

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

SURVEYING MEDICARE HMO BENEFICIARIES



**NOVEMBER 1995
OEI-06-91-00737**

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This report describes the rationales for and protocols of surveying Medicare beneficiaries in risk HMOs.

In 1995, the Office of Inspector General completed a series of four reports on Medicare risk HMOs. We started in 1993 by surveying beneficiaries enrolled in or recently disenrolled from Medicare risk HMOs. We hoped to better understand enrollment procedures and service access issues from their perspective. Using the beneficiary data set, we also examined the enrollment procedures and access issues for the HMOs as a group, for individual HMOs, and for developing HMO performance indicators.

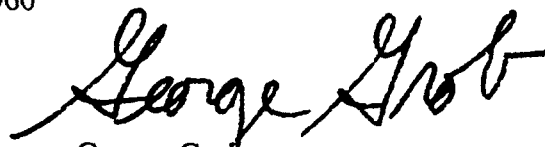
We selected a stratified, random sample of 4,132 enrollees and disenrollees from 45 Medicare risk HMOs in the Health Care Financing Administration's (HCFA) database. Of these, 2,882 beneficiaries returned usable surveys. Since our primary focus was Medicare beneficiaries' perceptions and experiences, we collected information directly from them. We did not attempt to validate their responses through record review or HMO contact, nor did we attempt to assess the quality or propriety of medical care rendered by the HMOs to these beneficiaries.

Our intent was not to prescribe specific corrective actions, but to identify, based on information from beneficiaries, areas apparently needing improvement and to suggest techniques HCFA can use to further monitor these areas.

As a follow-up to our first four reports, we prepared this one on survey protocols and summary findings for HCFA's internal use. HCFA staff, who may conduct or arrange for similar or related surveys in the future, had requested details of our survey methods and lessons learned about conducting such surveys. We hope this report will be useful to them and others interested in improving HMO services.

This report was prepared in the Dallas Regional Office of the Office of Evaluation and Inspections under the direction of Chester B. Slaughter, Regional Inspector General. Project staff included Michelle Adams and Judith Tyler, both of the Dallas Office.

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SURVEY GUIDELINES

OVERALL APPROACH: Why Do A Beneficiary Survey?

Our first reason for choosing a beneficiary survey as a method for studying Medicare risk HMOs was the particular issues on which we had focused. Generally, a serious concern about risk HMOs is that capitated payments, which will not vary with the actual services provided to enrollees, may encourage HMOs to provide fewer services than necessary or to restrict access to services. In addition, HMOs may possibly encourage disenrollment of beneficiaries whose expected medical costs will exceed the capitation rate. Our focus was to gauge the extent to which beneficiaries perceived Medicare risk HMOs provided needed health care, and if beneficiary disenrollment rates, either alone or combined with certain other factors, are a reliable HMO performance indicator. Directly asking beneficiaries detailed questions about their access to health services and reasons for leaving an HMO was, in our opinion, the best way to answer our study questions.

Our second reason for a beneficiary survey was our positive prior experience with these surveys. Beneficiaries have been an important and direct source of information about program effectiveness. We have conducted several annual surveys of Medicare beneficiaries to provide program managers feedback on topics such as claims processing experiences, knowledge of program rules and benefits, and use of program materials. We believe the results of our HMO beneficiary survey support our confidence in this method. (See Appendix A for summaries of the four reports in the HMO series.)

SAMPLING PLAN: Considerations For Choosing The Beneficiaries

To select our beneficiary sample, we needed a sampling technique that best suited our study focus and data analysis goals. We decided to use a stratified, two-stage sample in which the first stage would be selecting Medicare risk HMOs, and the second stage, beneficiaries associated with these HMOs.¹ The strata at the first stage were based on the HMO disenrollment rates for a defined period. At the second stage we categorized beneficiaries as currently enrolled or as recently disenrolled. We believed that this sampling technique would provide the greatest flexibility in data analysis. For example, if we had selected just current enrollees or just recent disenrollees, we could not know if, or how, their HMO experiences with service access were different. Without this contrasting data, we could not make any inferences about what is most likely to cause a beneficiary to leave or remain in an HMO. Another example is that selecting HMOs first permitted an analytical linkage between service access problems reported by beneficiaries and specific HMOs, HMO characteristics, or problem pervasiveness among HMOs.

SURVEY CONDUCT: Resources, Processes And Time Frames

We conducted the beneficiary survey with a core project team of three OIG program analysts over a 19-month period. The core team, who was responsible for the whole project, had substantial experience with project design and management, the Medicare program, interviewing techniques, survey construction, various methods of data analysis, and report layout and writing. In addition, other OIG personnel provided, at key junctures in the study process, support to the core project team in statistics, Spanish translation, sample selection, data management/tracking, data input, and administrative tasks. A computer system that could run DBase IV and SPSS-PC was used for data input and analysis. The overall process for completing the study included:

- ▶ ***Study Design (1 month):*** Selecting and developing a study focus, sampling frame and task schedule.
- ▶ ***Survey Construction (3 months):*** Researching, writing, pre-testing and revising the beneficiary survey instrument.
- ▶ ***Data Collection (3 months):*** Actual selection of sample, set-up of sample tracking log in DBase IV,² initial and second mailings of survey form, telephone interviews and follow-up with beneficiaries when necessary.
- ▶ ***Data Input (2 months):*** Concurrent with data collection, postcoding surveys where applicable, keying responses, and cleaning data for inconsistent, impossible or erroneous entries.
- ▶ ***Data Analysis (5 months):*** Finalizing analysis plan and actual data manipulation including non-response bias check, frequencies, cross-tabulations, measures of central tendency and variability, tests of statistical significance, and regression analyses.
- ▶ ***Report Writing (5 months):*** Determining content, organization, and number of reports supported by data analysis results; actual production of the draft reports issued for comment and revision.

SURVEY CONSTRUCTION: Accommodating Study Focus And Survey Population

- ▶ ***Study Focus:*** The primary focus of this study was the Medicare beneficiary's access to medical care through the HMO. We did not intend to study quality of care as such. Further, we specifically excluded a line of inquiry about beneficiary satisfaction with the HMOs, as the concept of satisfaction is less objective than, and sometimes independent of, the issues of membership in a Medicare risk HMO. Collateral information that we did solicit from the beneficiaries, however, was their demographic data, health status, and appraisal of HMO philosophy or priorities.

