, influence of family and friends, and a desire for better quality health care.

Table 13: Reasons for Joining a Medicare Risk HMO - 1996				
	Enrollees		Disenrollees	
Reason&"'	Reason to Join	Most Important	Reason to Join	Most Important
More affordable health care	68% (1,491,239)	54% (1,061,114)	70% (42,528)	55% (29,694)
HMO covers services Medicare doesn't	37% (8 16,334)	14% (268,676)	38% (23,266)	15% (8,254)
Family/friends recommended HMO	24% (521,082)	6% (109,292)	26% (15,670)	5% (2,668)
Better quality health care	21% (457,672)	7% (139,737)	23% (14,213)	10% (5,245)

Other beneficiary characteristics are consistent with their most important reasons for joining an HMO, especially their desire for more affordable health care (see Table D-8). Only 28 percent of beneficiaries had been members of another HMO before joining the one we sampled. The majority obtained their medical care from a non-HMO doctor or from no regular source. If the primary goal is to reduce the out-of-pocket costs for deductibles and co-insurance while gaining access to a wider array of services, HMO membership is a logical choice for many. Further, over 43 percent of enrollees and 39 percent of disenrollees paid no HMO premium beyond the regular Medicare Part B premium. Of the beneficiaries who did pay an additional HMO premium, the majority paid between $1 and $39 monthly. Interestingly, of the beneficiaries who rated their premium rates as expensive, 38 percent of disenrollees and 16 percent of enrollees paid $1 to $39 monthly.

While having the option to disenroll when they wish is important to choosing HMO membership for 17 percent of beneficiaries, most said a mandatory one year enrollment was not a deterrent.

At present, Medicare beneficiaries may disenroll from their managed care plans on a monthly basis. In early 1997, the U.S. General Accounting Office (GAO) suggested that, by limiting beneficiaries' option to change to fee-for-service except during an official open season, Medicare might achieve modest savings on money now spent on services for HMO members who change to fee-for service.[35] The downside of an official open season, as GAO acknowledged, is that "beneficiaries would lose an important consumer protection and might be less willing to enroll in managed care." HCFA responded that it would oppose such a change to the Medicare disenrollment policy. Nevertheless, the health provisions of the Balanced Budget Act of 1997 (Public Law 105-33) mandated the a more restrictive disenrollment policy beginning on January 1, 2002.

Table 14: Effect of Mandatory One-Year Enrollment - 1996			
	All	Enrollees	Disenrollees
If beneficiary had to stay in the HMO for one year, the effect on the enrollment decision would be:			
▸ more likely to join	34% (749,412)	34% (736,611)	22% (12,801)
▸ less likely to join	17% (37 1,062)	16% (351,497)	33% (19,565)
▸ no effect on decision	49% (1,085,769)	49% (1 ,059,294)	45% (26,475)

In 1996, before the law changed, we asked beneficiaries if their being required stay in the HMO for one year would effect their enrollment decisions (see Table 14). The largest proportion of disenrollees (45 %) and enrollees (49 %) said that such a requirement would have no effect on their decision to join an HMO. However, disenrollees (33 %) were much more likely than enrollees (16%) to say that, under those conditions, they would be less likely to join an HMO. These data suggest that, overall, 17 percent of beneficiaries may hesitate to join an HMO if they do not have the option to leave at will.

In 1996, 93 percent of enrollees had no plans to leave their HMOs; 4 percent wanted to leave but felt they could not afford to.

In 1996, 93 percent of enrollees had no plans to leave their HMOs; the remainder, an estimated 141,773 beneficiaries, either planned to leave or felt they couldn't even though they wanted to (see Table D-10). The plans of 4 percent were based on an anticipated move, an administrative reason we discuss further in the next section, or other unspecified reasons. Four percent of enrollees wanted to leave their HMOs, but felt they couldn't, largely for reasons of affordability, i.e., health care outside the HMO was too expensive or non-HMO doctors don't accept Medicare assignment. Compared to 1993, a larger proportion of enrollees in 1996 (93 % vs. 84%) said they were staying with their HMOs, and a smaller proportion (4 % vs. 10%) said they couldn't leave even though they wanted to.

In 1993 and 1996, disenrollees' most important reasons for leaving were a move, complaints about provider choices and availability, and costs of HMO membership; in 1996, 18 percent cited difficult access to medical care, including poor quality care.

Three major categories account for 91 percent of disenrollees' most important reasons for leaving their HMOs: administrative actions (31%), the health care delivery system itself (42%), and access to medical services (18 %) (see Table 15).*** Difficulties with

*** See Table D-9 for a more details on disenrollees' most important reasons for leaving their HMOs .

prescription drug coverage was the main reason for 4 percent of disenrollments; another 6 percent were due to a general desire for better care or a combination of reasons

Table 15: Disenrollees' Most Important Reasons for Leaving Their HMOs

	Percent	Beneficiaries
ADMINISTRATIVE REASONS (total)	31%	11,262
HEALTH CARE DELIVERY SYSTEM (total)	42%	15,190
► Provider problems: doctors/hospitals not conveniently located, no longer with HMO, not enough choice of or disliked doctors/hospitals; preferred provider not with HMO	20%	7,064
► Cost only or cost vs. service benefit (excluding Rx) too high; another HMO was better deal	8%	2,867
► Discomfort/dislike of HMO way of doing business; HMO not what expected based on enrollment information	6%	2,026
► Combination of reasons/other reasons, e.g., other coverage (VA, Medicaid)	9%	3,233
ACCESS TO MEDICAL SERVICES (total)	18%	6,779
► Poor quality medical care: wrong diagnosis/treatment, treatment delayed/denied/limited, getting sicker/not getting better, hospital discharge too soon, seen by personnel other than doctor.	5%	1,778
► Difficulties with appointments, referrals; quality or access compromised by emphasis on cost	4%	1,512
► Not personally well-treated by PCP/HMO personnel (rudeness, complaints ignored, doctor rushed or disinterested)	2%	869
► Combination of or other access problems, e.g., billing disputes or HMO slow to pay providers	7%	2,620
PRESCRIPTION DRUGS needed too expensive, not covered; drug coverage may have changed since enrollment	4%	1,301
General desire for better care or combination of reasons among categories	6%	2,055

► **Administrative reasons for disenrollment,** as we defined them, are business or procedural actions to end a beneficiary's HMO membership. They account for nearly a third of Medicare HMO disenrollments, but they have little to do, at least ostensibly, with HMO health care delivery or access to medical services. Absence from the HMO service area (17%) and changes in membership status, such as changing plans within the HMO (11%), were the most frequently reported administrative reasons. A few disenrollees (2%) cited involuntary reasons such as clerical error or an unpaid premium. In 1993, 29 percent of disenrollees reported ending their HMO memberships for administrative reasons, most often because of a planned move out of the service area.

► **Health care delivery system reasons are** related to the HMO infrastructure and ways of doing business, and they account for 42 percent of disenrollees' most important reasons for leaving. Reasons related to provider problems (20%) is the largest group within the category. Within this category, 9 percent of disenrollees didn't believe they had enough choices in HMO doctors or hospitals, or they wanted to use providers not currently associated with their HMOs. Another 8 percent said they left because their doctors or hospitals were no longer HMO providers; some followed their doctors to new HMOs. Nine percent felt their doctors or hospitals were not conveniently located. In keeping with their concerns about affordability and service coverage mentioned earlier, 8 percent of disenrollees left because HMO costs or costs versus service benefits were too high. Some disenrollees went to other HMOs they perceived as "a better deal. " Six percent left for reasons related to their discomfort with or dislike of their HMOs way of providing care; that is, some felt the HMO rules too restrictive while others found the HMOs were not what they expected from the marketing materials in terms of cost, covered services or restrictions on services. In 1993, the choice of primary HMO doctors and high beneficiary expenses were the two most important disenrolhnent reasons as well.

► **Access to medical services problems** accounted for 18 percent of the disenrollees' most important reasons for leaving their HMOs. Five percent reported poor quality medical care which includes a technical component (wrong diagnosis or treatment) as well as service access complaints, such as delayed, denied or limited treatments, or premature hospital discharges. Four percent encountered difficulty in making appointments and securing referrals, and compromised service access or quality due to a emphasis on holding costs down. Another 3 percent left because that they were not personally well-treated by their doctors or HMOs, which affected their service access. Seven percent mentioned a combination of these or other service access difficulties.

RECOMMENDATIONS

Overall, beneficiary responses about their HMO experiences in 1996 present a picture of good access to care, and program improvements since our 1993 beneficiary survey. In 1996, as in 1993, the majority of HMO disenrollees and enrollees reported medical care that maintained or improved their health, timely doctors' appointments, and good access to most Medicare-covered services. Since 1993, improvement is evident in the problem areas of inappropriate screening of health status at application, difficulty with making appointments by telephone, going out-of-plan for needed services, doctors' failure to take beneficiaries health complaints seriously, and disenrollees' perceptions that HMO care made their health worse.

A comparison of our 1993 and 1996 data also shows, however, that several problems have persisted with beneficiaries' understanding of and accessing services in the Medicare risk HMO program. While we initially recommended these same improvements, with HCFA concurrence, in 1995 based on our 1993 data, our 1996 data indicate these issues remain important today. Therefore, we strongly urge HCFA to make a concerted effort to refine and, perhaps intensify, its oversight of the Medicare risk HMO program in conjunction with its on-going improvement efforts. Other recent OIG reports, dealing specifically with problems in Medicare appeal and grievance processes,[36] and with Medicare's oversight of HMO performance and implications for Regional staffing,[37] support and amplify the following six recommendations:

- **HMOs should be more closely monitored to assure that they properly inform beneficiaries about their appeal and grievance rights.** In 1996, as in 1993, a substantial group of beneficiaries did not know about their appeal and grievance rights. Of the beneficiaries who did not know about their right of formal complaint, over half said they would have filed if they had known. We believe that beneficiaries' understanding of appeal and grievance rights is extremely important considering the lock-in and gate-keeper features of HMO enrollment and potential problems with service access. The facts that 7 percent of HMO beneficiaries perceived their primary HMO doctors did not take their health complaints seriously, and 15 percent thought that holding down the cost of care was most important to their HMOs further underscore this issue.

- **Beneficiaries should be better informed about HMO procedures for obtaining services.** Adequately informing beneficiaries about lock-in and the primary physician's role as gatekeeper is a Federal requirement. Failure to inform them can lead beneficiaries to incur medical expenses that Medicare will not cover and/or to disenroll from their HMOs. From the beginning, 14 percent of beneficiaries didn't know they needed referrals from their primary HMO doctors to see a specialist, and 5 percent weren't aware they could only use HMO doctors and hospitals except for emergent care and urgent care outside the service area.

