Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Beneficiary Interest in HMOs in 1995

JUNE GIBBS BROWN
Inspector General

FEBRUARY 1997
OEI-04-93-00151

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Department of Health and Human Services

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EXECUTIVE SUMMARY

PURPOSE

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

BACKGROUND

In all geographic areas, Medicare beneficiaries can obtain medical care through a fee-for-service arrangement. However, approximately 74 percent of beneficiaries also have an option of obtaining medical care through managed care plans known as health maintenance organizations (HMOs). As of April 1995, approximately 3.7 million beneficiaries were members in one of 271 Medicare-contracted HMOs.

The Health Care Financing Administration (HCFA) asked us to determine beneficiary interest in using health maintenance organizations (HMOs). As part of a broad 1995 national survey, we asked 942 beneficiaries about their awareness of and interest in joining HMOs. We excluded from our sample beneficiaries who were already enrolled in an HMO. Where possible, we compared beneficiary responses to their responses to a similar survey we conducted in 1994.

FINDINGS

More beneficiaries were aware of HMOs than in 1994

- Seventy percent of the beneficiaries said they had heard of HMOs. This is an increase from 1994 when 62 percent said they knew about HMOs.

- About 44 percent of beneficiaries said they knew whether or not they lived in locations where they could join an HMO. This is an improvement from 1994 when 36 percent said they knew.

- Fifty-four percent of the beneficiaries said they would like to learn more about Medicare-contracted HMOs. This is less than in 1994 when 64 percent said they wanted more information.

About a third of beneficiaries expressed an interest in joining an HMO

- Thirty-five percent of the beneficiaries expressed an interest in joining an HMO.

- Of the beneficiaries who were not interested in joining an HMO, about 33 percent said the main reason was they could not select their own physicians.

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

- Seventeen percent of the beneficiaries were aware that HMO members have appeal rights.

CONCLUSION

Clearly, beneficiary awareness of HMOs is increasing. The increase can be partly attributed to HCFA projects designed to help educate Medicare beneficiaries about managed care. For example, HCFA has updated the Medicare and Managed Care Plans brochure. The increase in awareness can also be partly attributed to the increase in number of HMOs available for Medicare beneficiaries to join. Over half of the beneficiaries who knew about HMOs had found out about them through advertising by the HMO.

However, 30 percent of the beneficiaries we surveyed said they had not heard of HMOs. Further, the most prevalent reason beneficiaries cited for not wanting to join an HMO was their inability to select and keep their physicians.

We recognize that HCFA has taken significant steps to enhance beneficiaries' choices in medical care. Still, there is always more that can be done. We suggest the following.

- Intensify outreach efforts to educate Medicare beneficiaries about Medicare HMOs. For example, HCFA could distribute their managed care brochures to senior citizen centers in locations where Medicare beneficiaries can join HMOs. In their educational materials, HCFA could highlight characteristics of Medicare HMOs, including the benefits offered and appeal rights.

- Explore ways that allow beneficiaries greater freedom to choose their own physicians in managed care settings.

AGENCY COMMENTS

The HCFA Administrator concurred with our conclusion that HCFA should intensify outreach efforts to educate beneficiaries about Medicare HMOs. He reported that the *1996 Medicare Handbook* mailed to all beneficiaries included an extensive description of the managed care benefit. The HCFA has also worked with beneficiary advocacy groups, and included representatives from those groups in the development of educational materials.

The Acting Assistant Secretary for Planning and Evaluation provided several useful comments which helped sharpen the interpretation of survey results. In response, we made changes to clarify our information where possible and appropriate.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION 1

FINDINGS

- Beneficiary Awareness of HMOs 4
- Interest in Joining an HMO 5

CONCLUSION 7

AGENCY COMMENTS 8

APPENDICES

Beneficiary Responses to 1995 Survey A-1

Agency Comments B-1

INTRODUCTION

PURPOSE

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

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 1995, Medicare insured about 37.6 million beneficiaries, and paid benefits totalling over $159 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. However, approximately 74 percent of beneficiaries also have an option of obtaining medical care through managed care plans known as health maintenance organizations (HMOs). As of April 1995, approximately 3.7 million beneficiaries were members in one of 271 Medicare-contracted HMOs.[2]

In the interest of expanding health care options, HCFA asked us to determine beneficiary interest in joining HMOs.