In order to construct a survey instrument that adequately covered access to services, we adapted a definition from the literature.^{3,4} 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 four areas: appointments, including waiting time and administrative processes for making them; restrictions on medical services; incidence and reasons for out-of-plan care; and behavior of primary HMO doctors and other HMO personnel towards beneficiaries.

To accommodate our study focus, the survey questions are written predominantly in terms of the processes of HMO membership, or the beneficiaries' perceptions of those processes. For example, instead of asking if the beneficiaries were satisfied with their primary physicians, we asked if they were referred for services when they believed they needed to be, or if their physicians took their health complaints seriously.

► **Survey Format:** We wrote two separate surveys (enrollee and disenrollee) in a parallel format. (See survey forms in Appendix D.) Each is divided into seven clearly labelled sections: 1) directions for completing the survey; 2) beneficiary demographics and self-assessment of their propensity to use medical services; 3) enrollment experience and understanding of HMOs; 4) self-reported health assessment; 5) and 6) coverage of the four operational areas defined for access to medical services, plus two questions on appeal rights; and 7) future plans for medical care (enrollees), or reasons for leaving an HMO (disenrollees). The sequence of the sections is basically chronological, starting with the time the beneficiaries enrolled and ending with their current status and evaluation of medical care received.

We also formatted the survey document in a user-friendly style that we thought was responsive to the needs of the study population. First, for easier reading, we used a larger (13-point) font and slightly expanded spacing between lines.⁵ Second, we used simple, one-idea questions with follow-up questions to capture details. For example, instead of asking "How often, if ever, did your primary HMO doctor fail to refer you to a specialist when you thought you needed to see one?" we asked two questions -- "Did your primary HMO doctor ever fail to refer you to a specialist..." AND "How often did your primary HMO physician fail to refer you to a specialist?" While these methods required more page space, we felt they improved the readability and comprehension of the survey, and thus, the quality of our data.

► **Refinements:** Despite the good response rate on the survey, we analyzed what in particular had worked well and what hadn't. Although the survey was 62 questions long, the majority of respondents successfully worked their way through to the end. If we had it to do over again, we would, nevertheless, eliminate unproductive questions and add others for areas we hadn't covered. Questions, that we might add, cover beneficiaries'

reasons for joining an HMO, comfort with premium costs and co-payments, or coverage problems with emergent or urgent care. Examples of candidates for deletion are:

- question 6 how beneficiary applied for membership -- no discernible pattern or linkage with other questions,
- question 17 occurrence of surgery -- overkill on establishing health status, and beneficiaries often did not link it to the preceding question on hospital admission,
- questions 30-32 lost/misplaced medical records -- apparently a rare problem
- questions 41-42 medical specialists (which ones) not covered by the HMO -- beneficiaries often did not link the two questions, and tended to respond in terms of specialists they needed to see or had seen.

Because of our decision to write simple, one-idea questions, we frequently used skip directions (e.g. Go to question 18) when beneficiaries answered the screening question in the negative. Many beneficiaries initially failed to follow the skip directions. However, the process seemed to be self-instructing, and eventually, most caught on to our meaning. Even if they did not, their answers on the screening questions were still usable. Several of our questions listed six or more response options, each one to be marked "yes" or "no". The length of the response list *per se* was not as problematic as having the respondents clearly mark each option. Our approach tends to encourage answering each option, but directing the respondent instead to "Mark all that apply" is an alternative worth experimentation.

SURVEY RESPONSE: Achieving High Response Rates And Managing Inquiries

The sampled beneficiaries were highly responsive to the survey. Of the 4,132 beneficiaries to whom we mailed surveys, 2,882 returned a usable document. The unweighted return rate was 70 percent overall, 77 percent for enrollees (N=1705), and 61 percent for disenrollees (N=1177). Respondents were predominantly female, white, and age 65 or older (average age of 74 years). Interestingly, they were better educated than we expected.⁶ Forty-three percent reported education beyond the high school level, such as vocational/technical training, college and postgraduate work. Another 29 percent were high school graduates. (See Appendix B for more demographic data.)

This good rate of return was achieved in about two months with only two follow-up mailings required. After initially sending the survey, we sent a reminder letter three weeks later to all those beneficiaries who had not returned the survey. In this letter, we answered the questions most commonly posed by beneficiaries who had called our "800" number after the first mailing. After two more weeks, we sent another reminder letter (different wording and appearance) and a replacement survey document (different cover color). (See Appendix C for samples of cover letters sent to beneficiaries.)

Our experience and informal discussions with other OEI staff revealed that, as a group, Medicare beneficiaries are relatively easy to survey because of their keen interest in the

program. After both mailings of the survey, many contacted us, in a largely informed, cooperative manner, by calling our "800" number and in writing. The highest volume of contact occurred from two to ten days after we completed a mailing. Disenrollees, who called in, often needed more encouragement to respond. We sometimes had to overcome the estrangement they felt about their HMO experience or their mistaken belief that we didn't really want responses from disenrollees. We found that frequent, but short, team meetings to rehearse answers to the most commonly asked questions and a list of HCFA Beneficiary Services contacts in the Regional Offices were invaluable tools for the data collection period. Study team members were also ready to complete the survey on the telephone with beneficiaries who required assistance. We believe that our preparation for answering beneficiary questions and being easily accessible to them by an "800" telephone number improved our response rate.

Examples of questions the beneficiaries typically asked:

Source of Survey

- Who are you?
- Are you trying to sell me something (e.g. health insurance)?
- Do you work for the HMO?
- Do you really work for the government?

Request for Assistance

- Can you tell me what HMO I should join?
- How can I get my HMO to ...?
- What does this question mean?
- Will you help me fill out the survey?

Request for Additional Information/Misconceptions

- What's the purpose of this survey?
- Why are you wasting taxpayers' money on this?
- I'm not in an HMO; I have a health plan.
- Am I in trouble if I can't complete it by the due date?
- Do I have to fill this out to get my Social Security check?
- I don't belong to the HMO anymore. Should I still answer the survey?
- That's not the name of my HMO. Did you change my HMO?

PRACTICAL POINTS OF SURVEY PROTOCOL

In surveying the Medicare population on their HMO experiences, we were also reminded of some practical considerations for communicating with our respondents.

- ▶ Don't assume that beneficiaries know what an HMO is or that they are enrolled.
- ▶ Don't assume that beneficiaries know the HMO by the Medicare product name; mention other names of the HMO.