- **Service access problems encountered by functionally limited, disabled, and chronically ill beneficiaries should be identified and carefully monitored, as they are especially vulnerable.** In 1993, we reported that disabled/ESRD disenrollees most often reported access problems in several crucial areas of their HMO care. Many disabled/ESRD enrollees wanted to leave their HMOs. In this report, the beneficiaries with more serious health conditions and with functional limitations in activities of daily living, as well as disabled beneficiaries, are reporting the same types of problems with their care.

- **Medicare risk HMOs should be monitored for inappropriate screening of beneficiaries' health status at application.** In 1996, 18 percent of beneficiaries reported being asked at application about their health problems. While this is an impressive drop from the 1993 rate of 43 percent, it indicates the possibility of ongoing health screening and selective enrollment by HMOs.

- **HCFA should systematically collect and track over time HMO-specific beneficiary-reported data on access to medical services through their HMOs and reasons for disenrolhuent.** Such HMO-specific data could strengthen information given to beneficiaries in making decisions about HMO enrollment. In addition, the data could be a powerful management tool that allows the development of performance standards and trends over time and the ability to judge if problems are pervasive or confined to specific HMOs. We also recommend the data collection cover the specifics of the process and experience of accessing services through the HMOs, rather than merely relying on general ratings or satisfaction scales.

- **HCFA should distinguish between administrative and non-administrative disenrolhuents.** Thirty-one percent of disemollees left their HMOs for administrative reasons such as moving from the service area or being switched between plans within the HMO. These reasons have little to do with HMOs' health care delivery or access to medical services. If HMO disenrollment rates are to be used as performance indicators, as GAO has suggested,[38] to avoid misinformation HCFA should either exclude administrative disenrollments from their consumer information or treat them separately.

The 1996 survey data also suggest the need for improving women's health care.

- **HCFA should take steps to better inform older women about gynecological services and health.** While we developed this recommendation from an HMO beneficiary survey, the educational need it suggests may be pertinent to all Medicare women. Among all women respondents, 23 percent didn't know if their HMOs required a referral to see a gynecologist. While this appears to be a specific instance of their being uninformed about HMO procedures, it may also indicate the women don't know because they haven't tried to make appointments for gynecological services. In fact, another 25 percent of the women said they didn't need to see a gynecologist. However, the National Cancer Institute recommends that older women should regularly have pelvic examinations and Pap tests. Further, for Pap tests, there

is no upper age limit, and hysterectomy is not a reason to discontinue them. Finally, the *Healthy People 2000* goals suggest a mammogram every 2 years.

Additional Office of Inspector General Work

Another Inspector General report in progress is also intended to assist HCFA in its examination and management of HMO issues. From this survey data we are completing a more in-depth analysis of how the functionally limited, disabled, and chronically ill beneficiaries perceive their access to needed care and services through HMOs.

AGENCY COMMENTS

Health Care Financing Administration

We received comments from the Health Care Financing Administration (HCFA) on this report. HCFA concurred with all of the report's recommendations, listing for each the improvement strategies already in place or under development. The full text of HCFA's comments is in Appendix F.

ENDNOTES

1. This excludes the effect of the point-of-service option which was relatively new for the Medicare program at the time we completed the data collection phase of our study.

2. "Medicare Managed Care Plans, " October 1997, a monthly report prepared by Office of Managed Care, HCFA.

3. In recent years, HCFA has begun to broaden the range of service delivery options within the Medicare managed care program. In October 1995, HCFA issued guidelines to HMOs on offering a point-of-service (POS) option to Medicare enrollees. The POS benefit increases flexibility for Medicare HMO enrollees by allowing them to seek care outside the HMO's provider network, typically with higher cost-sharing, i.e. the HMO will provide partial reimbursement for out-of-network services. In January 1997, HCFA launched the Medicare Choices demonstration project designed to provide beneficiaries a wider variety of managed care plans and to extend managed care options to rural areas. The demonstration plans include four provider sponsored networks, a preferred provider organization and a "triple option" hybrid that lets members see gatekeeper physicians, other plan providers without a gatekeeper referral, or providers outside the plan.

4. "Beneficiary Perspectives of Medicare Risk HMOs" (OEI-06-9 l-00730), "Medicare Risk HMO Performance Indicators" (OEI-06-91-00734)

5. "HMO Customer Satisfaction Surveys, " OEI-02-94-00360
"Medicare HMO Appeal and Grievance Processes Overview, " OEI-07-94-00280
"Medicare HMO Appeal and Grievance Processes: Beneficiaries Understanding, " OEI-07-94-0028 1
"Medicare HMO Appeal and Grievance Processes: Survey of HMOs, " OEI-07-94-00282
"Medicare HMO Appeal and Grievance Processes: Review of Cases," OEI-07-94-00283

6. We excluded diabetes, lung problems and an "other" category of serious health problems so that we could compare our 1993 and 1996 data. In 1996, other conditions beneficiaries considered serious included problems with hypertension, arthritis and joints, circulation, vision, prostate, gall bladder, Alzheimer's disease and Parkinsonism.

7. Disenrollees reported 25 percent had at least one of the most serious conditions, 20 percent had at least one functional limitation in the most basic activities of daily living, and 7 percent were disabled. Enrollee reports for the same categories were

29 percent in most ill, 18 percent most functionally limited, and 4 percent were disabled.

8. These data exclude the responses from beneficiaries who joined the sampled HMO through their or their spouse's work (12 %).

9. The length of enrollment in the HMO did not seem to affect beneficiary responses. The proportion of beneficiaries reporting health questions and required physical examinations at application was nearly the same for beneficiaries who had been enrolled for more than 12 months and for 12 months or less. (≥ 12 months, Q5 and 7)

10. An additional concern is that these indicators are based only on responses from beneficiaries who did enroll in an HMO. We cannot know, for this study, the experience of those who considered HMO membership, but did not enroll.

11. In 1993, we specifically asked beneficiaries about their experiences at application. However, some HMOs conducted a health assessment interview shortly after enrollment. If some of these responses referred to such health assessments, this may have inflated our 1993 data.

Health questions at application:
(1993) When you applied for HMO membership, were you asked about your health problems? Don't count questions about kidney failure or hospice coverage.

(1996) Before you actually joined the HMO, did an HMO representative ask you about your health problems? Don't count questions about kidney failure or hospice coverage.

Required physical exam:
(1993) Were you required to have a physical exam before you could join the HMO?
(1996) Were you required to have a physical exam before the HMO would let you join?

12. We did not ask about awareness of grievance rights in 1993.

13. Office of Inspector General, OEI-07-96-00281, December 1996.

14. We did not ask, for example, if beneficiaries had general knowledge of their right to complain. Instead, we referred to an HMO's refusal to provide or pay for services, which is closer to the example of "not being provided Medicare covered services."

15. Office of Inspector General, OEI-07-94-00282, December 1996.

16. Office of Inspector General, OEI-07-94-00283, December 1996.

17. Responses about appointments do not include waits for routine annual exams that a beneficiary might schedule well ahead of time or routine follow-up visits, such as a quarterly check-up.

18. The proportions of beneficiaries who had seen a doctor or had received services through the HMO while a member were similar irrespective of their enrollment status or length of enrollment.

Comparison of Beneficiaries Who Received Services by Length of Enrollment		
Stratum	**≤ 12 months**	**> 12 months**
Enrollees	**88.17 (83.3 - 92.5)**	**95.46 (89.0 - loo)**
Disenrollees	**90.85 (84.9 - 96.8)**	**96.59 89.7 - loo)**

19. *Healthy People* 2000 - *199.596 Review,* National Center for Health Statistics, Hyattsville, MD: Public Health Service: Department of Health and Human Services, 1996.

20. Additional services in this category are wheelchair or walker (6 %), non-emergency surgery (6 %), non-emergency hospital stays (4 %), nurse services (4%), and other services such as routine gynecological services, second opinions, diagnostic tests such as x-rays, eye and hearing exams (27%).

21. HCFA has instructed risk plans at section 2104.1 of the HMO/CMP Manual that emergency services "must be, or appear to be, needed immediately.. . . Do not retroactively deny a claim because a condition which appeared to be an emergency, turns out to be non-emergency in nature." In section 2105, urgently needed care are services "required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or injury."

22. We probably should not assume cause and effect here. For example, women may say they don't need to see a gynecologist because getting a referral is difficult or because of a mistaken belief that they don't need gynecological services because of age.

23. "Cancer Facts," Cancemet from the National Cancer Institute, last modified in March 1994.

24. Some literature indicates this attitude toward the older patient is a problem generally and is not necessarily confined to one particular care setting.

25. Twenty-four percent of disenrollees also said their doctors' refusal to order tests was an indicator of not taking their complaints seriously compared to 12 percent of enrollees. Other category (29% to 30%) includes doctor rushed or did a superficial exam, did nothing or seemed to ignore the beneficiary, did not answer questions, blamed the complaint on depression, just prescribed medication, said the complaints were not serious or important, or refused to make a referral to a specialist.

26. Fishman, Paul, Michael VonKorff, Paula Lozana and Julia Hect. "Chronic Care Costs in Managed Care," *Health Affairs*, May/June 1997, pp. 239-247.

27. McArthur, John H., D.B.A, and Francis D. Moore, M.D., "The Two Cultures and the Health Care Revolution: Commerce and Professionalism in Medical Care," *Journal of the American Medical Association,* 1997:277:985-989.

28. Ware Jr., John E., Martha S. Bayliss, William H. Rogers, Mark Kosinski and Alvin R. Tarlov. "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-For-Service Systems," *Journal of the American Medical Association,* 1996:276: 13: 1039-1047.

29. Morgan, Robert O., Beth A. Virnig, Carolee DeVito and Nancy A. Persily , "The Medicare-HMO Revolving Door -- The Healthy Go In and The Sick Go Out," The *New England Journal of Medicine,* July 17, 1997, pp. 169-75.

30. We classified beneficiaries as chronically ill if they reported at least one condition from the list of heart condition, heart attack, cancer, kidney failure, stroke or diabetes, and as functionally limited if they reported at least one limitation from a list of activities of daily living, i.e., problems with bathing or showering, using the toilet, getting in and out of bed, or climbing one flight of stairs.

31. Disabled disenrollees and enrollees comprise only 24 percent and 12 percent, respectively, of the functionally limited populations.

32. Lamphere, Jo Ann, Patricia Neuman, Kathryn Langwell, and Daniel Sherman, "The Surge in Medicare Managed Care: An Update," *Health Affairs*, May/June 1997, 16:3: 127-133.

