Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare + Choice HMO Extra Benefits

Beneficiary Perspectives

JUNE GIBBS BROWN
Inspector General

FEBRUARY 2000
OEI-02-99-00030

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 New York regional office prepared this report under the direction of John I. Molnar, Regional Inspector General, and Renee C. Dunn, Deputy Regional Inspector General. Principal OEI staff included:

REGION

Demetra Arapakos, *Team Leader*
Ellen Vinkey, *Project Leader*
Lucille Cop
Vincent Greiber

HEADQUARTERS

Tricia Davis, *Program Specialist*
Scott Horning, *Technical Support*
Brian Ritchie, *Technical Support*
Barbara Tedesco, *Statistician*

To obtain copies of this report, please call the New York Regional Office at (212) 264-2000.
Reports are also available on the World Wide Web at our home page address:

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

EXECUTIVE SUMMARY

PURPOSE

To determine the degree to which extra benefits influence beneficiaries' decisions to join Medicare + Choice health maintenance organizations (HMOs) and the extent to which they value and understand the extra benefits offered by these health plans.

BACKGROUND

The Medicare managed care environment has recently undergone significant change. Medicare + Choice provisions established in the 1997 Balanced Budget Act resulted in an increased number of health plan options for beneficiaries. In addition, a number of HMOs have recently dropped out of some markets, causing beneficiaries in these areas to consider other coverage options. As of September 1999, 17 percent of beneficiaries nationwide had chosen HMOs over the traditional fee-for-service program. This study will contribute important data to the body of knowledge on how and why beneficiaries choose Medicare HMOs, thereby assisting Medicare policy makers in their efforts to improve the Medicare program.

Generally, HMOs are paid a prospective capitated payment to provide all Medicare-covered services to their enrollees. Additionally, many provide enrollees with coverage that exceeds Medicare-covered services in the form of extra benefits. As of December 1998, over 50 percent of HMOs offered the following extra benefits: outpatient drug coverage, routine physicals, eye exams, ear exams, and immunizations. Other extra benefits that were offered, but to a lesser degree, include: health education, dental coverage, foot care, eye glasses and hearing aids.

We used three methods for this inspection. First, we conducted a mail survey of a stratified random sample of 600 recent Medicare+Choice HMO enrollees. Second, we conducted an analysis of beneficiary knowledge to determine their level of understanding of their extra benefits. Third, we reviewed written marketing materials from the plans associated with our sample beneficiaries.

FINDINGS

Lower Costs Are More Important Than Extra Benefits

Enrollees Say Lower Costs Main Reason For Joining. Three out of four recent HMO enrollees report that lower costs were one of the reasons they decided to join their health

plan. In fact, half (49 percent) say it was the most important reason. There are a number of different costs which may be lower for HMO enrollees than for Medicare beneficiaries in the fee-for-service program. These can include lower co-payments for doctor visits and the lack of an annual deductible that must be met out-of-pocket prior to coverage by the Medicare program. HMO enrollees can also be charged either no or a low monthly HMO premium. The most recent HCFA data available indicate that, as of December 1998, 7 percent of all HMOs do not require beneficiaries to make any co-payment for office visits and 70 percent of plans charge no monthly premium. Forty percent of beneficiaries report that they would not stay with their HMO if they did not get the benefit of lower costs.

Prescription Drug Coverage Most Important Extra Benefit. While half of recent enrollees say that extra benefits influenced their decision to join an HMO, one third of all recent enrollees indicate that prescription drug coverage was the single most important reason they chose their HMO. Approximately 68 percent of all HMOs offered drug coverage as of December 1998.

Most Enrollees Compare Plans and Extra Benefits When Joining a HMO. The majority of recent enrollees (63 percent) report that they looked at more than one plan before they joined their HMO, almost all of whom compared extra benefits. When deciding to join, many (64 percent) think they will get health care services with their HMO that they would not get if they chose the Medicare fee-for-service program.