- ▶ State clearly in several places that the survey was not sent by the HMO or a representative of an HMO physician.
- ▶ Be sure to arrange for an "800" telephone contact or other method so that beneficiaries can ask questions about the survey to a "real person".
- ▶ Whoever takes calls from the beneficiaries should be patient and prepared with answers for the most commonly asked questions.
- ▶ Let beneficiaries know that answering the survey a little late is better than not answering at all.
- ▶ Be relentless in eliminating Medicare jargon, acronyms and complex wording from the survey document.
- ▶ If the study team intends to do any follow-up with the responding beneficiaries, be sure to request their telephone numbers on the survey form.

DATA ANALYSIS: Understanding What The Numbers Say

After analyzing the survey data in a number of different ways, we presented the results in four different reports keyed to our study focus, issues and analysis plan.

▶ ***Beneficiary Perspectives:*** To provide a summary of beneficiary perspectives, we completed separate frequency distributions and cross-tabulations for weighted enrollee and disenrollee data⁷ and compared their answers per question. We also analyzed sub-populations of enrollees and disenrollees in the same way. Generally, beneficiary responses indicated Medicare risk HMOs provide adequate service access for most beneficiaries who have joined. In some instances, however, enrollees and disenrollees differed markedly in reporting their HMO experiences with disenrollees citing some problems more frequently.

▶ ***Issues Across HMOs:*** To provides insights into how beneficiaries' responses may have varied across our sampled 45 HMOs, we aggregated the unweighted enrollee and disenrollee data to the HMOs in our sample to identify distribution and intensity of access problems among HMOs. We explored HMO structural characteristics, such as model type, as well. We concluded that using beneficiary-level data linked back to the HMO provides additional insights into the issues of HMO enrollment procedures and service access. This type of information may prove especially useful in focusing monitoring efforts.

▶ ***Individual HMO Profiles:*** Each of the 45 sampled HMOs was profiled for 18 key survey questions grouped under 5 categories -- health screening, understanding of HMOs, appointments, services and personal treatment. For each key question, we compared the mean response for all sampled HMOs to the mean response for each sampled HMO. A

positive or negative difference between the means of at least one standard deviation was designated respectively as above or below average. The profiles differentiate the many aspects of enrollment procedures and service access within any HMO. The profile data means also suggested two other uses, i.e., the development of tolerance levels for acceptable HMO performance and as a supplement useful in the interpretation of other data sets.

► *Performance Indicators:* To determine if our data could be used to assess HMO performance, we analyzed both beneficiary-level and HMO-level data to construct regression models that explain the relationship between beneficiary survey data and future disenrollment, and specifically, how service access relates to disenrollment status. We also calculated more recent disenrollment rates for our sampled HMOs.

We found the questions most predictive of beneficiaries' future disenrollment included:

- Were complaints taken seriously by their HMO doctors?
- Did their primary HMO doctors provide Medicare services, admit them to the hospital, or refer them to a specialist when needed?
- Did they perceive their HMOs as giving too high a priority to holding down the cost of medical care compared to giving the best medical care?
- Did they perceive their health got worse as a result of the medical care they received in their HMO?
- Did they experience long waits (1 hour or more) in their primary HMO doctors' offices?

CONCLUSIONS

We believe our beneficiary survey and resulting reports have implications for the Medicare risk HMO program.

- ▶ ***Program Information:*** Our findings are another indicator or an update of program weaknesses that have previously been suggested by others. In addition, our data have highlighted some areas as problematic that earlier were viewed as functioning sufficiently well. Beneficiaries' awareness of their appeal rights is an example. The beneficiary data also show that, while disenrollees may be more intense in their criticism of HMOs, enrollees are also encountering some of the same difficulties in accessing HMO medical services.

- ▶ ***Program Management:*** Our experience with this survey has convinced us that Medicare beneficiaries, both enrollees and disenrollees, are an excellent source of detailed information about program operations. More than satisfaction ratings, we were able to gather data on the process and experience of HMO membership. We acknowledge that the survey data, not validated by review of medical files or HMO records, have limitations. Nevertheless, they still represent reality for beneficiaries who are free to act on their perceptions of their HMO experiences.

- ▶ ***Ongoing Evaluation:*** For both purposes of current program information and management, we urge HCFA to systematically and repeatedly collect data from both enrollees and disenrollees, with linkage to their specific HMOs. Such an approach, in combination with data from other sources, is 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.

ENDNOTES

1. We selected a stratified random sample from HCFA's Group Health Plan (GHP) data base. First, we sampled 45 HMOs from the 87 HMOs under a risk contract with HCFA as of February 1993. Beginning with the GHP data, we counted the number of enrollments occurring within calendar years 1991 and 1992. For this cohort, we then calculated the proportion of disenrollments within the following 12 months. Based on this disenrollment rate, we divided the 87 risk HMOs into three strata of 29 HMOs each. Within each strata, we selected 15 HMOs by simple random sampling. Second, from each sampled HMO, we randomly selected 50 Medicare beneficiaries who were enrolled as of February 28, 1993 and 50 who had disenrolled between November 1992 and February 1993 inclusive. When the total number per HMO for either group was less than 50, we selected them all. Using HCFA's Enrollment Data Base, we excluded, from the sampling universe, 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 2,217 enrollees and 1,915 disenrollees for a total of 4,132 beneficiaries.
2. We set up a case log in DBase to track each beneficiary's survey form from the time we mailed the survey until the time we entered the responses on a usable survey into our database.
3. 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.
4. 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.
5. A study funded by AARP, "Public Benefit Application Forms: How They Impede the Application Process," #9105, Public Policy Institute, December 1991 notes "...when writing documents for the elderly, it is essential to heed such factors as print size, typeface, graphics and layout, any of which could significantly interfere with reading comprehension."
 6. Based on their average age, many would have been of high-school age during the Depression which would have limited their access to higher education for financial reasons.

AARP, 1991, *op. cit.*, "...the majority of the [forms and material assessed] is written at the high school to college level. Yet...many older adults lack the education needed to read and understand the forms."

7. We weighted data to reflect the enrollment size of their Medicare risk HMOs, their enrollment status when sampled, and our decision not to assume knowledge about non-respondents.

