Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Beneficiary Interest in HMOs in 1997

JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1998
OEI-04-97-00032

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's Atlanta Regional Office prepared this report under the direction of Jesse J. Flowers, Regional Inspector General, and Christopher Koehler, Deputy Regional Inspector General. Principal OEI staff included:

REGION IV

Betty Apt, *Project Leader*
Jason Stanfield, *Contractor*
Joe Townsel, *Program Analyst*
Paula Bowker, *Program Analyst*
Janet Miller, *Program Analyst*

HEADQUARTERS

Wynethea Walker, *Program Specialist*
LindaMoscoe, *Technical Support*
Barbara Tedesco, *Statistician*

To obtain copies of this report, please call the Atlanta Regional Office at 404-562-7743.
Reports are also available on the World Wide Web at our home page address:

http://www.dhhs.gov/progorg/oei

E X E C U T I V E S U M M A R Y

PURPOSE

To determine Medicare beneficiary awareness of and interest in joining health maintenance organizations in 1997.

BACKGROUND

In all geographic areas, Medicare beneficiaries can obtain medical care through a fee-for-service arrangement. Many beneficiaries also have an option of obtaining medical care through managed care plans known as health maintenance organizations (HMOs). As of April 1998, approximately 5.6 million beneficiaries were members in one of 336 Medicare-contracted risk HMOs. Risk HMOs receive a fixed monthly Medicare payment per beneficiary. Such HMOs must provide a full range of Medicare services, and are at risk for any health care cost that exceeds the fixed payment.

During our 1997 survey of Medicare beneficiary satisfaction, we asked beneficiaries about their awareness of Medicare-contracted HMOs, and their interest in joining one. Several Health Care Financing Administration (HCFA) staff expressed an interest in this subject, and suggested questions for our survey.

We included in our sample only beneficiaries who were enrolled in Medicare's fee-for-service program. Where possible, we compared beneficiary responses to those of similar surveys we conducted in 1994 and 1995.

FINDINGS

General Awareness of HMOs by Beneficiaries Increased Each Year

- In 1997, 79 percent of beneficiaries said they had heard of HMOs. This is a statistically significant increase from 1995 and 1994 when 70 percent and 62 percent, respectively, said they knew about HMOs.

- In 1997, 40 percent of the beneficiaries said they would like to learn more about Medicare-contracted HMOs. This is a statistically significant decrease from 1995 and 1994 when 54 percent and 64 percent, respectively, said they wanted more information. This decrease may be because more beneficiaries are aware of HMOs, and do not think they need more information.

- About 75 percent of the beneficiaries were not aware they could appeal HMO decisions about their health care.

Beneficiary Awareness of Medicare HMOs in Their Area Remained the Same

- In both 1997 and 1995, 44 percent of beneficiaries said they knew whether or not they lived in locations where they could join an HMO. This lack of increase in awareness of local Medicare HMOs is puzzling since the number of HMOs available to beneficiaries has increased. Also, as shown above, the number of beneficiaries who had heard of HMOs has increased.

Beneficiary Interest in Joining an HMO Decreased

- In 1997, only 23 percent of beneficiaries expressed an interest in joining an HMO, compared to 35 percent in 1995. This is a statistically significant decrease.

- Of the beneficiaries who cited a reason for not joining an HMO, about 46 percent said inability to select their own physicians was the main reason.

- Only 7 percent of beneficiaries expressed concern about quality of care in an HMO. This is similar to beneficiary responses to our 1995 and 1994 surveys.

CONCLUSION

The Balanced Budget Act of 1997 expanded the types of managed care plans that will be available to beneficiaries. Accordingly, HCFA is currently negotiating contracts with managed care providers, and developing educational materials for beneficiaries. Our past studies and this study have shown, however, that over half of beneficiaries do not know whether or not a managed care plan is available that they can join. In preparing educational materials, HCFA could provide beneficiaries with information on managed care plans available in their local areas. Furthermore, in view of our survey results, it would also be useful for educational materials to emphasize beneficiaries' rights to appeal managed care decisions about their medical care.

We plan to continue our work on managed care issues. Accordingly, we will continue to monitor beneficiary knowledge and understanding of their choices. To this end, we hope to continue working with HCFA to develop information that will help them better meet beneficiary managed care needs.

TABLE OF CONTENTS

I N T R O D U C T I O N

PURPOSE

To determine Medicare beneficiary awareness of and interest in joining health maintenance organizations in 1997.

BACKGROUND

The Medicare Program

Medicare is a Federal health insurance program for individuals age 65 and older, and for certain categories of disabled people. In 1997, Medicare served approximately 38 million beneficiaries, and paid benefits totaling over $211 billion.[1] The Health Care Financing Administration (HCFA) within the Department of Health and Human Services has responsibility for the Medicare program.