33. Lamphere, et al., May/June, 1997.

34. Four percent of beneficiaries followed their doctors to the sampled HMO. Other reasons for joining given as the most important by 9 percent of disenrollees and 14 percent of disemollees include HMO membership was part of retirement plan or union benefit, less paperwork than regular Medicare, a replacement for services no longer available at military bases, or convenient source of medical care.

35. U . S . General Accounting Office, "Medicare HMOs: Potential Effects of a Limited Enrollment Period Policy," GAO/HEHS-97-50, February 1997.

"Medicare HMO members who disenroll and change to fee for service tend to use more services and more costly procedures than the average beneficiary under fee for service. Consequently, Medicare spends more money to serve an HMO member who changes to fee for service than it would have paid to the HMO to care for that beneficiary. "

36. "Medicare HMO Appeal and Grievance Processes, " Office of Inspector General, OEI-07-94-00280 to OEI-07-94-00283, December 1996.

37. "Medicare's Oversight of Managed Care: Monitoring Plan Performance," OEI-01-96-00190
"Medicare's Oversight of Managed Care: Implications for Regional Staffing, " OEI-01-96-00191

38. U.S. General Accounting Office, "Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance, " GAO/HEHS-97-23, October 1996.

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APPENDIX A

METHODOLOGY

Definition of access

Beyond referencing medical necessity and an actual or likely adverse effect on the beneficiary, the law and regulations do not clearly delineate what full access to services through an HMO means, In order to construct a survey instrument that adequately covered access to services, we adapted a definition from literature.[1,2] Basically, it uses five dimensions (availability, accessibility, accommodation, affordability, and acceptability) that represent the degree of "fit" between the patient and the health care system, e.g. existing services and the patient's medical needs, or price of services and the patient's ability to pay. To tailor the survey for Medicare risk HMOs, we expanded the idea of service availability to include the role of gatekeepers, primary physicians or others associated with the HMO, in preventing or facilitating beneficiaries' receipt of covered services. Operationally, we divided access into five areas: appointments, including waiting time and administrative processes for making them; restrictions on medical services; incidence and reasons for out-of-plan care; behavior of primary HMO doctors and other HMO personnel towards beneficiaries; and beneficiary awareness of appeal and grievance rights.

Sample selection

From HCFA's Group Health Plan (GHP) data base, we selected a two-stage random sample, stratified at the second stage.

At the first stage, we selected Medicare risk HMOs[3] from those under contract with HCFA as of June 1996. From a total of 208 risk HMOs, we excluded 76 because they: 1) had not been enrolling Medicare beneficaries for at least 6 months as of June 1996, 2) did not have at least 100 enrollees who had been members for 3 months or longer as of June 1996, or 3) did not have at least 60 disenrollees from March 1996 through June 1996 who had been members for 3 months or longer. We set these restrictions to avoid collecting data on HMOs and beneficiaries with little Medicare HMO experience and to assure an adequate sampling universe per HMO. From the remaining 132 HMOs, we randomly selected 40.

At the second stage, we selected Medicare beneficiaries from each sampled HMO. The universe of beneficiaries for each sampled HMO contained two strata -- Medicare beneficiaries (enrollees) who were enrolled as of June 1996 and Medicare beneficiaries (disenrollees) who had disenrolled from March 1996 through June 1996 for reasons other than death. From each sampled HMO, after excluding enrollees and disenrollees who had not been members for at least 3 months, we randomly selected 51 enrollees and 51 disenrollees. While we could have selected a proportional sample of beneficiaries, we chose not to because of a planned but separate analysis of the same data at the HMO level. Instead, for this report, we weighted the beneficiary data as described below.

Finally, using HCFA's Enrollment Data Base, we dropped beneficiaries who had died or who appeared as current enrollees, but had actually disenrolled since the last update to the GHP file. This process resulted in 2,038 enrollees and 2,027 disenrollees for a total of 4,065 beneficiaries.

Scope and data collection

Since this study's primary focus is the Medicare beneficiaries' perceptions of their risk HMO experiences, we only collected information from them. We surveyed both enrollees and disenrollees to compare their responses, and thus, to gain greater insight into HMO issues. We did not contact HMOs or their staffs, nor did we attempt to assess the quality or propriety of medical care rendered by the HMOs to these beneficiaries. We initially mailed structured survey forms to 4,065 beneficiaries in early August 1996. In mid-September 1996, we mailed a follow-up letter and second survey form to non-respondents; we closed data collection in October 1996.

With the exception of four questions on overall ratings of their HMO experiences, we did not directly and specifically ask beneficiaries about their satisfaction with the HMOs. Instead we asked for more concrete details on beneficiaries' perceptions and experiences, such as, how long were waits for appointments, or how often, if ever, did a primary physician fail to take health complaints seriously. Both enrollees and disenrollees provided information on sample and demographic data, enrollment experience, past health status and functional level, cost of HMO membership, HMO environment, and available HMO services. Additionally, enrollees were asked about current health status and future plans for HMO membership while disenrollees were asked about health status at disenrollment and reasons for disenrollment.

A total of 3,229 survey forms were returned. Of these, 3,003 were usable[4] yielding an unweighted return rate of 74 percent overall, 82 percent for enrollees (N= 1,665) and 66 percent for disenrollees (N = 1,338).

Weighting and interpretation

We weighted the collected data to reflect a non-response bias, differences in enrollment size among the sampled HMOs, and distribution of enrollees and disenrollees in the universe. To determine non-response bias, we tested unweighted data for differences of means and proportions to discern significant differences between respondents and non-respondents by four demographic characteristics -- age, race, sex and number of months enrolled in the sampled HMO. Since significant differences did exist, we conservatively weighted the sample to approximate the response rate per stratum per sampled HMO.' The weighted data also approximates the relative Medicare enrollment sixes of the sampled HMOs and the disproportionate distribution of enrollees and disenrollees in the universe (97% vs. 3%) for the sampling period.[6] For 1996, disenrollees from the sampled HMOs were about 13 percent of enrolled HMO members. We calculated this by taking the mean of the 1996 disenrolhnents for the sampled HMOs.

The results are generalizable to the 132 HMOs described in the sampling section, but not to those that didn't meet our sampling parameters. However, the beneficiary universe from which we sampled our enrollees and disenrollees was 96 percent and 99 percent, respectively, of enrollees and disenrollees who were members of all 208 HMOs for 3 months or longer.[7] Further, our universe of enrollees and disenrollees was 87 percent and 85 percent of all Medicare risk enrollees and disenrollees.

Because of the imbalance between enrollees and disenrollees, we primarily analyzed the two groups separately.[8] Comparisons between enrollees and disenrollees, or sub-populations of them form the basis for all tables in this report, particularly when these groups differed markedly in reporting their HMO experiences. All tables show the weighted percentages with the weighted number of respondents in parentheses.' Additionally, we computed 95% confidence intervals and statistical significance for key questions (see Appendix B). A few of the confidence intervals are quite broad, particularly for disenrollees, due to the small number of responses for some questions.

Comparability of 1993 and 1996 data

A core set of questions on enrollment experience and access to services appears in both the 1993 and 1996 survey forms. Throughout the report, we present this comparative data for key questions. One caveat is that for our 1993 study of beneficiary perspectives of Medicare risk HMOs, we selected the sample somewhat differently. At the first stage, selection of HMOs, we divided the universe into three strata based on disenrollment rates because we intended to study the usefulness of disenrollment rates as performance indicators. Our focus with the 1996 data does not include that line of inquiry. Also in 1993, we did not place any sampling limits on the length of an HMO's participation in the Medicare risk program or on its enrollment size. At the second stage, selection of beneficiaries, the processes were similar in 1993 and 1996 except that in 1993 we did not exclude beneficiaries who had less than three months' experience with the sampled HMO. However, a comparison of 1993 key questions, tabulated with and without responses from beneficiaries enrolled less than three months, usually showed a small difference of 1 percentage point or less.

Despite the differences in sample selection, the HMOs and beneficiaries sampled in 1993 and 1996 appear to have similar characteristics in the same proportions (see Appendix C). The HMOs are predominantly IPA models and for-profit. Enrollees and disenrollees are predominantly female, white, age 65 or older, and high school graduates or higher. The average length of enrollment in the sampled HMOs, calculated from HCFA data, is shorter in 1996. This is not surprising, however, given the rapid growth in the Medicare risk HMO program between 1993 and 1996. One difference is that a higher percentage of enrollees in 1996 report prior experience with HMO care before enrolling in the sampled HMO.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

APPENDIX A - ENDNOTES

1. Penchansky, Roy, DBA, and J. William Thomas, PhD, "The Concept of Access: Definition and Relationship to Consumer Satisfaction, " *Medical Care,* February 1981, 12:2: 127-140.

   Thomas, J. William, PhD, and Roy Penchansky, DBA, "Relating Satisfaction With Access to Utilization of Services, " *Medical Care,* June 1984, 22:6:553-568.

2. The Penchansky and Thomas five dimensions of access to services are:

   a. *Availability* - the relationship of the volume and type of existing services (and resources) to the client's volume and types of need. It refers to the adequacy of supply of medical providers, facilities and specialized programs and services, such as mental health and emergency care.
   b. *Accessibility* - the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost.
   c. *Accommodation* - the relationship between the manner in which the supply resources are organized to accept clients (including appointment systems, hours of operation, walk-in facilities, telephone services) and the client's ability to accommodate to these factors and the client's perception of their appropriateness.
   d. *Affordability* - The relationship of prices of services and the providers' insurance (or deposit requirements) to client's income, ability to pay and existing health insurance. Client perception of worth relative to total cost is a concern, as is client knowledge of prices, total cost and possible credit arrangements.
   e. *Acceptability* - the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients. In turn, providers have attitudes about the preferred attributes of clients or their financing mechanisms. Providers may be unwilling to serve certain types of clients or, through accommodation, make themselves more or less available.

3. Actually, the sample is a mix of HMOs and competitive medical plans (CMP). Since the rules governing their particpation in the Medicare risk program are the same, we use HMO to refer to both.

4. Of the 3,229 returned survey forms, 226 were not usable: 58 were returned for bad addresses, with no known forwarding address; 129 were not usable because the beneficiary was deceased or was unwilling/unable to complete the survey form; 39 were not usable because the beneficiary's responses indicated (s)he may not be

referring to the sampled HMO, or few to none of the key questions were answered.

5. The range of response rates for unweighted data per HMO was 59 percent to 92 percent for enrollees and 43 percent to 84 percent for disenrollees.