APPENDIX A

SUMMARY OF REPORT FINDINGS

Below, for each of the four reports, is a summary of findings. Throughout the reports, several recurrent themes are discernible. Overall, responses from Medicare beneficiaries in risk HMOs indicated adequate access to medical services. However, disenrollees more often reported problems than enrollees, as did ESRD/disabled beneficiaries compared to aged beneficiaries. Predictably, some HMOs performed better than others. When problems were reported, they were, despite the analysis method used, consistently in the areas of health screening at application, lack of awareness of appeal rights, difficulty with appointments and access to some services, and perceptions of declining health due to HMO care. The failure of physicians to take beneficiaries' health complaints seriously, and HMOs emphasizing cost control over providing the best care were two other problems beneficiaries perceived.

"Beneficiary Perspectives of Medicare Risk HMOs," OEI-06-91-00730

Generally, beneficiary responses indicated Medicare risk HMOs provide adequate service access for most beneficiaries who have joined. The majority of enrollees and disenrollees reported medical care that maintained or improved their health, timely appointments for primary and specialty care, good access to Medicare covered services and to hospital, specialty and emergency care, and sympathetic personal treatment by their HMOs and HMO doctors. In some instances, however, enrollees and disenrollees differed markedly in reporting their HMO experiences with disenrollees citing some problems more frequently.

Our survey results also indicated some serious problems with enrollment procedures and service access that, we believed, required HCFA's attention. Three items need immediate exploration: 1) better informing of beneficiaries about their appeal rights as required by Federal standards; 2) carefully examining service access problems reported by disabled/ESRD beneficiaries, an especially vulnerable group; and 3) monitoring HMOs for inappropriate screening of beneficiaries' health status at application. Other service access issues meriting examination by HCFA in the near future concerned beneficiaries' perceptions of problems with making routine appointments, declining health caused by HMO care, and HMOs' refusal to provide certain services.

"Medicare Risk HMOs: Beneficiary Enrollment and Service Access Problems," OEI-06-91-00731

Most enrollment and service access problems reported by beneficiaries are widespread among Medicare risk HMOs, but at varying degrees of intensity. Disenrollees generally

experienced problems at a higher degree of intensity than enrollees. Specific problems that were fairly or very wide-spread and intensive were: HMOs' asking beneficiaries about their health problems at application, beneficiaries' lack of awareness of appeal rights, disenrollees' perception of problems with access to medical services, and beneficiaries' perceptions that primary HMO doctors failed to take their health complaints seriously and that holding down the cost of medical care was more important to HMOs and HMO doctors than giving the best medical care possible. Beneficiaries in group or staff models and in non-profit HMOs were more likely to report enrollment and service access problems.

We concluded that using beneficiary-level data linked back to the HMO provides additional insights into the issues of HMO enrollment procedures and services access. This type of information may prove especially useful in focusing monitoring efforts. For example, it could answer questions such as, "Are problems widely distributed among HMOs or isolated incidents?" or "If the problem is wide-spread among HMOs, does it involve a substantial percentage of beneficiaries?" We also suggest that HCFA establish acceptable tolerance levels for monitoring, since a problem may be pervasive, but not necessarily critical.

"Individual Profiles of Medicare Risk HMOs," OEI-06-91-00733

The profiles differentiate the many aspects of enrollment procedures and service access within any HMO. This level of data could be used to pinpoint specific problematic HMOs and to indicate when corrective actions are needed. The profile data means also suggested two other uses, i.e., the development of tolerance levels for acceptable HMO performance and as a supplement useful in the interpretation of other data sets.

"Medicare Risk HMO Performance Indicators," OEI-06-91-00734

Overall, we found that adjusted disenrollment rates may provide an early alert of possible problems among Medicare risk HMOs. Adjustments include 1) annualizing rates among newer HMO risk contracts, and 2) accounting for administrative disenrollments, e.g., beneficiaries moving from service area, which tend to inflate disenrollment rates. After adjustments, HMOs with higher disenrollment rates had more enrollees who reported service access problems. Beneficiaries more likely to disenroll tended to report declining health due to their HMO care, being disabled/ESRD, an HMO emphasis of holding down the cost of care over giving the best medical care possible, and experiencing long waits in primary HMO doctors' offices.

The questions we found most predictive of beneficiaries' future disenrollment included:

- Were complaints taken seriously by their HMO doctors?
- Did their primary HMO doctors provide Medicare services, admit them to the hospital, or refer them to a specialist when needed?
- Did they perceive their HMOs as giving too high a priority to holding down the cost of medical care compared to giving the best medical care?
- Did they perceive their health got worse as a result of the medical care they received in their HMO?
- Did they experience long waits (1 hour or more) in their primary HMO doctors' offices?

We recommended that HCFA: 1) use adjusted disenrollment rates along with other available HMO information to target reviews of HMOs; 2) track disenrollment rates over time to detect potential problems among HMOs; 3) conduct disenrollment surveys that fully capture all the beneficiary's reasons for leaving the Medicare risk HMO; 4) monitor Medicare risk HMOs with high disenrollment rates and reported service access problems and work with HMOs to respond to the needs of beneficiaries at risk of disenrolling; 5) systematically and routinely survey enrollees on key indicators of service access to complement disenrollment data.

APPENDIX B

DEMOGRAPHIC PROFILE OF RESPONDENTS (Weighted Data)

	TOTAL POPULATION	DISENROLLEES	ENROLLEES
GENDER			
Female	60% (666,049)	53% (15,065)	60% (650,984)
Male	40% (446,205)	47% (13,139)	40% (433,067)
RACE/ETHNICITY			
White	90% (991,084)	88% (24,872)	90% (966,213)
Non-White	7% (83,684)	12% (3,332)	7% (80,352)
Unknown	3% (37,486)	0	3% (37,486)
AVERAGE AGE	74 Years	73 Years	74 Years
EDUCATION			
< Than High School	24% (274,156)	20% (5,683)	25% (268,473)
High School Diploma	29% (318,440)	22% (6,238)	29% (312,201)
> Than High School	43% (474,317)	49% (13,778)	42% (460,539)
No Response	4% (45,342)	9% (2,504)	4% (42,838)
MEDICARE CATEGORY			
Aged	97% (1,078,445)	92% (25,907)	97% (1,052,538)
Disabled/ESRD	3% (33,809)	8% (2,296)	3% (31,513)
COMPETITIVE AREA			
Competitive ¹	63% (700,103)	53% (14,878)	63% (685,225)
Noncompetitive	37% (412,152)	47% (13,325)	37% (398,826)
HMO EXPERIENCE			
Prior Experience	14% (154,069)	21% (5,997)	14% (148,072)
No Experience	82% (906,961)	71% (19,905)	82% (887,056)
No Response	4% (51,226)	8% (2,302)	4% (48,923)
AVERAGE LENGTH OF TIME IN HMO	36 Months	29 Months	36 Months
SERIOUS HEALTH CONDITIONS²			
2+ conditions	6% (61,003)	5% (1,254)	6% (59,749)
1 condition	24% (265,866)	22% (6,153)	24% (259,713)
None	60% (669,619)	58% (16,440)	60% (653,180)
No Response	10% (115,767)	15% (4,357)	10% (111,410)

¹ A competitive area is a county in which 2 or more of all Medicare risk HMOs, not just sampled HMOs, provide services. Beneficiaries were then matched to counties by zip codes of their mailing address.