Once Enrolled In a HMO, Medicare Beneficiaries Value Prescription Drugs, Regular Physicals, and Vision Benefits The Most

Three types of extra benefits are particularly valued by HMO enrollees. When asked which three benefits are most important to them, 87 percent of recent enrollees say prescription drugs, 70 percent say regular physicals, and 68 percent say vision benefits. According to HCFA data over 50 percent of plans offer some coverage at no extra cost to beneficiaries for drugs, regular physicals, and eye exams. The number of plans that offer eye glass coverage is much smaller; less than 5 percent. Although highly valued, the prescription drug benefit is least likely to meet enrollees' expectations. Forty percent report that they are not receiving the kind of drug coverage they expected. More specifically, a quarter say they spend more on drugs than they thought they would.

HMO Enrollees' Understanding of Their Extra Benefits is Uneven

Enrollees accurately report coverage of regular physicals but their understanding of other benefits is not as high. When we compared enrollees' answers about the extra benefits their plan provides to Medicare HMO contract data, just under 90 percent of recent enrollees' answers matched Medicare data with regard to coverage for regular

physicals. However, HMO enrollee understanding of other highly valued benefits, such as prescription drugs and vision care, is not has high.

While generally easy to understand, sample HMO marketing materials vary greatly. Almost all HMO plans in our sample (99 percent) include information on extra benefits in their marketing materials. However, significant variation exists in the format and length of these materials. In addition, when we reviewed information on prescription drug coverage, we found potential for confusion. For example, almost 10 percent of sample plan materials we reviewed did not indicate whether or not the plan provides prescription drug coverage.

RECOMMENDATIONS

The findings of this report indicate that lower costs and extra benefits, particularly drug coverage, are important to prospective HMO enrollees. We are also releasing two concurrent reports on HCFA's new marketing guidelines. A common thread among all of these reports is that beneficiaries seek out but do not always find adequate information they can use to make informed comparisons among Medicare + Choice HMOs. As noted in this study, many recent enrollees do not understand which extra benefits their plan offers and HMO marketing materials contain inconsistent marketing information.

Therefore, we recommend that HCFA develop mechanisms to assure comparability of Medicare + Choice HMO plan costs and benefits. HCFA has been taking steps to develop a standard format for plan benefit summaries. We support these steps and encourage the completion of this task. We believe that greater standardization can improve prospective enrollees' ability to make informed comparisons. Furthermore, enrollees' expectations are more likely to be fulfilled if standardized benefit information is available to them when choosing a Medicare + Choice health plan.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To determine the degree to which extra benefits influence beneficiaries' decisions to join Medicare + Choice health maintenance organizations (HMOs) and the extent to which they value and understand the extra benefits offered by these health plans.

BACKGROUND

The Medicare managed care environment has recently undergone significant change. The Balanced Budget Act of 1997 resulted in an increased number of health plan options for beneficiaries. In addition, a number of HMOs have recently dropped out of some markets, causing beneficiaries in these areas to consider other coverage options. This study will contribute important data to the body of knowledge on how and why beneficiaries choose Medicare HMOs, thereby assisting Medicare policy makers in their efforts to improve the Medicare program.

The Office of Inspector General (OIG) has conducted numerous inspections on Medicare HMOs (see Appendix A). Of primary relevance to this study are two concurrent reports [1]. The first, on new marketing guidelines, found that few approved marketing materials were in full compliance with HCFA requirements. The second found that limitations exist in HCFA's review process. The OIG is also conducting a study on the impact of HMO closures on Medicare beneficiaries. Additionally, the GAO released a report[2] in April 1999 which found that Medicare + Choice HMO plan materials are often confusing and hard to compare.

Increasing Health Care Plan Choices for Beneficiaries

The 1997 Balanced Budget Act established Medicare + Choice provisions which set forth a number of different "coordinated care" options for beneficiaries to choose from. These new options mean that beneficiaries now need to make informed choices between the traditional fee-for-service health care program and a number of different types of managed care organizations. Managed care options include: Medicare + Choice HMOs (formerly called risk-HMOs) and newer alternatives such as Medicare + Choice preferred provider

[1]"Medicare Managed Care: 1998 Marketing Materials" OEI-03-98-00271 and "Medicare Managed Care: Goals of National Marketing Guide" OEI-03-98-00270

[2]Medicare + Choice- New Standards Could Improve Accuracy and Usefulness of Plan Literature GAO/HEHS-99-92

organizations, provider sponsored organizations and private fee-for-service plans. The Health Care Financing Administration (HCFA) continues to take steps to help beneficiaries make informed health plan choices in this new environment. In November 1998, they began a large scale informational campaign to send every beneficiary in the country a mailing that describes the new Medicare + Choice options.