In all geographic areas, Medicare beneficiaries can obtain medical care through a fee-for-service arrangement. Many beneficiaries also have an option of obtaining medical care through managed care plans known as health maintenance organizations (HMOs).

Several people in HCFA asked us to determine beneficiary interest in joining HMOs when we conducted our 1994 beneficiary satisfaction survey. Because Congress and HCFA continue to seek ways to expand health care options for Medicare beneficiaries, we included the questions about HMOs in our 1995 and 1997 surveys.

Two Methods of Obtaining Medical Care

Fee-for-Service - Beneficiaries choose their own physicians, hospitals, and other medical care providers. Providers submit claims to Medicare for services to Medicare beneficiaries. For physician and most other outpatient services, Medicare pays 80 percent of the amount allowable for a covered service. Beneficiaries, or their secondary insurance, pay the remaining 20 percent of allowable charges, plus Medicare premiums and deductibles.

Managed Care: Beneficiaries enroll in Medicare-contracted organizations which manage their medical care. The managed care plan may determine the type of care a beneficiary receives, and may limit access to specialists and other providers. There are several types of managed care plans. Risk HMOs are the most prevalent.

[1]Health Care Financing Administration, United States Department of Health and Human Services, HCFA Statistics, October 1997.

Each risk HMO has a defined geographic area, and serves beneficiaries who live in that area. HMOs are responsible for providing a full range of Medicare services, and may offer other benefits not covered by Medicare, such as prescription drugs.

Medicare pays HMOs a set amount each month to provide beneficiaries all hospital and medical services available under fee-for-service. Beneficiaries continue to pay Medicare Part B premiums. They may also have to pay managed care providers a monthly premium and a copayment for services received. However, they do not pay Medicare deductibles or 20 percent of physician and outpatient charges that are required under the fee-for-service program.

Typically, after joining an HMO, a beneficiary selects a primary care physician who is affiliated with the HMO. All medical care is managed by that physician or a case manager. The primary care physician either provides needed services or refers a beneficiary to appropriate specialists or other health care providers associated with the HMO. In most instances, beneficiaries are required to obtain all their medical care through providers affiliated with the HMO they joined. However, emergency services may be obtained anywhere, and urgently needed care may be obtained elsewhere when a beneficiary is temporarily out of the HMO service area. Further, some HMOs have a "point of service" option which allows beneficiaries to obtain some care outside an HMO's contracted provider network by paying higher copayments for those services.

As of April 1998, approximately 5.6 million beneficiaries were members in one of 336 Medicare-contracted risk HMOs.[2]

METHODS

As part of a broad 1997 national survey to determine beneficiary satisfaction with Medicare,[3] we asked beneficiaries about their awareness of and interest in joining HMOs. HCFA staff assisted in developing the questions we used.

In July 1997, we mailed a questionnaire to 1269 randomly-selected Medicare beneficiaries for whom Part B claims had been filed in Calendar Year 1996. Beneficiaries were located both in areas that had Medicare HMOs and in areas that did not have Medicare HMOs. We excluded from our sample beneficiaries who were already enrolled in an HMO. We used standard equations for estimating sample size with a binary response variable.

Beneficiary participation in the survey was voluntary. A total of 977 beneficiaries returned completed questionnaires, for a response rate of 77 percent. Percentages in the report are based on the number of beneficiaries answering each question. Based on the response rate, estimates are within 3.2 percent of the true value at the 95 percent confidence level. Some individual

[2]Health Care Financing Administration, Medicare Managed Care Contract Report, April 1998.

[3]Office of Inspector General, United States Department of Health and Human Services. *Medicare Beneficiary Satisfaction: 1997*. OEI-04-97-00030.

findings may be less precise, depending on the number of beneficiaries who responded to specific questions. Appendix A shows beneficiary responses. Appendix B shows the confidence intervals.

Comparison to Previous Surveys

In 1994 and 1995, we conducted similar national surveys of Medicare beneficiaries to assess their awareness of and interest in joining an HMO.[4] Since most of the questions used in the 1997 survey were also used in our 1994 and 1995 surveys, we compared beneficiary responses in the three surveys.

We determined significant differences in beneficiary responses through use of a t-test. If there was a statistical difference between responses to the surveys, we stated the percent increased or decreased in the report. If there was not a statistical difference, we stated that the percent stayed about the same.

A consideration in surveys of this type is that the results may be biased if non-respondents are significantly different from respondents. To determine whether or not significant bias exist in this survey, we performed various analyses, including a comparison of age and gender for the 977 respondents and the 272 non-respondents. Our analyses revealed no significant difference, which suggests that our survey results were not biased based on age and gender. We were unable to determine if any non-response bias existed as a result of other factors, such as health, disability, and income.