² Health conditions are self-reported, and are for example, broken bones, cancer, heart attack, pneumonia or stroke.

APPENDIX C

SAMPLES OF COVER LETTERS TO BENEFICIARIES



MEDICARE SURVEY

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

April 14, 1993

Dear Medicare Member:

Please help us make the Medicare program better. All you need to do is complete the enclosed survey and return it by April 23, 1993. **No postage is required** for the return envelope.

We want to improve health care services provided to Medicare beneficiaries by health maintenance organizations -- HMOs. Since you have been an HMO member, your valuable experience will help us identify areas that need improvement.

Please take the time to complete the survey. It may seem long, but the questions are short, and you won't have to answer every one. Also, it is okay if someone helps you.

Anything you say will be **strictly confidential**. No one, including your HMO, will know your answers. To assure this, please **do not** write your name on the survey.

If you have any questions, call us toll free at 1-800-848-8960. Thank you very much for your help.

Sincerely,

Judith V. Tyler
Survey Project Leader



DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 5, 1993

Dear Medicare Member:

Several weeks ago, we sent you a survey asking about your experiences as a member of a health maintenance organization (HMO). We are concerned because we haven't received your completed survey yet.

Maybe you thought the survey didn't apply to you for the following reasons. If so, please consider our explanations.

1. We had the wrong name for your HMO on the survey.

Answer: HMOs often have several names. Check your HMO card or call us for other names your HMO uses.

2. You belong to a health plan, NOT an HMO.

Answer: A health plan is another name for an HMO.

3. You don't belong to the HMO anymore.

Answer: We know some Medicare members have left their HMOs. Information on WHY you left is very useful to us.

4. You couldn't complete the survey by the date we requested.

Answer: Don't worry about the return date. What you have to say about your HMO is the most important thing.

Please take the time to complete the survey if you still have it. Anything you say will be strictly confidential.

Please call us toll-free at 1-800-848-8960 if you need another survey, if you would like the survey written in Spanish, or if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Judith V. Tyler".

Judith V. Tyler
Survey Project Leader



MEDICARE SURVEY

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 19, 1993

Dear Medicare Member:

Several weeks ago, we wrote to you of our concern that we hadn't received your completed survey about your health maintenance organization (HMO). Our thanks to the many of you who called us. If you said you needed another survey, here it is. If you have already returned the survey, thank you.

If you didn't call us, you may think the survey doesn't apply to you. You may be wrong. Please call us at **1-800-848-8960** so we can be sure.

Finally, some of you simply may not wish to complete the survey. But, before you throw it away, please consider that we need information from you about the Medicare HMO program. We are sincere about wanting to improve Medicare. You can help us.

All you need to do is:

1. Return the completed survey to us by **June 2**. If you need a few extra days, that's okay. What you have to say about your HMO is the most important thing.
2. Use the enclosed envelope. No postage is required.
3. Remember anything you say will be **strictly confidential**. No one, including your HMO, will know your answers.

Please call us toll-free at **1-800-848-8960** if you would like the survey written in Spanish, or if you have any questions.

Sincerely,

Judith V. Tyler

Survey Project Leader

APPENDIX D

ENROLLEE AND DISENROLLEE SURVEY FORMS³

³ The enrollee and disenrollee forms are nearly identical, except for changes in verb tense, for the first 55 questions. Therefore, we have included a complete enrollee survey form, but just questions 56 through 64 for the disenrollee survey form.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH MAINTENANCE ORGANIZATIONS (HMOs) A Survey of Medicare Members

Form E

- ✓ Is your HMO's name printed in the box above? Sometimes an HMO will have several names. If you are not sure, call the HMO. If you are sure this is not your HMO, answer question 1 only.

- ✓ Anything you say will be strictly confidential. To assure this, please do not write your name on the survey.

- ✓ Please read the directions on the next page.

- ✓ Call us toll free at 1-800-848-8960 if you have questions.

DIRECTIONS

- ✓ When the question says "HMO," we mean the HMO you belong to now. Your HMO's name is in the box on the front cover.

- ✓ You will NOT answer every question. Skip a question when we say -- (Go to question ____).

- ✓ For most questions, you should choose just ONE answer. We will tell you when you should do something different.

- ✓ You may change your answer. Mark out the answer you DON'T want. Make sure we know which answer you DO want.

- ✓ You may add comments. Write them by the questions.

Section 1: Tell Us About You

These questions ask for some basic information about you.

✓ **May we call you if we have further questions about your HMO?**

___ yes (area code:___)(telephone number:_____)

___ no

1. Are you currently a member of the HMO named on the front cover?
(Remember, you may know the HMO by another name.)

___ A) yes

___ B) no, I left the HMO **(Stop. Return the survey to us.)**

___ C) I have never been a member of that HMO.
(Stop. Return the survey to us.)

2. What is the highest level of education you completed?

___ A) less than high school

___ B) high school diploma

___ C) vocational/technical training

___ D) some college, no degree

___ E) college degree

___ F) postgraduate or professional degree

3. Immediately before joining the HMO, where did you usually receive your health care?

___ A) another HMO

___ B) doctor's office

___ C) community clinic or health center

___ D) hospital outpatient clinic

___ E) hospital emergency room

___ F) no regular place

4. I worry about my health less than other people my age.

- A) true
- B) false
- C) I don't know

5. I usually go to the doctor as soon as I start to feel bad.

- A) true
- B) false
- C) I don't know

Section 2: When You Joined The HMO

These questions ask about what happened when you joined the HMO.