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 pay the remaining 20 percent of allowable charges, plus Medicare premiums and deductibles.

HMOs - Beneficiaries enroll in Medicare-contracted HMOs which manage their medical care. Each HMO has a defined geographic area, and the HMO 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.

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[1] Health Care Financing Administration, United States Department of Health and Human Services, Data Compendium, March 1995.

[2] Health Care Financing Administration Press Release, November 27, 1995.

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. Beneficiaries are required to obtain all their medical care through providers affiliated with the HMO they joined, except for emergency and urgently needed care when they are out of the HMO service area.

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 the managed care plan 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.

METHODS

As part of a broad 1995 national survey to determine beneficiary satisfaction with Medicare,[3] we asked beneficiaries about their awareness of and interest in joining HMOs. We used questions that were developed by HCFA staff.

In September 1995, we mailed a questionnaire to 1244 randomly-selected Medicare beneficiaries for whom Part B claims had been filed in Calendar Year 1994. 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 942 beneficiaries returned completed questionnaires, for a response rate of 76 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. The individual findings may be less precise, depending on the number of beneficiaries who responded to specific questions. Appendix A shows beneficiary responses.

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 significant differences exist in this survey, we performed various analyses, including a comparison of age and gender for the 942 respondents and the 302 non-respondents. The analyses revealed no significant difference, which suggests that our survey results

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[3]Office of Inspector General, United States Department of Health and Human Services. *Medicare Beneficiary Satisfaction: 1995*. OEI-04-93-00150.

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 and disability.

Comparison to Previous Survey

In 1994, we conducted a similar national survey of Medicare beneficiaries to assess their awareness of and interest in joining an HMO.[4] Since most of the questions used in the 1995 survey were also used in our 1994 survey, we were able to compare beneficiary responses in 1994 and 1995. We have determined significant differences in beneficiary responses through use of a t-test.

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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.

FINDINGS

MORE BENEFICIARIES WERE AWARE OF HMOs THAN IN 1994

Seventy percent of 918 beneficiaries who responded to our question about awareness said they had heard of HMOs. This is an increase from 1994 when 62 percent said they had heard of HMOs.

We asked the 308 beneficiaries who said they lived in a location with an HMO to tell us how they heard about the HMO. Seventy-eight percent (240 of 308) of them responded. Table 1 shows that most of those who had heard of HMOs did so through advertisements.

TABLE 1
HOW BENEFICIARIES BECAME AWARE OF HMOs

METHOD	BENEFICIARIES RESPONDING TO QUESTION*	
	Number	Percent
Advertising (Television, Newspaper, Direct Mail)	138	58
Family and Friends	55	23
Former or Current Employment	22	9
Insurance Companies	9	4
Physicians	9	4
Previous Experience in an HMO	4	2
Other (Hospitals, Senior Citizen Centers, and Newscasts)	15	6

*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 survey.

About 44 Percent of the Beneficiaries Knew Whether or Not They Lived in a Location Where They Could Join an HMO

We asked beneficiaries if they lived in a location where they could join an HMO. Thirty-four percent of the beneficiaries (308 of 916) said they lived in a county with HMOs that contract with Medicare. About 10 percent said they did not live in locations where beneficiaries could join HMOs. Table 2 shows that in 1995 more

beneficiaries than in 1994 knew whether they lived in locations served by Medicare HMOs.

TABLE 2
BENEFICIARIES WHO ARE AWARE OF HMOs THEY CAN JOIN

	YES	NO	DON'T KNOW
1995	34%	10%	56%
1994	26%	10%	64%

Fewer Beneficiaries Wanted More Information About HMOs Than in 1994

Fifty-four percent of 796 beneficiaries who answered our question said they would like to learn more about Medicare-contracted HMOs. This is less than the 64 percent who, in 1994, said they wanted more information about HMOs.

ABOUT A THIRD OF BENEFICIARIES EXPRESSED AN INTEREST IN JOINING AN HMO

Thirty-five percent of the 796 beneficiaries who answered our question expressed an interest in joining an HMO. In 1994, 27 percent said they would be interested. However, as shown in Table 3, we offered a "Don't Know" response in the 1994 survey which we did not include in the 1995 survey. Therefore, we cannot determine if there is a significant difference between responses to the 1994 and 1995 surveys.