6. Formulas used to weight data:

Enrollees

$$\frac{\text{HMO universe (N = 132)}}{\text{HMO sample (N = 40)}} \times \frac{\text{Enrollee universe per sampled HMO}}{\text{Sampled enrollees per HMO}}$$

Disenrollees

$$\frac{\text{HMO universe (N = 132)}}{\text{HMO sample (N = 40)}} \times \frac{\text{Disenrollee universe per sampled HMO}}{\text{Sampled disenrollees per HMO}}$$

7.

Comparison of Beneficiary Universe Size			
Stratum	**≥ 3 months (132 HMOs)**	**≥ 3 months (208 HMOs)**	**All members (208 HMOs)**
Enrollees	3,218,351	3,335,189	3,719,713
Disenrollees	110,539	112,015	130,436

8. For those tables that do not show the proportion of all beneficiaries answering a question, that proportion is usually the same as or one point (+/-) that of the proportions shown for enrollees.

9. Respondents did not answer every survey question. Many respondents were not eligible to answer every item because the survey form used screening questions. Thus, the weighted value of the beneficiaries eligible to answer varied by question. Some beneficiaries simply did not answer questions for which they were eligible. To accommodate these two factors, we calculated a response rate for each question based on the weighted value of eligible respondents. Questions with response rates of less than 50% are not reported. The majority of questions had response rates of 80 % to 99 % . In addition, percentages throughout the report are based only on the weighted responses to each question, not on the weighted value of all survey respondents.

APPENDIX B

Point Estimates, Confidence Intervals and Statistical Significance for Key Survey Questions

Table B-l : Point Estimates, Confidence Intervals, and Statistical Significance for Key Questions

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

	Enrollees				Disenrollees		
Proportion of beneficiaries:	Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval
✓ Believed care given by PCP was good to excellent.	90.78	1.22	88.4 - 93.2	**	71.97	2.75	66.6 - 77.4
✓ Believed HMO was good to excellent in orovidina needed services.	91.49	1.oo	89.5 - 93.5	**	69.06	3.08	63.0 - 75.1
✓ Believed HMO rules made getting needed services easy or very easy.	66.92	1.86	63.3 - 70.6	**	51.80	3.45	45.0 - 58.6
✓ Believed HMO was definitely worth the cost of Medicare and/or HMO premiums.	57.11	2.14	52.9 - 61.3	**	44.99	3.73	37.6 - 52.2
Health at enrollment was:							
▸ good to excellent	74.92	1.32	72.3 - 77.5		71.30	2.16	67.1 - 75.6
▸ fair	20.83	1.19	18.5 - 23.2		23.85	2.18	19.6 - 28.1
▸ poor to very poor	4.25	0.65	3.0 - 5.5		4.81	.91	3.0 - 6.6
Health at time of survey was:							
✓ ▸ good to excellent	69.17	1.45	66.3 - 72.0	**	63.12	2.06	59.1 - 67.2
▸ fair	25.50	1.47	22.6 - 28.4		26.28	1.46	23.4 - 29.1
✓ ▸ poor to very poor	5.33	0.70	4.0 - 6.7	**	10.60	1.61	7.4 - 13.8
✓ Reported medical care through HMO caused health to:							
▸ improve	43.28	1.75	39.9 - 46.7	**	29.56	2.05	25.5 - 33.6
▸ worsen	2.57	0.57	1.5 - 3.7	**	11.31	1.73	7.9 - 14.7
Asked at application about health problems.	17.74	1.91	14.0 - 21.5		19.90	4.05	12.0 - 27.8
Didn't know they could change their minds about enrolling after they applied.	8.96	1.46	6.1 - 11.8		14.97	2.10	10.9 - 19.1
Didn't know PCPs must give referrals to specialists.	13.68	1.36	11.O - 16.3		13.96	2.28	9.5 - 18.4

Table B-l : Point Estimates, Confidence Intervals, and Statistical Significance for Key Questions

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

Proportion of beneficiaries:	Enrollees				Disenrollees		
	Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval
Didn't know they must use HMO doctors/hospitals (except emergency and urgent care outside service area).	4.84	0.86	3.2 - 6.5		5.71	1.16	3.4 - 8.0
✓ Didn't know they had the right to appeal HMOs' refusals to provide/pay for services.	26.67	1.78	23.2 - 30.2	**	35.26	2.02	31.3 - 39.2
✓ Didn't know they had the right to formally complain about other problems (grievance).	27.84	2.09	23.7 - 31.9	**	39.87	2.08	35.8 - 44.0
✓ Didn't know about both appeal and grievance rights.	23.72	1.87	20.1 - 27.4	**	33.88	1.93	30.1 - 37.7
✓ Were aware of complaint rights but had not filed.	71.86	1.96	68.0 - 75.7	**	58.52	1.97	54.7 - 62.4
✓ Did not file because they had no problems with HMO.	96.11	0.74	94.7 - 97.6	**	81.13	4.04	73.2 - 89.0
✓ Were aware of complaint rights and had filed.	2.92	0.56	1.8 - 4.0	**	7.19	1.97	3.3 - 11.1
Of these, didn't feel complaint was handled fairly.	35.87	10.97	14.4 - 57.4		41.59	13.7	14.7 - 68.4
Were not aware of rights, but would have filed if aware.	54.92	4.30	46.5 - 63.3		54.98	5.10	45.0 - 65.0
Waited for scheduled appointments w/PCPs:							
▸ 1 to 8 days	79.36	1.97	75.5 - 83.2		78.05	1.79	74.5 - 81.6
▸ 13 to >20 days	13.14	1.89	9.4 - 16.8		13.38	1.63	10.2 - 16.6
✓ Of those who had been very sick, didn't get an appointment within a day or two.	4.07	0.91	2.3 - 5.9	**	14.81	2.39	10.1 - 19.5

Table B-I: Point Estimates, Confidence Intervals, and Statistical Significance for Key Questions

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

Proportion of beneficiaries:	Enrollees				Disenrollees		
	Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval
Of those needing to see a specialist, waited for scheduled appointments:							
▸ 1 to 8 days	69.55	2.80	64.1 - 75.0		64.05	2.74	58.7 - 69.4
▸ 13 to >20 days	12.07	1.36	9.4 - 14.7		12.49	1.59	9.4 - 15.6
✓ Waited for PCP in office and exam room:							
▸ half hour or less	87.15	1.42	84.4 - 89.9	**	74.91	3.02	69.0 - 80.8
▸ longer than half hour	12.85	1.42	10.1 - 15.6	**	25.09	3.02	19.2 - 31 .o
✓ Encountered busy appointment telephones:							
▸ all to most of time	9.74	1.34	7.1 - 12.4	**	15.65	1.69	12.3 - 19.0
▸ a few times to never	82.62	1.61	79.5 - 85.8	**	75.82	2.12	71.7 - 80.0
✓ Gave up trying to make appointments due to busy telephone lines.	5.57	1.27	3.1 - 8.1	**	12.12	1.51	9.2 - 15.1
✓ PCP failed to provide needed Medicare-covered services:							
▸ yes	3.36	0.65	2.1 - 4.6	**	12.13	1.73	8.7 - 15.5
▸ no	96.64	0.65	95.4 - 97.9	**	87.87	1.73	84.5 - 91.3
✓ Of those needing to see a specialist, PCP never failed to give referral.	95.01	0.76	93.5 - 96.5	**	85.82	2.27	81.4 - 90.3
✓ Of those who had health problems, PCP usually explained all treatment options.	89.63	0.90	87.4 - 91.4	**	77.05	2.19	72.8 - 81.3
✓ Were seen only by a member of doctor's staff when they had doctor's appointment.	6.97	0.88	5.2 - 8.7	**	15.91	2.16	11.7 - 20.1
✓ Of these, happened 2 to >3 times in last 6 months.	41.90	7.07	28.0 - 55.8	ns	53.48	8.55	36.7 - 70.2

Table B-l : Point Estimates, Confidence Intervals, and Statistical Significance for Key Questions

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

Proportion of beneficiaries:	Enrollees				Disenrollees		
	Point Estimate	Standard Error	95% Confidence interval		Point Estimate	Standard Error	95% Confidence interval
✓ Women who were offered a: Pap test	58.21	3.27	51.8 - 64.6	**	50.10	2.47	45.3 - 55.0
mammogram	70.59	2.78	65.1 - 76.0	**	59.63	2.72	54.3 - 65.0
Beneficiaries who were offered none of preventive or screening services.	5.05	1.03	3.0 - 7.1		7.07	1.95	3.2 - 10.9
✓ Of those needing non-routine services, had to wait for HMO pre-approval.	12.67	2.13	8.5 - 16.8	**	23.57	2.56	18.6 - 28.6
✓ Of these, waited for HMO pre-approval 5 times in last 6 months.	0.97	0.99	0.0 - 2.9	**	6.99	3.18	0.8 - 13.2
✓ Of these, waited for pre-approval:							
▸ C I day to 6 days	54.93	7.46	40.3 - 69.6	ns	41.63	6.47	28.9 - 54.3
▸ 3 weeks or longer	13.73	4.06	5.8 - 21.7	**	26.87	9.10	9.0 - 44.7
✓ Had sought out-of-plan care.	5.82	0.91	4.0 - 7.6	**	10.26	1.63	7.1 - 13.5
Of these, believed they:							
▸ needed the care even if HMO would not approve it.	32.88	4.82	23.4 - 42.3		32.44	7.33	18.1 - 46.8
✓ ▸ wouldn't have to pay for it.	2.77	1.61	0.0 - 5.9	* *	19.54	7.06	5.7 - 33.4
✓ Of those using emergent or urgent care services, HMO refused to pay.	10.25	2.24	5.9 - 14.6	**	20.13	4.12	12.1 - 28.2
✓ Of women answering re: HMO policy for requiring a referral to a gynecologist, said:							
▸ referral required	34.08	3.46	27.3 - 40.9	**	60.79	4.62	51.7 - 69.8
▸ don't know	38.01	3.14	31.9 - 44.2	**	15.75	3.19	9.5 - 22.0
✓ Of women <u>not</u> answering regarding HMO policy for a referral to a gynecologist, said they didn't need to see a gynecologist.	64.33	3.91	56.7 - 72.0	**	80.41	5.76	69.1 - 91.7

Table B-l : Point Estimates, Confidence Intervals, and Statistical Significance for Key Questions