Medicare + Choice HMOs

As indicated above, there are a variety of different types of Medicare + Choice managed care organizations. Most use a gatekeeper (usually a primary care physician) who must approve additional medical services. Historically, there have been a number of ways that managed care organizations contracted with HCFA to provide services. Most recently the majority of managed care organizations were Medicare risk-HMOs. Under these contracts, established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), plans were paid a prospective capitated payment to provide all Medicare-covered services to beneficiaries. Within the last year, Medicare risk-HMO contracts have been converted to Medicare + Choice contracts. All Medicare + Choice organizations are paid on a risk basis. The amount of the capitated payment is based on a complicated formula which is currently under going change. The formula includes factors such as: fee-for-service program historical expenditures; inflation estimates; differences in county level spending; and the individual characteristics of the plan's enrollees.

The percentage of Medicare beneficiaries who choose managed care health plans over the traditional fee-for-service program continues to grow. In 1994, prior to the implementation of Medicare + Choice, 5 percent of Medicare beneficiaries were enrolled in risk HMO plans, with the vast majority remaining in the traditional fee-for-service program. As of September 1999, 17 percent of Medicare beneficiaries nationwide (approximately 6 million), had chosen risk HMOs over the traditional fee-for-service program. Because the geographical distribution of enrollment varies widely, the percentage of beneficiaries enrolled in risk HMOs is much greater in some parts of the country. In Arizona and California, for example, approximately 40 percent of beneficiaries were enrolled in a risk HMO as of September 1999. In contrast, nine States had no Medicare beneficiaries enrollees in risk HMO enrollees (Alaska, Iowa, Mississippi, Montana, North Dakota, South Dakota, Utah, Vermont, and Wyoming).

Extra Benefits Offered by Medicare + Choice HMOs

Many Medicare + Choice HMOs provide enrollees coverage that exceeds the required Medicare benefits for beneficiaries in the fee-for-service program. There are two kinds of extra benefits that these HMOs can provide for Medicare beneficiaries-- those funded out of savings (mandated by Medicare to the extent that the plan has savings) and optional benefits the HMO decides to provide (sometimes at an additional charge to beneficiaries). Historically, fee-for-service Medicare beneficiaries have purchased Medigap insurance to cover some of the health care expenses that Medicare does not cover and to reduce their

out-of-pocket costs. Medicare + Choice HMO beneficiaries who enroll in plans that offer extra benefits can get some of the same coverage that Medigap insurance provides without paying a Medigap premium. Two examples of extra benefits offered include prescription drug coverage and eye exams, neither of which are covered in the fee-for-service program.

Extra Benefits Funded Out of Savings. Plans are required to use revenues that exceed their allowable profits to fund extra noncovered benefits for Medicare enrollees. These extra benefits can take the form of either additional health care coverage or reduced beneficiary cost sharing, such as the elimination of the HMO monthly premium that Medicare gives HMOs the option to charge.

As of December 1998, over 50 percent of plans offered each of the following: routine physicals, eye and ear exams, outpatient drug coverage and immunizations. Other extra benefits that were offered, but to a lesser degree, included the following: health education, dental coverage, foot care, eye glasses and hearing aids. It is important to note that in many instances the amount of coverage being offered is limited. For example, most HMOs limit the coverage they provide for drugs to some specified dollar amount each year.

In addition to cost sharing benefits offered in the form of waived HMO monthly premiums some HMOs reduce costs by eliminating co-payments for office visits. As of December 1998, 70 percent of plans waived the monthly premium and 7 percent of risk HMOs did not require beneficiaries to make any co-payment for office visits.

Optional Extra Benefits. As indicated earlier, Medicare + Choice HMOs are also allowed to offer extra benefits to Medicare beneficiaries beyond those required to spend the savings. They are usually inclined to do so in response to local market forces. Plans that offer extra benefits and no premiums are more likely to attract beneficiaries. While plans are allowed to charge for these benefits, they must do so within certain guidelines. Often these benefits are offered to beneficiaries in the form of one or more high-option packages. As of December 1998, just over half of Medicare risk HMOs offered a high-option plan.