6. How did you apply for membership in the HMO? Did you:

- A) tell an HMO representative, who contacted you, that you wanted to apply?
- B) contact the HMO on your own to apply?
- C) sign up for membership at work? **(Go to question 10)**
- D) I didn't apply for membership. **(Go to question 10)**

7. When you applied for HMO membership, were you asked about your health problems? **(Don't count questions about kidney failure or Medicare hospice coverage.)**

- A) yes
- B) no
- C) I don't remember

8. Were you required to have a physical exam before you could join the HMO?

A) yes

B) no

C) I don't remember

9. When you applied for HMO membership, did you know you could change your mind and back out before the HMO membership took effect?

A) yes

B) no

C) I don't remember

10. Did you know, from the beginning, that an HMO member must be referred to a specialist by a primary HMO doctor?

A) yes

B) no

C) I don't remember

11. Did you know, from the beginning, that an HMO member could only use HMO doctors and hospitals (except in emergencies outside the HMO's service area)?

A) yes

B) no

C) I don't remember

Section 3: How Is Your Health?

These questions ask about your health while you have been an HMO member.

12. When you first joined the HMO, how would you rate your health overall?

- A) excellent
- B) good
- C) fair
- D) poor
- E) very poor

13. Have you seen an HMO doctor or received any health care services through the HMO while you have been a member?

- A) yes
- B) no **(Go to question 55)**
- C) I don't remember **(Go to question 55)**

14. While you have been in the HMO, have you ever had serious health problems, such as: **(Mark each answer "yes" or "no".)**

- | yes | no | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | A) a heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | B) cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | C) kidney failure |
| <input type="checkbox"/> | <input type="checkbox"/> | D) a stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | E) broken bones |
| <input type="checkbox"/> | <input type="checkbox"/> | F) internal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | G) pneumonia |

15. While you have been a member of the HMO, have you ever had any of the following health problems? **(Mark each answer "yes" or "no".)**

yes no

- A) high blood pressure
- B) a heart condition
- C) diabetes
- D) difficulty breathing
- E) joint pain or swelling
- F) poor blood circulation
- G) problems with urinating
- H) poor digestion
- I) women's problems
- J) eye problems, other than needing glasses
- K) ear, nose or throat problems
- L) skin problems
- M) memory loss
- N) difficulty swallowing
- O) dizziness or loss of balance
- P) mental health problems including depression
- Q) weight too high or too low

- R) a health problem not listed here or in question 14. **(Please explain the health problem briefly.)**

16. While you have been in the HMO, have you ever been admitted to the hospital?

- A) yes
- B) no **(Go to question 18)**
- C) I don't remember **(Go to question 18)**

17. Did you ever have surgery while you were a patient in the hospital?

- A) yes
- B) no
- C) I don't remember

18. During the last year, have you seen your primary HMO doctor or specialist(s), by referral, to check your health?

- A) yes
- B) no **(Go to question 20)**
- C) I don't remember **(Go to question 20)**

19. During the last year, about how many total visits have you had with your primary HMO doctor or specialists?

- A) 1 to 3 visits
- B) 4 to 6 visits
- C) 7 to 9 visits
- D) 10 to 12 visits
- E) more than 12 visits

20. During the last year, have you ever been a patient in a nursing home?

- A) yes
- B) no
- C) I don't remember

Section 4: How Has The HMO Treated You?

These questions ask what it has been like to be a member of the HMO.

21. Has your primary HMO doctor ever failed to take your complaints about your health seriously?

- A) yes
- B) no (**Go to question 23**)
- C) I don't remember (**Go to question 23**)

22. How often has your primary HMO doctor failed to take your complaints about your health seriously?

- A) all the time
- B) most of the time
- C) about half the time
- D) a few times
- E) I don't remember

23. How long do you usually have to wait for a scheduled appointment with your primary HMO doctor?

- A) 1 to 4 days
- B) 5 to 8 days
- C) 9 to 12 days
- D) 13 to 16 days
- E) 17 to 20 days
- F) longer than 20 days

24. When you go to the appointment, how long do you usually have to wait in the office before you see your primary HMO doctor?

- A) less than a ½ hour
- B) ½ hour to 1 hour
- C) 1 hour to 1 ½ hours
- D) 1 ½ hours to 2 hours
- E) longer than 2 hours

25. When you have been very sick, has your primary HMO doctor, his staff or HMO office staff made sure you had an appointment within a day or two?

- A) yes
- B) no
- C) I haven't been very sick
- D) I don't remember

26. How long do you usually have to wait for a scheduled appointment with a specialist?

- A) 1 to 4 days
- B) 5 to 8 days
- C) 9 to 12 days
- D) 13 to 16 days
- E) 17 to 20 days
- F) longer than 20 days

27. When you have telephoned to make an appointment with your primary HMO doctor, has the line ever been busy?

- A) yes
- B) no **(Go to question 30)**
- C) I don't remember **(Go to question 30)**

28. How often has the line been busy?

- A) all the time
- B) most of the time
- C) about half the time
- D) a few times
- E) I don't remember

29. Have you ever given up on making appointments because of the busy telephone line?

- A) yes
- B) no
- C) I don't remember

30. Has your primary HMO doctor, his staff or the HMO office staff ever lost or misplaced your medical records, including test results?

- A) yes
- B) no (**Go to question 33**)
- C) I don't remember (**Go to question 33**)

31. How often have your medical records been lost or misplaced?

- A) all the time
- B) most of the time
- C) about half the time
- D) a few times
- E) I don't remember

32. Have lost or misplaced medical records ever kept you from using HMO services?

- A) yes
- B) no
- C) I don't remember

33. Has your primary HMO doctor, his staff or HMO office staff ever told you:
(Mark each answer "yes" or "no".)

yes no

- ___ ___ A) you are too sick to be in the HMO?
___ ___ B) the HMO can't afford to provide the medical care you need?
___ ___ C) you would probably receive better care if you left the HMO?
___ ___ D) you ask for too many appointments or services?
___ ___ E) you must leave the HMO if you need nursing home care?

Section 5: Available HMO Services

These questions ask about services that the HMO has made available to you.

34. Has your primary HMO doctor ever failed to provide Medicare covered services that you believed you needed?

- ___ A) yes
___ B) no (**Go to question 36**)
___ C) I don't remember (**Go to question 36**)

35. How often has your primary HMO doctor failed to provide these Medicare covered services that you believed you needed?