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

Proportion of beneficiaries:	Enrollees				Disenrollees		
	Point Estimate	Standard Error	95% Confidence interval		Point Estimate	Standard Error	95% Confidence Interval
✓ PCP at sometime had failed to take health complaints seriously.	7.00	.91	5.2 - 8.8	**	18.66	1.68	15.4 - 22.0
Of these, happened all to most of time	28.25	7.74	13.0 - 43.4		40.46	5.34	30.0 - 50.9
✓ Believed most important to PCP was:							
▸ giving best care possible	73.94	1.75	70.1 - 77.4	**	57.27	2.88	51.6 - 62.9
▸ holding down cost of care	7.08	0.85	5.4 - 8.7	**	14.96	2.39	10.3 - 19.6
✓ Believed most important to HMO was:							
▸ holding down cost of care	15.03	1.13	12.8 - 17.2	**	26.50	2.64	21.3 - 31.7
▸ giving best care possible	61.66	1.52	58.7 - 64.7	**	43.31	3.97	35.5 - 51.1
✓ Were encouraged to leave the HMO.	1.21	0.37	0.5 - 1.9	**	6.99	1.31	4.4 - 9.6
Most important reason for joining the HMO was wanting more affordable health care.	53.8	1.55	50.8 - 56.8		54.73	3.00	48.9 - 60.6
✓ Would be less likely to join an HMO if required to remain a member for a year.	16.37	1.05	14.3 - 18.4	**	33.25	3.20	27.0 - 39.5
Enrollees who had no plans to leave their HMOs	92.70	.89	91 .o - 94.4				
Disenrollees who left their HMOs for administrative reasons.					30.79	6.26	18.5 - 43.1

Table B-2: Point Estimates, Confidence Intervals, and Statistical Significance for Key 1993-96 Questions

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

Proportion of beneficiaries:	Enrollees			Disenrollees		
	1993 Point Estimate and 95% Confid. interval	1996 Point Estimate and 95% Confid. interval		1993 Point Estimate and 95% Confid. interval	1996 Point Estimate and 95% Confid. interval	
✓ Asked at application about health problems	42.9% (35.4 - 50.4)	17.7% (14.0 - 21.5)	**	48.3% (39.5 - 57.1)	19.9% (12.0 - 27.8)	**
✓ Encountered busy appointment telephones all to most of time	18.8% (13.2 - 24.4)	9.7% (7.1 - 12.4)	**	34.2% (24.3 - 44.0)	15.7% (12.3 - 19.0)	**
✓ PCP at sometime didn't take health complaints seriously	11.6% (8.6 - 14.5)	7.0% (5.2 - 8.8)	**	38.8% (27.6 - 50.1)	18.7% (15.4 - 22.0)	**
✓ Reported medical care through HMO caused health to worsen	NA	NA		21.9% (12.8 - 31.1)	11.3% (7.9 - 14.7)	**
✓ Had sought out-of-plan care	NA	NA		22.1% (15.5 - 28.7)	10.3% (7.1 - 13.5)	**
✓ PCP didn't fail to provide needed Medicare-covered services.	NA	NA		78.1% (70.0 - 86.2)	87.9% (84.5 - 91.3)	**
Believed holding down cost of care was most important to:						
▸ primary care physician	9.6% (5.9 - 13.3)	7.1% (5.4 - 8.7)		27.6% (17.6 - 37.5)	15.0% (10.3 - 19.6)	
▸ HMO	10.8% (8.3 - 13.4)	15.0% (12.8 - 17.2)		35.0% (25.5 - 44.4)	26.5% (21.3 - 31.7)	

APPENDIX C

DEMOGRAPHIC COMPARISON OF 1993 AND 1996 DATA

BY BENEFICIARY
Weighted Data

Demographics	Enrollees '93	Enrollees '96	Disenrollees '93	Disenrollees '96
SEX				
Female	60% (650,984)	56% (1,226,765)	53% (1 5,065)	55 % (34,004)
Male	40% (433,067)	44% (968,928)	47% (13,139)	45% (27,910)
RACE/ETHNICITY				
White	90% (966,213)	83% (1,81 2,704)	88% (24,872)	82% (50,565)
Non-White	7% (80,352)	11% (242,742)	12% (3,332)	8% (5,243)
Unknown	3% (37,486)	6% (140,247)	0	10% (6,106)
AVERAGE AGE	74 Years	73 Years	73 Years	72 Years
EDUCATION				
< Than High School	25% (268,473)	20% (432,333)	20% (5,683)	19% (11,564)
High School Diploma	29% (312,201)	30% (648,906)	22% (6,238)	24% (15,226)
> Than High School	42% (460,539)	44% (978,774)	49% (1 3,778)	45% (27,790)
No Response	4% (42,838)	6% (135,679)	9% (2,504)	12% (7,335)
MEDICARE CATEGORY				
Aged	97% (1,052,538)	96% (2,098,465)	92% (25,907)	93% (57,687)
Disabled/ESRD[1]	3% (31,513)	4% (97,229)	8% (2,296)	7% (4,227)
HMO EXPERIENCE				
Prior Experience	14% (148,072)	26% (560,948)	21% (5,997)	21% (1 2,996)
No Experience	82% (887,056)	66% (1,451,278)	71% (19,905)	71% (39,212)
No Response	4% (48,923)	8% (183,466)	8% (2,302)	8% (4,853)
AVERAGE LENGTH OF TIME IN HMO	36 Months	34 Months	29 Months	21 Months

BY HMO

YEAR	MODEL TYPES			TAX STATUS		STATES
	IPA	Group	Staff	Profit	Nonprofit	Number
1993 (N=45)	30 (67%)	9 (20%)	6 (13%)	33 (73%)	12 (27%)	22
1996 (N=40)	29 (73%)	8 (20%)	3 (8%)	28 (70%)	12 (30%)	19

[1] For the 1996 survey, no ESRD beneficiaries were selected in the disenrollee sample.

APPENDIX D

SUPPLEMENTARY TABLES FOR BENEFICIARY SURVEY FINDINGS

Table D-l: Beneficiaries' Health and Functional Status

	Enrollees		Disenroliees	
	1993	1996	1993	1996
While in the HMO, reported no serious health problems, e.g. broken bones or cancer. *	67% (653,180)	61% (1 ,177,968)	69% (16,440)	64% (43,058)
	Enrollees 1996		Disenrollees 1996	
While in the HMO, reported no serious health problems which include diabetes, lung problems, and "other".	46% (971,796)		49% (28,578)	
Had no functional limitations (activities of daily living).	68% (1,439,410)		71% (40,898)	
Had no serious health problems and no functional limitations.	41% (834,681)		43% (24,392)	

* For comparative purposes, excludes diabetes, lung problems, and "other" category of serious health problems reported by beneficiaries.

Table D-2: Beneficiary Self-Reported Changes in Health Status - 1996

		Enrollees' Health at Enrollment				Disenroiiee ;' Health at Enrollment		
Health Now *	Total	Excellent to Good (75%)	Fair (21%)	Poor to Very Poor (4%)	Total	Excellent to Good (73%)	Fair (22%)	Poor to Very Poor (5%)
Excellent to Good	(69%)	86% (1,250,683)	23% (91,596)	7% (5.994)	(64%)	83% (26,745)	10% (962)	9% (205)
Fair	(25%)	12% (181,654)	70% (283,944)	36% (27,672)	(26%)	13% (4,059)	70% (13,418)	25% (563)
Poor to Very Poor	(5%)	2% (61,794)	8% (31,147)	57% (44,349)	(11%)	4% (1,353)	20% (1.896)	66% (1,460)

* In 1996, 67% of enrollees and 60% of disenroliees had been enrolled in the sampled HMOs for more than 12. months.

Table D-3: Appointment Times				
	Enrollees		Disenrollees	
	1993	1996	1993	1996
Were able to get a doctor's appointment in a day or 2 when they were very sick.	94% (636,620)	96% (1,048,575)	65% 114,579)	85% 126,301)
For a scheduled appointment with their primary HMO doctors, usually waited:				
► 1 to 4 days	52% (484,306)	58% (990,519)	52% (11,876)	49% (24,800)
► 5 to 8 days	26% (245,809)	22% (375,635)	23% (5,325)	29% (14,819)
. 9 to 12 days	6% (58,994)	8% (129,013)	7% (1,594)	9% (4,349)
► 13 to more than 20 days	16% (150,632)	13% (226,212)	18% (4,219)	13% (6,972)
	Enrollees 1996		Disenrollees 1996	
For a scheduled appointment with specialists, usually waited:				
. 1 to 4 days	40% (5 19,608)		32% (I 0,473)	
► 5 to 8 days	30% (394,210)		33% (10,822)	
► 9 to 12 days	13% (1 68,415)		17% (5,601)	
↗ 13 to more than 20 days	18% (23 1,604)		19% (6,351)	
Usually waited in the office and exam room before seeing their primary HMO doctors:				
► less than 1/2 hour	87% (I ,767,833)		75% (40,707)	
► 1/2 hour to 1 hour	12% (236,776)		21% (1 1,604)	
. more than 1 hour	1% (23,847)		4% (2,032)	

Table D-4: Appointment Handled by Nurse or Technician - 1996			
	All	Enrollees	Disenrollees
Seen only by a nurse or technician when beneficiary had an appointment with primary HMO doctor.	7% (150,091,	7% (141,467)	16% (8,624)
In the last 6 months, for those who could remember, this happened:			
► 1 time	58% (54,028)	59% (51,976,	47% (2,052)
► 2 times	30% (19,954)	30% (18,670)	29% (1,284)
► 3 times or more	12% (11,051)	11% (10,021)	24% (1,030)

Table D-5: Non-Routine Services - 1996			
	All	Enrollees	Disenrollees
Experienced delays in non-routine services because HMO had to approve them first.	13% (184,653)	13% (175,330)	24% (9,323)
Non-routine services for which they experienced delays.			
► referrals to specialists	63% (113,305)	63% (106,919)	69% (6,386)
. physical therapy	24% (43,287)	25% (42,338)	10% (949)
► special tests, e.g., CAT scan, stress test	17% (31,012)	17% (29,182)	20% (1 ,830)
In the last 6 months, waited for HMO approval of non-routine services:			
► 1 or 2 times	77% (118,448)	77% (113,150)	64% (5,298)
► 3 or 4 times	21% (31,919)	20% (29,753,	26% (2.161)
► 5 or more times	3% (4,235)	2% (3,425)	10% (810)
In the last 6 months, usually waited for HMO approval:			
► less than 1 day to 6 days	54% (83,384)	55% (80,05 1)	42% (3,333)
► 1 to 2 weeks	31% (48,204)	31% (45,681)	32% (2,523)
. 3 weeks or longer	14% (22,157)	14% (20,006)	27% (2,151)

Table D-6: Routine Preventive and Screening Services Offered in the Last Year Compared to Healthy People 2000 Goals'