In addition to the extra benefits and reduced cost sharing mentioned above, there are other cost advantages which affect many HMO enrollees. Although they must pay the $45.50 monthly Medicare Part B premium for doctor visit coverage, they generally pay significantly lower co-payments for office visits than they would in the fee-for-service program. In addition, Medicare + Choice HMOs generally do not require the payment of an annual deductible amount prior to covering services. Interestingly, a number of State Health Insurance Program counselors report a recent significant increase in Medigap

premiums and note that these increases are driving many beneficiaries to consider switching from traditional fee-for-service Medicare to HMOs.

METHODOLOGY

Multiple Methods

We used three methods for this inspection. First, we conducted a mail survey of recent Medicare+Choice HMO enrollees. Second, we conducted an analysis of beneficiary understanding of their extra benefits. Third, we reviewed written marketing materials from the plans associated with our sample beneficiaries.

Sample Selection

Using the HCFA's Group Health Plan (GHP) Master file, we selected a stratified random sample of 600 beneficiaries who had enrolled in Medicare+Choice HMOs between August 1, 1998 and January 31, 1999. (Throughout the balance of this report the term HMO will be used to refer to Medicare+Choice HMOs.) The sample was stratified based on the size of the HMO plan the beneficiary was in. The three strata included: beneficiaries enrolled in plans with less than 20,000 enrollees; beneficiaries in plans with 20,000-50,000 enrollees and beneficiaries in plans with greater than 50,000 enrollees.
We included only beneficiaries who had recently enrolled which improved the likelihood that survey respondents were able to recall the decision making process they went through when choosing between Medicare providers. Beneficiaries who were new to their HMO only because their HMO merged with another HMO were dropped from the universe.

Beneficiary Survey

A self-administered questionnaire was mailed to all 600 sample beneficiaries. Follow-up postcards and a second mailing of questionnaires were used to achieve a 74 percent response rate. Data collection was done during April and May 1999. In order to ensure that the questions we asked used language that was familiar to respondents, we held a focus group at a local senior citizen center to get Medicare beneficiary input on a draft version of the questionnaire. After incorporating what we learned from the focus group, we pre-tested the survey instrument again, by mailing it to beneficiaries who filled it out and then provided feedback through telephone discussions. This helped us to ensure that the instructions were clear and the questions were relevant. The mail survey included questions about the extra benefits beneficiaries' HMOs offer and the relative importance of different factors when they were choosing a HMO plan.

Analysis of Beneficiary Knowledge

To assess beneficiaries' understanding of the extra benefits covered by their HMO, we compared their answers to survey questions about the extra benefits their HMO provides to HCFA information on coverage offered by their HMOs. HMO contract numbers were used to match beneficiaries' HMOs with the pertinent HCFA coverage data. In a small number of instances, HCFA data was not available for a given contract. We performed this analysis for all beneficiaries in our sample who answered the pertinent survey questions and for whom HCFA coverage data was available.

Marketing Material Analysis

We requested the written marketing materials used to communicate with prospective plan members from all HMOs associated with our sample beneficiaries. We asked plans to submit materials used between June 1, 1998 and January 1, 1999, the period during which our sample beneficiaries would most likely have been comparing HMO plans. Almost all of the sample plans submitted the materials requested; our analysis was performed on 191 of the 206 plans included in our sample. The total number of Medicare + Choice risk HMOs at the time we pulled our sample was 297. Using a structured review sheet, we evaluated whether extra benefit coverage was provided, whether language was clear, if limitations were listed prominently, how thoroughly the drug benefit was explained, and, the degree to which variation existed among marketing materials.

Methodology Limitations

There are several limitations to our analysis of beneficiary knowledge. The HCFA's data does not include all extra benefits HMOs offer, so our comparison of what beneficiaries say they get and what their HMO contracts with HCFA to provide is limited. Two of the primary benefits we are unable to address in this analysis are dental care and transportation coverage. Second, and most importantly, we did not have data indicating whether sample beneficiaries were enrolled in their HMOs basic or optional hi-rider plan. As a result, to the extent that sample beneficiaries have opted for a hi-rider plan, our analysis may overstate the number of beneficiaries who overestimate their extra benefit coverage.