----- ---- ---- ---- ----

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

[4]Office of Inspector General, United States Department of Health and Human Services. *Medicare Beneficiary Interest in HMOs* (OEI-04-93-00142). *Medicare Beneficiary Interest in Joining HMOs in 1995* (OEI-04-93-00151).

F I N D I N G S

GENERAL AWARENESS OF HMOs BY BENEFICIARIES INCREASED EACH YEAR

Seventy-nine percent of 933 beneficiaries who responded to our question about awareness said they had heard of HMOs. Table 1 shows that the percent of beneficiaries aware of HMOs has increased over the last two years. This is logical as the number of HMOs available to beneficiaries increased from 200 in 1994 to over 335 in 1998. The increase in awareness each year was statistically significant.

TABLE 1
BENEFICIARY AWARENESS OF HMOs

	1994	1995	
Beneficiaries Aware of HMOs	62%	70%	79%

Fewer Beneficiaries Wanted More Information About HMOs

Forty percent of 883 beneficiaries who answered our question said they would like to learn more about Medicare-contracted HMOs. Table 2 shows that the percent of beneficiaries who want more information has declined each of the last two years. The decrease each year was statistically significant. This decrease may be because more beneficiaries are aware of HMOs, and do not think they need more information.

TABLE 2
BENEFICIARY DESIRE FOR MORE INFORMATION

	1994	1995	1997
Yes	64%	54%	40%
No	36%	46%	60%

Although Beneficiary Awareness of HMO Appeal Rights Increased, Over Three-fourths Still Were Unaware

In the 1995 and 1997 surveys, we asked beneficiaries if they were aware that Medicare HMO members could appeal decisions HMOs made about their medical care. Table 3 shows that the percent of beneficiaries aware of these rights increased. However, over three-fourths are still unaware.

TABLE 3
BENEFICIARY AWARENESS OF APPEAL RIGHTS IN HMOs

	1995	
Yes	18%	24%
No	82%	76%

Respondents to our survey were not members of an HMO. An OIG survey of HMO members conducted in 1995 showed that HMO members were knowledgeable about their general right to complain about HMO services--OEI-07-94-00281.

BENEFICIARY AWARENESS OF MEDICARE HMOs IN THEIR LOCAL AREA REMAINED THE SAME

We asked beneficiaries if they lived in a location where they could join an HMO. Over half said they did not know, which is the same as in our 1995 survey. This is somewhat puzzling since the number of HMOs available to beneficiaries has increased, and the number of beneficiaries who had heard of HMOs increased. Table 4 shows that responses to the 1997 survey are about the same as in 1995.

TABLE 4
BENEFICIARY RESPONSES ON AVAILABILITY OF HMOs TO JOIN

	1994	1995	1997
Beneficiaries who said they did live in an area with Medicare HMOs	26%	34%	36%
Beneficiaries who said they did not live in an area with Medicare HMOs	10%	10%	8%
Beneficiaries who said they did not know if they lived in an area with Medicare HMOs	64%	56%	56%

We asked the 341 beneficiaries who said they lived in a location with an HMO to tell us how they heard about the HMO. Seventy-two percent (246 of 341) of them responded. Table 5 shows that most of those who had heard of HMOs did so through advertisements.

TABLE 5
HOW BENEFICIARIES BECAME AWARE OF HMOs

METHOD	BENEFICIARIES RESPONDING TO QUESTION	
	Number	Percent*
Advertising (Media Ads, Direct Mail, Salesmen,)	169	69
Family and Friends	61	25
Health Care Provider (Physician, Home Health Agency, Hospital)	20	8
Former or Current Employment	16	7
Insurance Companies	6	2
Presentations (Meeting, Seminar, Conference)	3	1
Previous Experience in an HMO	1	.4
Other (Senior Citizen Center, Newscasts)	2	1

*Some beneficiaries mentioned two ways of learning about HMOs. Therefore, the percentages total more than 100%.

These methods of awareness are similar to those identified by beneficiaries during our 1994 and 1995 surveys.

BENEFICIARY INTEREST IN JOINING AN HMO DECREASED

In 1997, 23 percent of 843 beneficiaries who answered our question expressed an interest in joining an HMO. In 1995, 35 percent said they would be interested. The decrease in percent of Medicare beneficiaries who said they would be interested in joining an HMO is statistically significant. Comparisons to 1994 should be made with the knowledge that we changed our question in 1995. As shown in Table 6, we offered a "Don't Know" response in the 1994 survey which we did not include in the 1995 and 1997 surveys.