Q35	Healthy People 2000		Enrollees			Disenrollees		
Standard	Goal	Progress	All	≤12 mos.	>12 mos.	All	≤12 mos.	>12 mos.
Pap test: women aged ≥70 w/ uterine cervix;[2] received test w/in preceding 1 to 3 yrs.	70%	53% 1994	58% (634,286)	53% (184,504)	61% (449,781)	50% (14,689)	36% (4,155)	59% (10,533)
mammogram: women aged ≥70 who received breast exam and test w/in preceding 2 years	60%	45% 1994	71% (769,140)	64% (223,060)	74% (546,080)	60% (17,515)	49% (5,616)	66% (11,899)
prostate cancer screen: men aged ≥50 received digital rectal exam during the last year	40%	38% 1992	58% (502,610)	60% (160,553)	57% (342,057)	59% (13,990)	53% (3,917)	62% (3,917)
blood pressure reading: no standard that approximated our data	NA	NA	83% (1,633,243)	83% (512,760)	84% (1,120,483)	83% (43,781)	78% (14,704)	85% (29,077)
blood cholesterol screen: adults (>17yrs) who had blood cholesterol checked w/in preceding 5 yrs	75%	54% 1993 w/in 2 years	65% (1,275,300)	61% (380,930)	67% (894,370)	65% (34,346)	59% (11,146)	68% (23,200)
colon cancer screen:								
▸ fecal occult blood test w/in preceding 2 years	50%	36%[3]	31% (608,881)	30% (188,429)	31% (420,452)	27% (14,312)	20% (3,669)	31% (10,643)
▸ proctosigmoidoscopy ever received	40%							
flu shot:[4] older people	80%	NA	63% (1,241,580)	52% (321,218)	69% (920,362)	61% (32,053)	43% (8.137)	70% (23,916)
pneumonia immunization: older people	80%	NA	36% (697,195)	29% (181,448)	39% (515,747)	32% (1 6,978)	29% (5,369)	34% (11,609)
none of these services offered	NA	NA	5% (98,974)	6% (37,193)	5% (61,781)	7% (3,708)	9% (1.646)	6% (2,061)

[1] Does not include beneficiaries who said they had not seen an HMO doctor or had not received any health care services through the HMO while they had been a member.

[2] Number of sampled Medicare women with uterine cervix is unknown.

[3] 36% in 1992, people aged ≥65 who had fecal blood test with a routine checkup in past 2 years

[4] Since this is a seasonal service, the rate for > 12 months is probably a more accurate indicator within the beneficiary data.

Table D-7: Seeking Out-of-Plan Care				
	Enrollees		Disenrollees	
	1993	1996	1993	1996
Beneficiaries who went out-of-plan	7% (65,629)	6% (113,168)	22% (5,187)	10% (5,144)
	Enrollees 1996		Disenrollees 1996	
Beneficiaries went out of plan because:				
. Needed care even if HMO would not approve	32% (36,715)		32% (1,662)	
. Temporarily out of service area	19% (22,077)		25% (1,287)	
▸ Couldn't get HMO services quickly enough	15% (16,657)		11% (588)	
▸ Didn't think they would have to pay	3% (3,148)		20% (1,001,	
. Primary HMO doctor wouldn't make referral to specialist	9% (9,819)		10% (512)	
▸ Primary HMO doctor wasn't helping beneficiary	8% (9,187)		12% (612)	

Table D-8: Other Components of Enrollment Decisions - 1996			
	All	Enrollees	Disenrollees
Immediately before joining the HMO, source of health care was:			
. another HMO	28% (573,944,	28% (560,948,	23% (12,996)
. non-HMO doctor	54% (1,113,451)	54% (1,080,283)	58% (33,168)
▸ no regular source	15% (300,241)	15% (291,207)	16% (9,034)
. other	4% (81,651)	4% (79,788)	3% (1,863)
Beneficiaries who pay no HMO premium.	43% (933,966,	43% (910,814)	39% (23,152)
Of those who do pay a premium, the monthly amount s:			
▸ $1 to $19	29% (296,430)	28% (288,107)	27% (8,323)
▸ $20 to $39	30% (321,103)'	30% (306,954)	45% (14,149,
. $40 to $59	29% (298,032)	29% (293,810)	14% (4,222)
▸ $60 to $79	6% (87,226)	6% (85,167)	7% (2,059)
. $80 or more	4% (44,185)	4% (41,735)	8% (2,450)

Table D-9: Disenrollees' Most Important Reasons for Leaving Their HMOs		
	Percent	Beneficiaries
ADMINISTRATIVE REASONS (total)	31%	11,262
▸ Moved or frequently out of service area	18%	6,439
▸ Membership ended involuntarily (clerical error, HMO no longer part of retirement benefit, unpaid premium)	2%	819
. Changed plan within HMO, or other administrative change	11%	4,004
HEALTH CARE DELIVERY SYSTEM (total)	42%	15,190
▸ Discomfort/dislike of HMO restrictions or way of doing business	3%	996
. HMO not what expected based on enrollment information (costs, covered services, or restrictions)	3%	1,030
▸ Cost only or cost vs. service benefit (excluding Rx) too high; another HMO was better deal	8%	2,867
▸ Doctors/hospitals not conveniently located	3%	1,110
▸ Doctors or hospitals no longer with HMO; may have followed doctor to new HMO	8%	2,735
. Not enough choice of or disliked doctors/hospitals; preferred provider not with HMO	9%	3,219
▸ Joined another HMO; no specific reason given	2%	831
. Other coverage (e.g. Medicaid, VA) or setting (e.g. nursing home)	4%	1,292
▸ Combination of reasons/other reasons	3%	1,110
ACCESS TO MEDICAL SERVICES (total)	18%	6,779
. Appointment difficulties	1%	392
. Billing disputes or HMO slow to pay providers	1%	376
. Referral problems (denied or difficult access to services)	2%	846
. Not personally well-treated by PCP/HMO personnel (rudeness, complaints ignored, doctor rushed or disinterested)	2%	869
• Poor quality medical care (wrong diagnosis/treatment, treatment delayed/denied/limited, getting sicker/not getting better, hospital discharge too soon, seen by personnel other than doctor).	5%	1,778
. Quality or access compromised by emphasis on cost	1%	274
. Combination of or other access problems	6%	2,244
'RESCRIPTION DRUGS needed too expensive, not covered; drug :overage may have changed since enrollment	4%	1,301
;eneral desire for better care or combination of reasons among :ategories	6%	2,055

Table D-IO: Enrollees' Plans for Future Health Care		
	1993	1996*
Had no plans to leave their present HMOs.	84% (771,929,	93% (1,803,200)
Planned to leave because of a move.	2% (22,317)	1% (16,514)
Planned to leave for reasons other than moving.	4% (37,02 1)	3% (50,780)
Couldn't leave, but wanted to.	10% (93,774)	4% (74,479)

* Does not total 100% due to rounding.

APPENDIX E

SUPPLEMENTARY AND STATISTICAL TABLES FOR FUNCTIONALLY LIMITED, DISABLED, AND CHRONICALLY ILL BENEFICIARIES

Table E-l: Beneficiary Perspectives and Functional Limits - 1996

	Enrollees		Disenrollees	
Service Access Through Physician	≥1 Limit	No Limits	≥1 Limit	No Limits
Received appointment with physician w/in l-2 days when verv sick.	92% (233,233)	97% (768,985)	87% (7,320)	84% (17,717)
Primary physician explained treatment options.	85% (280,598)	91% (1,143,058)	68% (6,742)	79% (25,390,
Physician failed to give needed Medicare-covered services.	8% (26,111)	2% (35,857)	20% (2,047)	11% (4,136)
Physician failed to admit beneficiary to hospital when needed.	3% (6.110)	1% (8,241)	8% (522)	4% (660)
Physician failed to refer beneficiary to a specialist when needed.	6% (11,235)	5% (58,280)	25% (2,072)	12% (3,313)
	Enrollees		**Disenrollees**	
Physician Attitudes/HMO Administration	≥ 1 Limits	No Limits	≥ 1 Limits	No Limits
Physician did not take health complaints seriously.	16% (58,381)	5% (72,319)	24% (2,418)	17% (6,444)
Cost most important to primary physician	9% (25,475)	8% (1 14,317)	27% (1,795)	18% (5,631)
Experienced delays in receiving non-routine services in past 6 months.	16% (41,497,	11% (123,089)	30% (2,589)	22% (6,495)
fase of obtaining care was:				
▸ easy or very easy	55% (184,029)	70% (1,092,719)	40% (4,388)	55% (21,128)
▸ neither easy nor hard	35% (1 16,287)	26% (408,357)	29% (3,198)	28% (1 0,837)
▸ hard or very hard	11% (35,229)	5% (70,889)	31% (3,468)	16% (6,225)

Table E-2: Beneficiary Perspectives and Medicare Status - 1996				
	Enrollees		Disenrollees	
Service Access Through Physician	Aged	Disabled	Aged	Disabled
Received appointment with physician w/in l-2 days when very sick.	96% (982,645,	95% (63,365)	85% (23,952,	87% (2,330)
Primary physician explained treatment options.	89% (1,399,300)	92% (73,799)	78% (31,090)	61% (2,176)
Physician failed to give needed Medicare-covered services.	3% (62,609,	4% (3,233)	11% (5,265)	27% (970)
Physician failed to admit beneficiary to hospital when needed.	1% (12,747)	4% (2,061)	4% (829)	19% (377)
Physician failed to refer beneficiary to a specialist when needed.	4% (64,581)	16% (12,935)	13% (4,586)	36% (918)
	Enrollees		Disenrollees	
Physician Attitudes/HMO Administration	Aged	Disabled	Aged	Disabled
Physician did not take health complaints seriously.	7% (127,608)	13% (11,106)	17% (7,943)	39% (1,441)
Cost most important to primary physician.	9% (138,033)	5% (4,030)	20% (7,135)	24% (516)
Experienced delays in receiving non-routine services in past 6 months.	12% (159,867)	23% (15,463)	23% (8,222)	34% (1,101)
Ease of obtaining care was:				
▸ easy or very easy	68% (1,283,272)	45% (40,033)	52% (24,640)	45% (1,640)
▸ neither easy nor hard	27% (517,876)	31% (26,971)	29% (13,834)	18% (659)
▸ hard or very hard	5% (85,526)	24% (21,226)	18% (8,616)	37% (1.364)