- ___ A) all the time
___ B) most of the time
___ C) about half the time
___ D) a few times
___ E) I don't remember

36. Has your primary HMO doctor ever failed to admit you to the hospital when you believed you needed to be admitted?

- A) yes
- B) no (**Go to question 38**)
- C) I don't remember (**Go to question 38**)

37. How many times has your primary HMO doctor failed to admit you to the hospital?

- A) 1 time
- B) 2 times
- C) 3 times
- D) 4 times
- E) more than 4 times
- F) I don't remember

38. Has your primary HMO doctor ever failed to refer you to a specialist when you thought you needed to see one?

- A) yes
- B) no (**Go to question 40**)
- C) I don't remember (**Go to question 40**)

39. How often has your primary HMO doctor failed to refer you to a specialist?

- A) all the time
- B) most of the time
- C) about half the time
- D) a few times
- E) I don't remember

40. Overall, what do you think is most important to your primary HMO doctor?

- A) holding down the cost of your medical care
- B) giving you the best medical care possible
- C) I don't know

41. Has your primary HMO doctor, his staff or HMO office staff ever told you a medical specialist that you need is not covered by your HMO?

- A) yes
- B) no **(Go to question 43)**
- C) I don't remember **(Go to question 43)**

42. What medical specialist(s) have they mentioned? **(Mark each specialist they mentioned.)** Doctors that specialize in:

- A) the heart
- B) feet
- C) urinary system including kidneys and bladder
- D) skin
- E) digestion including stomach and intestines
- F) women's problems
- G) ears and hearing only
- H) ears, nose and throat
- I) eyes, other than glasses
- J) bones, joints and muscles
- K) arthritis and joints
- L) lungs
- M) nervous system, including the brain
- N) mental health
- O) surgery
- P) cancer
- Q) diabetes

- R) other (explain) _____

43. Has your primary HMO doctor, his staff or HMO office staff ever told you a medical service that you need is not covered by your HMO?

- A) yes
- B) no **(Go to question 45)**
- C) I don't remember **(Go to question 45)**

44. Are the following medical services the ones they said the HMO does not cover? **(Mark each answer "yes" or "no".)**

yes no

- A) care in a skilled nursing home
- B) second opinion by another HMO doctor before surgery
- C) drugs you cannot give to yourself, such as medicine given in a shot
- D) laboratory tests and X-rays that help your doctor decide what is wrong
- E) chiropractors
- F) artificial legs, arms or breast forms after surgery
- G) kidney dialysis -- a way to clean your blood when your kidneys don't work anymore
- H) medical equipment for home use, such as oxygen equipment or a wheelchair

45. Has the HMO ever refused to approve a Medicare covered service that your primary HMO doctor wanted you to have?

- A) yes
- B) no **(Go to question 47)**
- C) I don't remember **(Go to question 47)**

46. How often has the HMO refused to approve a Medicare covered service that your primary HMO doctor wanted you to have?

- A) all the time
- B) most of the time
- C) about half the time
- D) a few times
- E) I don't remember

47. Has the HMO ever refused to pay a doctor or hospital for your emergency care that you were billed for?

- A) yes
- B) no
- C) I don't remember

48. Have you ever, on your own, gotten Medicare covered services that your primary HMO doctor or the HMO did not first approve? (**Do not include dentists, glasses or emergency care.**)

- A) yes
- B) no (**Go to question 51**)
- C) I don't remember (**Go to question 51**)

49. Do the following statements explain why you got Medicare covered services on your own that your primary HMO doctor or the HMO did not first approve? (Mark each answer "yes" or "no".)

yes no

- A) I needed the care, even if they would not approve it.
- B) I couldn't get services quickly enough through the HMO.
- C) My primary HMO doctor wasn't helping me.
- D) My primary HMO doctor failed to refer me to a specialist.
- E) The HMO staff didn't care about me.
- F) My HMO was wrong when they said the service wasn't covered by Medicare.
- G) I didn't want to go through my primary HMO doctor to see a specialist.
- H) I didn't know that I would have to pay for it.

50. During the last year, how many times have you gotten Medicare covered services on your own that your primary HMO doctor or the HMO did not first approve? (Your best estimate is fine.)

- A) 1 to 3 times
- B) 4 to 6 times
- C) 7 to 9 times
- D) 10 to 12 times
- E) more than 12 times

51. Overall, what do you think is most important to your HMO?

- A) holding down the cost of your medical care
- B) giving you the best medical care possible
- C) I don't know

52. Do you know that you have the right to appeal your HMO's refusal to provide or pay for services?

A) yes (**Go to question 54**)

B) no

C) I don't remember

53. If you had known about your rights, would you have appealed any of your HMO's refusals to provide or pay for services?

A) yes

B) no

C) My HMO has not refused to provide or pay for services.

Section 6: Future Health Care Plans

These questions ask about your current health and plans for HMO membership.

54. Has the medical care that you have received through your HMO caused your health to:

A) improve a lot

B) improve a little

C) stay about the same

D) get a little worse

E) get much worse

F) I don't know

55. How would you rate your overall health now?

A) excellent

B) good

C) fair

D) poor

E) very poor

56. Do you plan to leave the HMO in the near future?

- A) yes, because I didn't agree to join the HMO in the first place
(Stop. Return the survey to us.)
- B) yes, because I am moving out of the HMO's service area
(Go to question 57)
- C) yes (Go to question 60)
- D) no (Go to question 58)

57. If you were not moving, would you have planned to leave the HMO in the near future for other reasons?

- A) yes (Go to question 60)
- B) no (Stop. Return the survey to us.)
- C) I don't know (Stop. Return the survey to us.)

58. Do you want to leave the HMO, but feel that you can't leave?

- A) yes
- B) no (Stop. Return the survey to us.)

59. Do the following statements explain why you can't leave the HMO? (Mark each answer "yes" or "no".)

yes no

- A) I can't afford private health insurance.
- B) I can't afford non-HMO doctors.
- C) The HMO is the only way I can afford all the medical care I need.
- D) I can't get Medicaid.
- E) There isn't another HMO close-by.
- F) It's too much trouble to find other health care.
- G) My family doesn't want me to leave.
- H) Medicine is too expensive outside the HMO.

60. Do the following statements about personal preferences explain why you plan to leave (or want to leave) the HMO? (Mark each answer "yes" or "no".)

yes no

- | | | |
|-----|-----|---|
| ___ | ___ | A) I don't like the choice of primary HMO doctors. |
| ___ | ___ | B) I can't see the same primary HMO doctor every time. |
| ___ | ___ | C) I don't like going through my primary HMO doctor to get medical services |
| ___ | ___ | D) My primary HMO doctor left the HMO. |
| ___ | ___ | E) I want to use the doctor I had before I joined the HMO. |
| ___ | ___ | F) The HMO services have changed. |
| ___ | ___ | G) The premium and/or copayments are too expensive. |
| ___ | ___ | H) A friend or relative has encouraged me to leave. |
| ___ | ___ | I) I want to use another hospital. |
| ___ | ___ | J) Getting to the HMO is too difficult. |
| ___ | ___ | K) I don't like the HMO building |
| ___ | ___ | L) I don't like where the HMO is located. |

✓ (If you marked ALL answers "no", go to question 62.)