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

FINDINGS

Lower Costs Are More Important Than Extra Benefits

Enrollees Say Lower Costs Main Reason For Joining

Three out of four recent HMO enrollees report that lower costs were one of the reasons they decided to join their health plan. Of the enrollees who say cost is the most important reason they joined their HMO, a quarter indicate that no monthly HMO premium was the most important factor, 15 percent cite low co-payments for doctors visits, and 9 percent cite their low monthly premium.

As indicated in the background, there are a number of different costs which may be lower for HMO enrollees than for Medicare beneficiaries in the fee-for-service program. These can include lower co-payments for doctor visits and the lack of an annual deductible that must be met out-of-pocket prior to coverage by the Medicare program. Enrollees can also be charged either no or a low monthly premium. The most recent HCFA data available indicate that, as of December 1998, 7 percent of all HMOs do not require beneficiaries to make any co-payment for office visits and 70 percent of plans charge no monthly premium.

Forty percent of beneficiaries report that they would not stay with their HMO if they did not get the benefit of lower costs; they would either choose a less expensive HMO or switch to the Medicare fee-for-service program. Many (38 percent) do not know what they would do if costs increased.

Prescription Drug Coverage Most Important Extra Benefit

While half of recent enrollees say that extra benefits in general influenced their decision to join an HMO, prescription drug coverage was particularly important. One third of all recent enrollees indicate that this coverage was the single most important reason they chose their HMO. Approximately 68 percent of all HMOs offered drug coverage as of December 1998. Only 5 percent of recent enrollees cite any other individual extra benefit as their main reason, with almost all of these saying that coverage for regular physicals was of primary importance.

Participating Doctors, Proximity, and Plan Reputation Also Considered

Recent enrollees cite other factors as playing a role in their decision to join. These include the HMO's participating doctors, its proximity, and its reputation. Over half report that the doctors at the HMO are one of the reasons they decided to join. Expressing this

sentiment, one beneficiary reports, "most of my doctors are with this HMO"; another recent HMO enrollee says, "I went to an HMO because of cost and because my doctor was in the plan." The proximity and reputation of the HMO are two other considerations that enrollees report influence their decision to join. Just over 40 percent report that the plan's close location to their home and reputation for quality care are important.

Most Enrollees Compare Plans and Extra Benefits When Joining a HMO

The majority of recent enrollees (63 percent) report that they looked at more than one plan before they joined their HMO, almost all of whom compared extra benefits. Many recent enrollees (64 percent) think they will get health care services with their HMO that they would not get if they were in the Medicare fee-for-service program. The majority of recent HMO enrollees report that they do not think they gave anything up in order to receive these extra benefits; the few who think they did make a trade-off report that they lost the freedom to use a particular MD or specialist.

Once Enrolled In a HMO, Medicare Beneficiaries Value Prescription Drugs, Regular Physicals, and Vision Benefits The Most

These Three Benefits Are Also Used The Most

Three types of extra benefits are particularly valued by HMO enrollees. When asked which three benefits are most important to them, 87 percent of recent enrollees say prescription drugs, 70 percent say regular physicals and 68 percent say vision benefits[3]. In addition, just under a quarter of enrollees included dental care on their list of most valued extra benefits. Of least importance to recent enrollees is acupuncture, with one half saying this is the benefit they value the least. As indicated in the background, according to HCFA data over 50 percent of plans offer some coverage at no extra cost to beneficiaries for drugs, regular physicals, and eye exams. The number of plans that offer eye glass coverage is much smaller; less than 5 percent.

Recent enrollees report using a large number of their extra benefits, even within the relatively short time frame that they have been members of their HMO. A majority of recent enrollees say they used five of eleven commonly offered extra benefits within six months of joining their plan. These five benefits include, in order of frequency, prescription drugs, regular physicals, eye exams, eye glasses, and health education services. Almost half of recent HMO enrollees say that they would choose another HMO or switch to the Medicare fee-for-service program if their HMO stopped offering extra benefits.