Table E-3: Beneficiary Perspectives and Chronic Illness - 1996

Service Access Through Physician	Enrollees		Disenrollees	
	Chron. Ill	Not Ill	Chron. Ill	Not Ill
Received appointment with physician w/in l-2 days when verv sick.	96% (391,906)	97% (617,497,	86% (9,342)	86% (16,033)
Primary physician explained treatment options.	89% (500,790)	90% (916,539,	76% (10,132)	77% (22,086)
Physician failed to give needed Medicare-covered services.	5% (30,957)	3% (33,800)	9% (1 ,237)	14% (4,804)
Physician failed to admit beneficiary to hospital when needed.	2% (6,140)	2% (7,871)	8% (675)	3% (491)
Physician failed to refer beneficiary to a specialist when needed.	6% (28,345)	5% (48,883)	17% (2,043)	13% (3,237)
Physician Attitudes/HMO Administration	**Enrollees**		**Disenrollees**	
	Chron. Ill	Not Ill	Chron. Ill	Not Ill
Physician did not take health complaints seriously.	8% (48,558)	7% (89,932)	17% (2,282)	19% (6,704)
Cost most important to primary physician.	8% (38,964)	8% (93,132)	18% (1,874)	20% (5,359)
Experienced delays in receiving non-routine services in past 6 months.	12% (56,667)	13% (111,513)	32% (3,718)	20% (5,207)
Ease of obtaining care was:				
▸ easy or very easy	70% (403,291)	65% (861,301)	57% (7,733)	50% (17,760)
▸ neither easy nor hard	23% (131,778)	30% (395,847,	24% (3,314)	30% (10,462)
▸ hard or very hard	7% (37,884)	5% (64,139,	19% (2,600)	20% (7,017)

Table E-4: Point Estimates, Confidence Intervals, and Statistical Significance by Functional Status

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

		1 + Functional Limits				No Functional Limits		
	Proportion of beneficiaries:	Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval
	Received appointment with physician w/in 1-2 days when very sick.							
	▸ enrollees	91.55	3.59	84.5 - 98.6		97.42	0.73	96.0 - 98.9
✓	▸ disenrollees	88.64	3.25	82.3 - 95.0	ns	83.65	2.71	78.3 - 89.0
	Primary physician explained treatment options.							
✓	▸ enrollees	84.99	2.64	79.8 - 90.2	**	91.23	0.90	89.5 - 93.0
✓	▸ disenrollees	68.47	5.21	58.3 - 78.7	**	79.10	2.87	73.5 - 84.7
	Physician failed to give needed Medicare-covered services.							
✓✓	▸▸ enrollees disenrollees	19.84 7.88	4.13 2.93	11.7 2.1 -- 13.6 28.0	****	10.65 2.30	0.46 1.70	7.3 1.4 -- 14.0 3.2
	Physician failed to admit beneficiary to hospital when needed.							
✓	▸ enrollees	2.89	1.55	0.0 - 6.0	ns	1.19	0.44	0.3 - 2.1
✓	▸ disenrollees	8.18	3.08	2.1 - 14.2	ns	3.99	1.69	0.8 - 7.3
	Physician failed to refer beneficiary to a specialist when needed.							
	▸ enrollees	6.38	2.28	1.9 - 10.8		4.91	0.95	3.0 - 6.8
✓	▸ disenrollees	25.16	5.31	14.8 - 35.6	**	11.56	1.82	8.0 - 15.1

Table E-4: Point Estimates, Confidence Intervals, and Statistical Significance by Functional Status

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

	1 + Functional Limits				No Functional Limits			
Proportion of beneficiaries:	Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval	
Physician did not take health complaints seriously.								
✓ ► enrollees	16.39	3.29	9.9 - 22.8	**	4.64	0.68	3.3 - 6.0	
✓ ► disenrollees	23.90	3.69	16.7 - 31.1	**	16.62	2.19	12.3 - 20.9	
Cost most important to primary physician.								
► enrollees	9.37	2.70	4.1 - 14.7		8.35	0.98	6.4 - 10.3	
► disenrollees	26.59	5.29	16.2 - 37.0		18.63	3.01	12.7 - 24.5	
Experienced delays in receiving non-routine services in past 6 months.								
► enrollees	16.17	3.75	8.8 - 23.5		11.37	2.35	6.8 - 16.0	
► disenrollees	29.76	6.86	16.3 - 43.2		22.07	2.42	17.3 - 26.8	
Ease of obtaining care was easy or very easy								
✓ ► enrollees	54.84	3.30	48.4 - 61.3	**	69.51	2.09	65.4 - 73.6	
✓ ► disenrollees	39.70	5.50	28.9 - 50.5	**	55.32	3.67	48.1 - 62.5	
Ease of obtaining care was neither easy nor hard								
✓ ► enrollees	34.66	3.23	28.3 - 41 .O	**	25.98	1.90	22.3 - 29.7	
► disenrollees	28.93	3.83	21.4 - 36.4		28.38	2.50	23.5 - 33.3	
Ease of obtaining care was hard or very hard								
✓ ► enrollees	10.50	2.63	5.3 - 15.7	**	4.51	0.78	3.0 - 6.0	
✓ ► disenrollees	31.38	2.42	20.2 - 42.6	**	16.30	2.42	11.6 - 21.0	

Table E-5: Point Estimates, Confidence Intervals, and Statistical Significance by Medicare Status

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

		Age 65 or Older				Disabled		
	Proportion of beneficiaries:	Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval
	Received appointment with physician w/in 1-2 days when very sick.							
	▸ enrollees	96.01	0.93	94.2 - 97.8		94.56	3.33	88.0 - 100.0
	▸ disenrollees	85.00	2.41	80.3 - 89.7		87.09	6.40	74.5 - 99.6
	Primary physician explained treatment options.							
	▸ enrollees	89.47	0.91	87.7 - 91.3		92.03	3.09	86 0 - 98.1
✓	▸ disenrollees	78.48	2.55	73.5 - 83.5	**	61.03	8.83	43.7 - 78.3
	Physician failed to give needed Medicare-covered services.							
	▸ enrollees	3.36	0.68	2.0 - 4.7		3.67	2.02	0.0 - 7.6
✓	▸ disenrollees	11 .oo	1.61	7.8 - 14.2	**	27.54	8.91	10.1 - 45.0
	Physician failed to admit beneficiary to hospital when needed.							
	▸ enrollees	1.44	0.48	0.5 - 2.4		4.01	2.69	0.0 - 9.3
✓	▸ disenrollees	3.82	1.40	1.1 - 6.6	**	19.23	8.87	1.8 - 36.6
	Physician failed to refer beneficiary to a specialist when needed.							
✓	▸ enrollees	4.40	0.68	3.1 - 5.7	**	16.26	6.10	4.3 - 28.2
✓	▸ disenrollees	12.65	2.04	8.7 - 16.6	**	36.15	8.27	19.9 - 52.4

Table E-5: Point Estimates, Confidence Intervals, and Statistical Significance by Medicare Status

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

	Proportion of beneficiaries:	Age 65 or Older				Disabled		
		Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval
	Physician did not take health complaints seriously.							
	▸ enrollees	6.75	0.93	4.9 - 8.6		12.83	5.38	2.3 - 23.4
✓	▸ disenrollees	17.05	1.86	13.4 - 20.7	**	39.27	8.24	23.1 - 55.4
	Cost most important to primary physician.							
	▸ enrollees	8.54	1.05	6.5 - 10.6		5.42	3.20	0.0 - 11.7
	▸ disenrollees	19.77	3.13	13.6 - 25.9		23.68	9.27	5.5 - 41.8
	Experienced delays in receiving non-routine services in past 6 months.							
	▸ enrollees	12.17	2.04	8.2 - 16.2		23.49	10.15	3.6 - 43.4
	▸ disenrollees	22.65	2.29	18.2 - 27.1		33.94	11.68	11 .O - 56.8
	Ease of obtaining care was easy or very easy.							
		68.02	1.84	64.4 - 71.6	**	45.37	7.80	30.1 - 60.7
✓	▸ enrollees	52.33	3.59	45.3 - 59.4		44.77	8.16	28.8 - 60.8
	▸ disenrollees							
	Ease of obtaining care was neither easy nor hard							
	▸ enrollees	27.45	1.68	24.2 - 30.7		30.57	7.22	16.4 - 44.7
✓	▸ disenrollees	29.38	2.04	25.4 - 33.4	**	17.99	6.74	4.8 - 31.2
	Ease of obtaining care was hard or very hard							
✓	▸ enrollees	4.53	0.74	3.1 - 6.0	**	24.06	6.15	12.0 - 36.1
✓	▸ disenrollees	18.30	3.00	12.4 - 24.2	**	37.24	8.91	19.8 - 54.7

Table E-6: Point Estimates, Confidence Intervals, and Statistical Significance by Health Status

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

		Chronically Ill				Not Chronically Ill		
	Proportion of beneficiaries:	Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval
	Received appointment with physician within 1-2 days when very sick.							
	▸ enrollees	86.50	3.20	79.2 - 92.0		85.56	0.97	83.7 - 88.5
	▸ disenrollees							
	Primary physician explained treatment options.							
	▸ enrollees	88.90	2.13	84.7 - 93.1		90.39	1.51	87.4 - 93.3
	▸ disenrollees	75.76	3.33	69.2 - 82.3		77.47	2.68	72.2 - 82.7
	Physician failed to give needed Medicare-covered services.							
✓	▸ enrollees	5.38	1.76	1.9 - 8.8	**	2.60	0.63	1.4 - 3.8
	▸ disenrollees	8.77	3.13	2.6 - 14.9		13.63	2.50	8.7 - 18.53
	Physician failed to admit beneficiary to hospital when needed.							
	▸ enrollees	1.60	0.78	0.1 - 3.1		1.51	0.59	0.4 - 2.7
✓	▸ disenrollees	7.80	2.76	2.4 - 13.2	**	3.43	1.78	0.0 - 6.9
	Physician failed to refer beneficiary to a specialist when needed.							
	▸▸ enrollees disenrollees	17.42 5.57	4.11 2.01	9.4 1.6 -- 25.5 9.5		12.76 5.00	0.99 2.75	7.4 3.1 -- 18.2 6.9

Table E-6: Point Estimates, Confidence Intervals, and Statistical Significance by Health Status

KEY: ✓ = statistical significance tested ** = difference is significant at .05 level ns = not significant at .05 level

		Chronically Ill				Not Chronically Ill		
	Proportion of beneficiaries:	Point Estimate	Standard Error	95% Confidence Interval		Point Estimate	Standard Error	95% Confidence Interval
	Physician did not take health complaints seriously.							
	▸ enrollees	8.38	2.68	3.1 - 13.6		6.80	1.02	4.8 - 8.8
	▸ disenrollees	17.36	2.73	12.0 - 22.7		18.87	2.26	14.4 - 23.3
	Cost most important to primary physician.							
	▸ enrollees	7.79	1.78	4.3 - 11.3		8.26	1.10	6.1 - 10.4
	▸ disenrollees	18.48	5.23	8.2 - 28.7		19.83	3.45	13.1 - 26.6
	Experienced delays in receiving non-routine services in past 6 months.							
	▸ enrollees	12.07	2.41	7.3 - 16.8		12.93	2.56	7.9 - 17.9
✓	▸ disenrollees	32.17	5.14	22.1 - 42.4	**	19.69	2.82	14.2 - 25.2
	Ease of obtaining care was easy or very easy							
✓	▸ enrollees	70.39	2.46	65.6 - 75.2	ns	65.19	2.29	60.7 - 69.7
	▸ disenrollees	56.66	7.97	41.0 = 72.3		50.40	2.86	44.8 - 56.0
	Ease of obtaining care was neither easy nor hard							
✓	▸ enrollees	23.00	2.25	18.6 - 27.4	**	29.96	2.89	24.3 - 35.6
	▸ disenrollees	24.29	4.13	16.2 - 32.4		29.69	2.13	25.5 - 33.9
	Ease of obtaining care was hard or very hard							
	• enrollees	6.61	1.42	3.8 - 9.4		4.85	0.91	3.1 - 6.6
	▸ disenrollees	19.05	5.23	8.8 - 29.3		19.91	2.73	14.6 - 25.3

APPENDIX F

TEXT OF AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 – 0001

DATE: MAR 1 3 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Arm Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Beneficiary Perspectives of Medicare Risk Health Maintenance Organizations (HMOs)," (OEI-06-9500430)

We have reviewed the above referenced draft report which describes beneficiaries' experiences with their Medicare risk HMOs in 1996.