TABLE 3
BENEFICIARY INTEREST IN JOINING AN HMO

	YES	NO	DON'T KNOW
1995	35%	65%	
1994	27%	39%	34%

Beneficiaries Want to Choose Their Physicians

Of the 65 percent who said they would not be interested in joining an HMO, 63 percent (330) cited one or more objections. Table 4 shows that most beneficiaries were concerned about their inability to select their doctors if they joined an HMO.

Only 7 percent of the 330 beneficiaries expressed concern about quality of care in an HMO. These concerns are similar to those expressed by beneficiaries in 1994.

TABLE 4
WHY BENEFICIARIES OBJECT TO JOINING AN HMO

OBJECTION	BENEFICIARIES RESPONDING TO QUESTION*	
	Number	Percent
Inability to Select Physician(s)	108	33
Desire to Keep Present Physician	88	27
Satisfied with Insurance Coverage	43	13
Perceived Restrictions in an HMO	27	8
Perceived Poor Quality of Care	22	7
Lack of Enough Information on HMOs	14	4
Friends' and Relatives' Bad Experiences	11	3
Other (Too Old, Do Not See Advantage, Too Far to Drive, and Too Expensive)	28	8

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

Few Beneficiaries Knew About Their Appeal Rights

In the 1995 survey, we asked beneficiaries if they were aware that Medicare HMO members could appeal decisions HMOs made about their medical care. Only 17 percent (149 of 883) were aware of this. (Readers should recall that respondents to this 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.)

CONCLUSION

Clearly, beneficiary awareness of HMOs is increasing. The increase can be partly attributed to HCFA projects designed to help educate Medicare beneficiaries about managed care. For example, HCFA has updated the Medicare and Managed Care Plans brochure. The increase in awareness can also be partly attributed to the increase in number of HMOs available for Medicare beneficiaries to join. Over half of the beneficiaries who knew about HMOs said they found out about them through HMO advertising. However, 30 percent of the beneficiaries we surveyed said they had not heard of HMOs.

The most prevalent reason beneficiaries cited for not wanting to join an HMO was their inability to select and keep their physicians. We recognize that HCFA has taken significant steps to enhance beneficiaries' choices in medical care. For example, under HCFA guidelines, some HMOs are implementing a "point of service" option which allows beneficiaries to obtain health care services outside the HMO's contracted provider network for specified services. Beneficiaries usually pay higher copayments for those services received outside the HMO.

Still, there is always more that can be done. We suggest the following.

- Intensify outreach efforts to educate Medicare beneficiaries about Medicare HMOs. For example, HCFA could distribute their managed care brochures to senior citizen centers in locations where Medicare beneficiaries can join HMOs. In their educational materials, HCFA could highlight characteristics of Medicare HMOs, including the benefits offered and appeal rights.

- Explore more ways that allow beneficiaries greater freedom to choose their own physicians in managed care settings.

AGENCY COMMENTS

The HCFA Administrator concurred with our conclusion that HCFA should intensify outreach efforts to educate beneficiaries about Medicare HMOs. He reported that the *1996 Medicare Handbook* mailed to all beneficiaries included an extensive description of the managed care benefit. The HCFA has also worked with beneficiary advocacy groups, and included representatives from those groups in the development of educational materials.

The Acting Assistant Secretary for Planning and Evaluation provided several useful comments which helped sharpen the interpretation of survey results. In response, we made changes to clarify our information where possible and appropriate.

Appendix B shows the full text of the comments provided by HCFA and ASPE.