[3]Eye exams and eye glasses

However, The Prescription Drug Benefit Is Least Likely to Meet Enrollees' Expectations

Although a majority of all enrollees (80 percent) say that overall their expectations are being met, 40 percent report that they are not receiving the kind of drug coverage they expected when they joined their HMO. More specifically, a quarter say they spend more on drugs than they thought they would. Some of the reasons enrollees may be less than satisfied with drug coverage include: annual limits on drugs that they view as too low to meet their needs effectively; plan rules regarding generic vs. non-generic drugs; and, the amount of the co-payment required at the time a prescription is filled.

Most HMO enrollees do, in fact, have some limitations on their drug coverage. Ninety percent report that they are required to make a co-payment when they fill a prescription. In addition, over half of recent enrollees say their plan puts a limit on the amount of money the HMO will pay for drugs in a given year. Enrollees report limits ranging from $200 to $4000.

HMO Enrollees' Understanding of Their Extra Benefits is Uneven

Enrollees Most Accurately Report Coverage of Regular Physicals But Their Understanding of Other Benefits is Not as High

When we compared enrollees' answers about extra benefits provided by their HMO to Medicare data on the benefits HMOs are contracted to provide, just under 90 percent of enrollees' answers matched Medicare program data with regard to coverage for regular physicals. However, HMO enrollee understanding of other benefits is not as accurate. As the table on the next page indicates, enrollees have a less accurate understanding about the other six benefits we analyzed. These include three highly valued benefits: drug coverage, eye exams, and eye glasses.

Table 1
HMO Enrollee Understanding of Extra Benefit Coverage

Benefit	Enrollees Who Accurately Report Coverage
Regular Physicals	89%
Prescription Drugs	80%
Eye Exams	75%
Ear Exams	42%
Foot Care	39%
Hearing Aid	25%
Eye Glasses	14%

Enrollees who do not accurately report their extra benefit coverage fall into three categories: those who overestimate their coverage, those who underestimate it, and those who say they do not know whether or not they have coverage for a particular benefit. Generally, HMO enrollees are more likely to overestimate, rather than underestimate, the benefits their HMO provides. Furthermore, many enrollees do not know whether or not they are receiving extra benefits. For example, over one third of all recent enrollees report that they do not know whether their HMO provides coverage for hearing aids, ear exams or foot exams.

While Generally Easy to Understand, Sample Marketing Materials Vary Greatly

We reviewed sample HMO marketing materials used to communicate with prospective Medicare HMO plan members. These materials included marketing pamphlets, booklets describing plan benefits, as well as plan applications. Our analysis focused primarily on whether the materials provide clear information on extra benefits. Almost all HMO plans in our sample include information on extra benefits in their marketing materials. Also, we found that the majority of plans list this information prominently and use language that we judged relatively easy to understand.

However, when we reviewed marketing material information on prescription drug coverage, we found potential for confusion. Almost 10 percent of sample plan marketing

materials we reviewed did not indicate whether or not the plan provides prescription drug coverage. When drug coverage is addressed, a few plans do not indicate the amount of the annual dollar limit.

Additionally, our review found significant variation in marketing information. For example, we found variation in the length of materials, with some plan materials being very lengthy, while others are only a few pages long. Lengthier materials may make it more difficult for prospective HMO enrollees to locate and understand information on extra benefit coverage and cost sharing requirements. The format of extra benefit information included in sample marketing materials also varies. For example, only 35 percent of marketing materials provide a reference for extra benefit information in their table of contents.

A recent OIG report looked at the HCFA review process for HMO marketing materials. That report found that only 13 percent of materials were in full compliance with guidelines used by HCFA to ensure accurate materials that are useful to prospective enrollees. In addition, 40 percent were found to be confusing, and 28 percent contained jargon.

RECOMMENDATION

The findings of this report indicate that lower costs and extra benefits, particularly drug coverage, are important to prospective HMO enrollees. As noted earlier, we are also releasing two concurrent reports on HCFA's new marketing guidelines. A common thread among all of these reports is that beneficiaries seek out but do not always find adequate information they can use to make informed comparisons among Medicare + Choice HMOs. As noted in this study, many recent enrollees do not understand which extra benefits their plan offers and HMO marketing materials contain inconsistent marketing information.