Medicare beneficiaries may join a risk HMO through the Medicare program. In return for a predetermined monthly amount per enrollee, the HMO must provide all Medicare-covered services that are medically necessary, except hospice care. Once enrolled, beneficiaries are usually required to use HMO physicians and hospitals. As of October 1997, the Health Care Financing Administration (HCFA) reported 307 risk HMO plans serviced 5,049,296 Medicare enrollees.

Using HCFA databases, OIG selected a two-stage random sample of 4,065 enrollees and disenrollees from 40 Medicare risk HMOs. Since the report's primary focus was Medicare beneficiaries' experiences in their risk HMOs, OIG collected information directly from them. As in the study conducted in 1993, OIG surveyed both enrollees and disenrollees to compare their responses, and to gain greater insight into HMO issues.

HCFA concurred with all OIG recommendations. Our detailed comments are as follows:

OIG Recommendation 1

HMOs should be more closely monitored to assure that they properly inform beneficiaries about their appeal and grievance rights.

HCFA Response

We concur. HCFA is striving to improve beneficiary outreach and education, especially for beneficiaries in HMOs, to make them aware of their appeal and grievance rights. HCFA will also be working with the Information Counseling and Assistance (ICAs) grantees and beneficiary advocacy groups to promote further education to beneficiaries in this area.

We would add, however, that HCFA's existing monitoring protocol and the review of member and marketing materials that takes place by HCFA Regional Office staff, already incorporates distinct functional components that evaluate plans on their ability to communicate clearly Medicare beneficiaries' appeal and grievance rights. In addition, Medicare beneficiaries are advised of their appeal rights each time a service claim is denied or service authorization is denied, limited or reduced. HCFA reviews member and marketing materials on an ongoing basis. Claims and service denials are audited for compliance at least every two years, and on an as-needed basis.

OIG Recommendation 2

Beneficiaries should be better informed about HMO procedures for obtaining services.

HCFA Response

We concur. The newly developed Medicare managed care database (Medicare Compare) will assist in improving beneficiaries' understanding of procedures and restrictions within managed care plans. The May version of the database will include information about choice of doctors and whether referrals to specialists are needed. For example, data for each plan will display one of the following scenarios with respect to physician access: limitations to the plan's network of physicians, limitations to group practice physicians, no restrictions to physicians and/or whether the plan offers an out of network option. If an enrollee is limited to physicians within the group practice, the database will indicate if referrals to specialists are needed.

In addition to *Medicare Compare,* HCFA and its regional offices now can use the *Medicare Managed Care Marketing Guidelines* to assist them in oversight activities that relate to *this* issue. For instance, *the Marketing Guidelines* provide health plans with a model evidence of coverage document that contains standardized definitions, including terms such as *exclusion, covered service, services not covered* and *prior authorization.* We believe that use of *the Marketing Guidelines* will assist HCFA staff in its compliance efforts, and will help ensure that Medicare beneficiaries receive consistent information.

OIG Recommendation 3

Service access problems encountered by functionally limited, disabled, and chronically ill beneficiaries should be identified and carefully monitored, as they are especially vulnerable.

HCFA Response

We concur. Admittedlv, HCFA's ability to monitor access for all Medicare beneficiaries enrolled in managed care plans has been limited. We believe, however, that HCFA's Quality Improvement System for Managed Care (QISMC) will strengthen our ability to define and enforce geographically-relevant access-to-care standards. Historically, HCFA's and States' reviews of managed care plans have focused on structural standards

that have looked at a plan's infrastructure and capacity to provide adequate access to care, or to improve care, as opposed to looking at whether the plan actually provided adequate access to care across all of its populations, including functionally limited, disabled, and chronically ill populations. In addition to defining and elaborating on what HCFA's expectations are with regard to health plans' internal quality assessment and performance improvement, QISMC contains a separate domain and substandard that is intended to ensure that the health plan's service planning takes into account the needs of its entire membership and the organization works to reduce barriers to access. QISMC standards will apply to both Medicare +Choice plans and health plans contracting with State Medicaid agencies for the Medicaid population. These standards will serve as the basis for HCFA reviewers to monitor plans' performance and compliance based on data. For purchasers, including HCFA and state Medicaid agencies, QISMC will elaborate on the "tools" available and develop a strategy for purchasers to use to improve the care of their beneficiaries. Purchasers have a responsibility to use available data and work with plans to improve the quality of care they deliver. Such tools include standards, publishing data, technical assistance and collaborative quality improvement projects, and incentives.

In addition to QISMC, the Health of Seniors component of HEDIS will help HCFA assess whether Medicare beneficiaries believe they receive adequate access to health care services. This survey will reach 1,000 Medicare beneficiaries in all contracting health plans, including presumably, beneficiaries who are functionally limited, disabled or chronically ill.

OIG Recommendation 4

Medicare risk HMOs should be monitored for inappropriate screening of beneficiaries' health status at application

HCFA Response

We concur. We agree that the issue identified in the report warrants carefully regulatory attention from HCFA. We would add, however that HCFA, through its Regional Offices, already monitors health plan adherence to prohibitions against pre-enrollment health screening. This is accomplished as follows:

(1) HCFA staff review all pre-enrollment member, marketing and enrollment materials to be certain that contracting health plans do not attempt to screen individuals by asking questions relating to health status. Health plans may ask if the beneficiary is in a hospice, has end stage renal disease, is eligible for Medicaid, or whether the beneficiary is in an institution, such as a nursing home, sanatorium or long term care hospital. Health plans cannot utilize materials not otherwise approved in advance by the HCFA regional office staff.

(2) HCFA requires that all contracting health plans incorporate the requirements mentioned earlier into the organization's training and employee education programs. HCFA staff review companies' printed policies and procedures to be certain that applicable requirements germane to health screening are fully incorporated into the documents. HCFA staff routinely review these materials during monitoring reviews.

(3) HCFA staff interview health plans' marketing directors and marketing staff to assess their level of understanding of health screening requirements and prohibitions.

OIG Recommendation 5

HCFA should systematically collect and track over time HMO-specific beneficiary-reported data on access to medical services through their HMOs and reasons for disenrolhnent.

HCFA Response

We concur. The report mentions that HCFA is planning to release HEDIS measures to the public. This is correct. We should point out that HEDIS contains 3 measures looking at access to services--adults' access to preventive/ambulatory health services, availability of primary care providers, and availability of behavioral health care providers. These data would support the recommendation that HCFA's data collections should go beyond relying on general ratings or satisfaction scales.

In addition, we have already added reasons for disenrollment to the form that the Social Security Administration uses when beneficiaries disenroll at district offices. The Medicare +Choice Hotline will use this form when it begins to accept disenrollments some time next year. We collect this information via the Enrollment Broker Demonstration.

OIG Recommendation 6

HCFA should distinguish between administrative and non-administrative disenrollments.

HCFA Response

We concur. HCFA is aware of the critical need to distinguish between administrative reasons for disenrollment and "for cause" reasons for disenrollment. HCFA is currently developing a more thorough listing of reasons for disenrolhnent from which beneficiaries can choose when asked why they are disenrolling.

OIG Recommendation 7

HCFA should take steps to better inform older women about gynecological services and health.

HCFA Response

We concur. The May version of Medicare Compare also has built in specifications about the annual gynecological exam benefit. For example, if enrollees are limited to physicians within the group practice, the database will provide further information about whether referrals are needed and it specifically makes reference when the annual gynecological exam does not require a referral from the primary care physician.

This information will be available on the Internet as well as print materials, e.g., 1998 Medicare Handbook. The data in Medicare Compare will be used to print out information by area to all 39 million beneficiaries. In essence, beneficiaries that live in the Washington, D.C. area will receive a hardcopy of plans that are offered in their local area and comparison information with respect to benefits and services provided by those plans including the information above. This effort is part of HCFA's overall public education campaign that will take place over the next year.

The beneficiary education plan for expanded Medicare prevention benefits in 1998 consists of two components:

> Phase I, the awareness campaign is a broad dissemination targeting the entire Medicare population. A one-page message focusing on informing the beneficiary about the availability of new prevention benefits, namely annual mammogram, pap smears and pelvic examinations, diabetes monitoring and self-management education, colorectal cancer screening, and bone mass measurement, was distributed to HCFA partners and contractors. In addition, the message contained information regarding other ongoing covered services (flu/pneumococcal pneumonia).
>
> Phase II, the health promotion campaign, will begin later in 1998. This phase is designed to encourage appropriate use of the prevention services by beneficiaries. In phase II, HCFA will join with the Center for Disease Control, Division of Cancer Prevention and Control, to develop a beneficiary health promotion campaign focusing on colorectal cancer screening. Depending upon the results of the market research, the health promotion campaign may also include pap smear and cervical cancer screening, and mammography. In addition, we are recommending expanding HCFA's National Mammography 2000 campaign to include pap smear and cervical cancer screening information. This would be accomplished using materials created by the National Cancer Institutes of the National Institute of Health and capitalizing on the information and dissemination strategies of the National Mammography 2000 effort. Strategies for promoting the use of diabetes monitoring and self-management education and bone mass measurement will be developed once regulations have been completed.