61. Of the reasons you marked "yes" in question 60, which one is the most important reason you plan to leave (or want to leave) the HMO?

___ is the letter of the most important reason.

62. Do the following statements about HMO services explain why you plan to leave (or want to leave) the HMO? (Mark each answer "yes" or "no".)

yes no

- ___ ___ A) I can't see my primary HMO doctor or specialist as often as I need.
___ ___ B) My primary HMO doctor has failed to provide treatments I need.
___ ___ C) I can't get medical services fast enough when I am really sick.
___ ___ D) I am not allowed to see the specialist(s) I need.
___ ___ E) I am not allowed to go to the hospital when I need to.
___ ___ F) Too many of the medical services I need are not covered.
___ ___ G) The HMO won't approve Medicare covered services that my primary HMO doctor wants me to have.
___ ___ H) My primary HMO doctor, his staff or HMO office staff have encouraged me to leave.
___ ___ I) Making appointments by telephone is too difficult.
___ ___ J) I have to wait too long for scheduled appointments.
___ ___ K) I have to wait too long at the office to see the doctor.
___ ___ L) I am getting sicker because of the care I receive through the HMO.

✓ (If you marked ALL answers "no", go to question 64.)

63. Of the reasons you marked "yes" in question 62, which one is the most important reason you plan to leave (or want to leave) the HMO?

_____ is the letter of the most important reason.

64. Now look back at your answers for question 61 and question 63. Circle the one answer that is THE MOST IMPORTANT REASON you plan to leave (or want to leave) the HMO.

✓ (Go to question 65 if we have not mentioned your most important reason.)

65. Please explain the most important reason you plan to leave (or want to leave) the HMO if we have not mentioned it.

66. **(This question is ONLY for those who plan to leave the HMO.)** After you leave the HMO, where will you usually go to receive your health care?

- A) another HMO
- B) doctor's office
- C) community clinic or health center
- D) hospital outpatient clinic
- E) hospital emergency room
- F) no regular place

✓ **Please return your completed survey to us in the envelope provided.**

✓ Please write here any comments you have about the survey or your HMO.

Questions 56 through 64 for the disenrollee survey form.

56. Do the following statements explain why you are no longer in the HMO?
(Mark each answer "yes" or "no".)

yes no

- ___ ___ A) I moved out of the HMO service area.
___ ___ B) The HMO was no longer a part of Medicare.
___ ___ C) The company I worked for dropped the HMO.
___ ___ D) I was taken out of the HMO without my knowledge.

✓ (If you marked ALL answers "no", go to question 58.)

57. Would you have left the HMO anyway for other reasons?

- ___ A) yes
___ B) no (Stop. Return the survey to us.)
___ C) I don't know

58. Do the following statements about personal preferences explain why you left (or would have left) the HMO? (Mark each answer "yes" or "no".)

yes no

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A) I didn't like the choice of primary HMO doctors. |
| <input type="checkbox"/> | <input type="checkbox"/> | B) I couldn't see the same primary HMO doctor every time. |
| <input type="checkbox"/> | <input type="checkbox"/> | C) I didn't like going through my primary HMO doctor to get medical services. |
| <input type="checkbox"/> | <input type="checkbox"/> | D) My primary HMO doctor left the HMO. |
| <input type="checkbox"/> | <input type="checkbox"/> | E) I wanted to use the doctor I had before I joined the HMO. |
| <input type="checkbox"/> | <input type="checkbox"/> | F) The HMO services changed. |
| <input type="checkbox"/> | <input type="checkbox"/> | G) The premium and/or copayments were too expensive. |
| <input type="checkbox"/> | <input type="checkbox"/> | H) A friend or relative encouraged me to leave. |
| <input type="checkbox"/> | <input type="checkbox"/> | I) I wanted to use another hospital. |
| <input type="checkbox"/> | <input type="checkbox"/> | J) Getting to the HMO was too difficult. |
| <input type="checkbox"/> | <input type="checkbox"/> | K) I didn't like the HMO building |
| <input type="checkbox"/> | <input type="checkbox"/> | L) I didn't like where the HMO was located. |

✓ (If you marked ALL answers "no", go to question 60.)

59. Of the reasons you marked "yes" in question 58, which one was the most important reason you left (or wanted to leave) the HMO?

_____ is the letter of the most important reason.

60. Do the following statements about HMO services explain why you left (or would have left) the HMO? (Mark each answer "yes" or "no".)

yes no

- A) I couldn't see my primary care doctor or specialist as often as I needed.
- B) My primary HMO doctor refused to provide treatments I needed.
- C) I couldn't get services fast enough when I was really sick.
- D) I was not allowed to see the specialist(s) I needed.
- E) I was not allowed to go to the hospital when I needed to.
- F) Too many of the medical services I needed weren't covered.
- G) The HMO wouldn't approve Medicare covered services that my primary HMO doctor wanted me to have.
- H) My primary HMO doctor, his staff or HMO office staff encouraged me to leave.
- I) Making appointments by telephone was too difficult.
- J) I had to wait too long for scheduled appointments.
- K) I had to wait too long at the office to see the doctor.
- L) I was getting sicker because of the care I received through the HMO.

✓ (If you marked ALL answers "no", go to question 62.)

61. Of the reasons you marked "yes" in question 60, which one was the most important reason you left (or wanted to leave) the HMO?

is the letter of the most important reason.

62. Now look back at your answers for question 59 and question 61. Circle the one answer that was THE MOST IMPORTANT REASON you left (or would have left) the HMO.

✓ (Go to question 63 if we have not mentioned your most important reason.)

63. Please explain the most important reason you left (or would have left) the HMO if we have not mentioned it.

64. After you left the HMO, where did you usually receive your health care?

- A) another HMO
- B) doctor's office
- C) community clinic or health center
- D) hospital outpatient clinic
- E) hospital emergency room
- F) no regular place

✓ Please return your completed survey to us in the envelope provided.

✓ Please write here any comments you have about the survey or your HMO.