Therefore, we recommend that HCFA develop mechanisms to assure comparability of Medicare + Choice HMO plan costs and benefits. HCFA has been taking steps to develop a standard format for plan benefit summaries. We support these steps and encourage the completion of this task. We believe that greater standardization can improve prospective enrollees' ability to make informed comparisons. Furthermore, enrollees' expectations are more likely to be fulfilled if standardized benefit information is available to them when choosing a Medicare + Choice health plan.

APPENDIX A

SELECTED LIST OF RECENT OFFICE OF INSPECTOR GENERAL HMO INSPECTIONS

Office of Inspector General, US Department of Health and Human Services, "Medicare Managed Care- 1998 Marketing Materials," OEI-03-98-00271, February 2000.

Office of Inspector General, US Department of Health and Human Services, "Medicare Managed Care- Goals of National Marketing Guide," OEI-03-98-00270, February 2000.

Office of Inspector General, US Department of Health and Human Services, "Medicare Beneficiary Interest in HMOs in 1997," OEI-04-97-00032, September 1998.

Office of Inspector General, US Department of Health and Human Services, "Capitation Rates for Medicare Managed Care Plans Are Inflated Due to Improper Payments Included in Rate Calculations," A-14-97-00206, September 1998.

Office of Inspector General, US Department of Health and Human Services, "Medicare HMO Appeals and Grievance Processes: Beneficiary Understanding," OEI-07-94-00281, December 1996.

APPENDIX B

CONFIDENCE INTERVALS FOR KEY FINDINGS

KEY FINDINGS	POINT ESTIMATE	CONFIDENCE INTERVAL
HMO enrollees report that lower costs are the most important reason they decided to join their HMO.	71%	± 4.5
Recent enrollees indicate that drug coverage was the single most important reason they chose their HMO.	30%	± 5.0
Enrollees say prescription drugs are one of the three extra benefits they value the most.	87%	± 3.4
Enrollees say regular physicals are one of the three extra benefits they value the most.	70%	± 4.5
Enrollees say vision benefits are one of the three extra benefits they value the most.	68%	± 4.6
Recent enrollees' answers matched Medicare data with regard to coverage for regular physicals.	89%	± 3.2
Enrollees have a less accurate understanding about prescription drug coverage.	80%	± 4.2
Enrollees have a less accurate understanding about eye exam coverage.	75%	± 4.4
Enrollees have a less accurate understanding about eye glass coverage.	14%	± 3.6
Some sample plan materials did not indicate whether or not the plan provides prescription drug coverage.	8%	± 4.0

APPENDIX C

BENEFICIARY NON-RESPONDENT ANALYSIS

When surveys are used to collect data, the results may be biased if non-respondents differ from respondents. For this inspection, a beneficiary for whom a HMO Extra Benefit Questionnaire was not received is a non-respondent. Additionally, a sample HMO that did not answer our request for marketing materials is a non-respondent. We tested for non-response bias among sample beneficiaries. However, since only a small percentage (8 percent) of sample HMOs did not submit marketing materials, it was not necessary to perform a HMO non-respondent analysis. To test for the presence of any bias in our analysis of beneficiary questionnaires, we first obtained information from HCFA's Enrollment Database for all 600 beneficiaries who were sent a mail questionnaire. The results are shown in the tables that follow.

A total of 441 beneficiary surveys were returned, for a response rate of 74%. To test for the presence of any non-response bias, we analyzed the variables which might influence whether an individual would respond to the survey or that might affect his or her responses. For the 600 beneficiaries in our survey we looked at: gender, race and whether the beneficiary was enrolled in a small, medium or large Medicare HMO (strata). For purposes of this analysis, race was divided into white and non-white in order to assure that the numbers in each cell would not be too small to make meaningful comparisons. These categorical variables were tested using Chi-square with the appropriate degrees of freedom.