TABLE 6
BENEFICIARY INTEREST IN JOINING AN HMO

	1994	1995	1997
Yes	27%	35%	23%
No	39%	65%	77%
Don't Know	34%	Not Asked	Not Asked

Beneficiaries responding to this survey were enrolled in Medicare's fee-for-service program. It is possible that most beneficiaries who wish to join an HMO have done so, and most beneficiaries who have not joined an HMO wish to remain in fee-for-service.

Beneficiaries Want to Select Their Physicians

Of the 77 percent who said they would not be interested in joining an HMO, half (344) cited one or more objection. Table 7 shows that most beneficiaries were concerned about their inability to select their doctors if they joined an HMO.

TABLE 7
WHY BENEFICIARIES OBJECT TO JOINING AN HMO

OBJECTION	BENEFICIARIES RESPONDING TO QUESTION	
	Number	Percent*
Inability to Select Physician(s)	158	46
Satisfied with Present Situation/Insurance	75	22
Perceived Poor Reputation of HMOs	45	13
Perceived Restrictions in an HMO	37	11
Perceived Poor Quality of Care	23	7
Lack of Enough Information on HMOs	8	2
Desire to Keep Present Physician	5	1
Other (Too Far to Drive, Too Expensive, and Perceived Loss of Benefits)	5	1

*Some beneficiaries mentioned two objections to joining HMOs. Therefore, the percentages total more than 100%.

C O N C L U S I O N

The Balanced Budget Act of 1997 expanded the types of managed care plans that will be available to beneficiaries. Accordingly, HCFA is currently negotiating contracts with managed care providers, and developing educational materials for beneficiaries. Our past studies and this study have shown, however, that over half of beneficiaries do not know whether or not a managed care plan is available that they can join. In preparing educational materials, HCFA could provide beneficiaries with information on managed care plans available in their local areas. Furthermore, in view of our survey results, it would also be useful for educational materials to emphasize beneficiaries' rights to appeal managed care decisions about their medical care.

We plan to continue our work on managed care issues. Accordingly, we will continue to monitor beneficiary knowledge and understanding of their choices. To this end, we hope to continue working with HCFA to develop information that will help them better meet beneficiary managed care needs.

A P P E N D I X A

RESPONSES TO 1997 SURVEY OF BENEFICIARIES

In some cities, Medicare beneficiaries, like yourself, can join managed care plans such as health maintenance organizations (HMOs). In an HMO, the primary care doctor authorizes, arranges for, and coordinates all medical services for you. You are usually required to receive all your medical care from the HMO's doctors, hospitals, and other providers that belong to the HMO.

QUESTION **RESPONSES**

1. Before today, had you ever heard of HMOs?

Yes	733
No	200
Not Answering: 44	

---

2. a. Are there HMOs in your city or town that Medicare beneficiaries can join?

Yes	341
No	71
Don't Know	524
Not Answering: 41	

b. If yes, how did you hear about those HMOs? (Open-ended question)

(N = 246, Number Answering Question)

HMO Advertising	169
Family and Friends	61
Health Care Providers	20
Former or Current Employers	16
Insurance Company	6
Presentations	3
Previously in HMO	1
Other	2
Not Answering: 95	

QUESTION **RESPONSES**

---

3. a. If there were HMOs in your city or town that Medicare beneficiaries could join, would you be interested in joining?

Yes	193
No	650
Not Answering: 134	

b. If no, what would be your objections? (Open-ended question)

(N = 344, Number Answering Question)

Inability to Select Physician	158
Satisfied with Present Situation/Insurance	75
Perceived Poor Reputation	45
Perceived Restrictions	37
Perceived Poor Quality of Care	23
Lack of Information on HMOs	8
Desire to Keep Present Physician	5
Other	5
Not Answering: 306	

---

4. Before today, were you aware that Medicare HMO members can appeal decisions HMOs make about their medical care?

Yes	201
No	627
Not Answering: 149	

---

5. Would you like to learn more about Medicare HMOs?

Yes	351
No	532
Not Answering: 94	

A P P E N D I X B

Confidence Intervals

Description	Estimate	Boundaries for the 95% Confidence Intervals
Beneficiaries who had heard of HMOs	79%	+/- 2.6%
Beneficiaries who wanted to learn more about HMOs	40%	+/- 3.2%
Beneficiaries not aware of HMO appeal rights	76%	+/- 2.9%
Beneficiaries who did not know if Medicare HMOs were available in their area	56%	+/- 3.2%
Beneficiaries interested in joining an HMO	23%	+/- 2.8%
Beneficiaries not interested in HMOs due to inability to select physician	46%	+/- 5.3%