The results of this analysis are presented in tables C(1-3). The Chi-square values given in the tables provide a test of the difference between the distribution of the respondents and that of the non-respondents for the variable of interest. Also provided in the tables are the response rates by the different values of the variables. The differences in these tables between the response rates for gender and HMO size are not statistically significant. Table C-3, however, shows a statistically significant difference between respondents and non-respondents with respect to race. In order to test whether this difference introduced any bias, we analyzed answers to a couple of key survey questions given by white and non-white respondents. The two questions we looked at were: whether cost influenced the decision to join the HMO and whether prescription drugs was the single most important benefit that influenced the beneficiary's decision to join their HMO. With respect to the first question, the proportion of white and non-white respondents who answered yes differed by 10 percentage points, so further analysis was required. Assuming that non-respondents from each of racial groupings would have answered the same as respondents with the same designation, we calculated hypothetical global response rates for all 600 beneficiaries in the sample. This calculation gave only a slightly lower percentage (69% vs. 71%) of beneficiaries

who report that cost influenced their decision to join the HMO. This difference is not statistically significant.

Given the results of this analysis, we believe that the inspection findings fairly represent the experience and opinions of Medicare HMO beneficiaries to whom the questionnaires were sent. We therefore believe that our survey results can be generalized to the universe of HMO Medicare beneficiaries who joined Medicare+Choice HMOs between August 1,1998 and January 31, 1999.

CHI-SQUARE Values for Testing Significance of Differences Between Respondents and Non-Respondents For (1) Gender (2) Size of HMO (Strata) and (3) Race

Table C-1
GENDER

	Respondents	Non-Respondents	Total	Percent
Male	190 (43%)	66 (42%)	256	74%
Female	251 (57%)	93 (58%)	344	73%
Total	441	159	600	74%

Chi-Square=0.118
Degrees of Freedom = 1

Table C-2
HMO SIZE (Strata)

	Respondents	Non-Respondents	Total	Percent
Small (>20,000 enrollees)	145 (33%)	55 (35%)	200	73%
Medium (20,000-50,0000)	141 (32%)	59 (37%)	200	71%
Large (<50,000)	155 (35%)	45 (28%)	200	78%
Total	441	159	600	74%

Chi-Square=2.670
Degrees of Freedom = 2

Table C-3
RACE

	Respondents	Non-respondents	Total	Percent
White	377 (86%)	116 (74%)	493	76%
Non-White	62 (14%)	41 (26%)	103	60%
Total	439	157	596	74%

Chi-Square=11.633
Degrees of Freedom = 1

APPENDIX D

AGENCY COMMENTS

We provided the agency with a working draft copy of this report and we did not receive comments.

June Gibbs Brown
Inspector General

OIG Final Report "Medicare + Choice HMO Extra Benefits: Beneficiary Perspectives," OEI-02-99-00030

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is our final report on the influence of extra benefits on beneficiaries' decisions to join Medicare + Choice HMOs. This report also addresses the extent to which these beneficiaries value and understand the extra benefits offered by their health plans.

Based on a survey of 600 recent Medicare + Choice enrollees, we found that in general lower costs are more important than extra benefits. Once enrolled in a HMO, Medicare beneficiaries value prescription drugs, regular physicals, and vision benefits the most. However, the prescription drug benefit is least likely to meet enrollees' expectations. We also evaluated how well enrollees' understand their extra benefit coverage and found that they accurately report coverage of regular physicals, but their understanding of other benefits is not as high. Finally, we reviewed HMO marketing material descriptions of extra benefits coverage and found that, while generally easy to understand, sample HMO marketing materials vary greatly.

We are also releasing two concurrent reports on HCFA's new marketing guidelines. A common thread among all of these reports is that beneficiaries seek out but do not always find adequate information they can use to make informed comparisons among Medicare + Choice HMOs. **Therefore, we recommend that HCFA develop mechanisms to assure comparability of Medicare + Choice HMO plan costs and benefits.** We recognize that HCFA has been taking steps to develop a standard format for plan benefit summaries and encourage the completion of this task.

Please submit within 60 days your plan to implement the recommendations or explain why it is not possible to do so. If you have any questions, please call me or George Grob, Deputy Inspector General for Evaluation and Inspections, or have your staff call Stuart Wright at (410) 786-3144 with any comments or questions.

Attachments