APPENDIX A

RESPONSES TO 1995 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	PERCENTAGE
1. Before today, had you ever heard of HMOs?		
Yes	643	70
No	275	30
Not Answering: 24		
2. a. Are there HMOs in your city or town that Medicare beneficiaries can join?		
Yes	308	34
No	89	10
Don't Know	519	56
Not Answering: 26		
b. If yes, how did you hear about those HMOs? (Open-ended question)		
(N = 241, Number Answering Question)		
HMO Advertising	129	54
Family and Friends	55	23
Former Employers	22	9
Insurance Company	9	4
Physicians	9	4
Previously in HMO	4	2
Other	15	6

QUESTION	RESPONSES	PERCENTAGE

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

Yes	276	35
No	520	65
Not Answering: 79		

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

(N = 330, Number Answering Question)

Inability to Select Physician	108	33
Desire to Keep Present Physician	88	27
Satisfied with Present Insurance	43	13
Perceived Restrictions	27	8
Perceived Poor Quality of Care	22	7
Lack of Information on HMOs	14	4
Friends/Relatives Poor Experiences	11	3
Other	28	8

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

Yes	149	18
No	684	82
Not Answering: 80		

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

Yes	462	56
No	400	46
Not Answering: 80		

APPENDIX B

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JAN 6 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Beneficiary Interest in HMOs in 1995," (OEI-04-93-00151)

We reviewed the above-referenced report that examines beneficiary awareness of and interest in joining health maintenance organizations.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

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DIG-EC
DIG-EI
DIG-OI
DIG-MP

Comments of the Health Care Financing Administration (HCFA) on Office of Inspector General (OIG) Draft Report: "Medicare Beneficiary Interest in HMOs in 1995," (OEI-04-93-00151)

OIG Recommendation

- o Intensify outreach efforts to educate Medicare beneficiaries about Medicare HMOs. For example, HCFA could distribute its managed care brochures to senior citizen centers in locations where Medicare beneficiaries can join HMOs. In its educational materials, HCFA could highlight characteristics of Medicare HMOs, including the benefits offered and appeal rights.

- o Explore ways that allow beneficiaries greater freedom to choose their own physicians in managed care settings.

HCFA Response

We concur. HCFA has been particularly active in reaching out to a wide variety of beneficiary advocacy groups and included several of them in internal managed care training efforts. We also included these groups and other Departmental organizations in the development of educational materials. As a result of this outreach, our presence and voice among these groups have enabled us to develop additional channels for distribution and feedback. These channels include many senior citizen centers as suggested by the OIG.

HCFA is committed to continuing efforts to enhance the beneficiaries' Medicare program knowledge, including their rights and options. Much of this effort relies on the development and distribution of clearly stated, objective information upon which an informed choice can confidently be made.

This Summer (1996) HCFA mailed the Medicare Handbook to all beneficiaries. This handbook included an extensive description of the managed care benefit. If OIG resurveys, we would be interested to see if this effort has significantly changed both the overall awareness of HMO options and the appeal rights for HMO beneficiaries. The Medicare and managed care brochure has again been revised and widely distributed. Both the brochure and the handbook have advertised that further information is available through the Medicare 800 number. The hotline inquiries regarding access to HMOs have increased significantly and are documented on the contractor's monthly reports. HCFA has also been active in development and distribution of Medicare managed care plan comparative information. Several HCFA Regional Offices prepared comparative

information to assist beneficiaries in their regions in selecting among the options available. State and regional Insurance Counseling and Assistance Programs (ICAs) as well as some advocacy groups have also produced managed care informational materials and comparison charts. Within HCFA central office, a major project is underway to develop and distribute comparison information on all Medicare managed care contractors and make it available via electronic as well as traditional means. HCFA participated with the OIG in the development, publication, and distribution of the Medicare Beneficiary Advisory Bulletin entitled, "What Medicare Beneficiaries Need to Know About Health Maintenance Organizations (HMO) Arrangements: Know Your Rights."

HCFA encourages contracting plans and other organizations to provide materials that describe the physician selection process in managed care plans and the beneficiary's ability to change primary care physicians within the plans. While the need to select from a plan physician is essential to the managed care model, the fact that more than 70 percent of physicians now have contractual relationships with HMOs is lessening the need to sever a long-standing relationship. Indeed, the fastest growing HMO model contracts with individual practicing physicians to provide services to members in their offices.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

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Date Sent

TO: June Gibbs Brown
Inspector General

FROM: Acting Assistant Secretary for
Planning and Evaluation

SUBJECT: Comments on the Office of the Inspector General (OIG) Draft Report: "Medicare Beneficiary Interest in HMOs in 1995," (OEI-04-93-00151)

The report on Medicare beneficiaries' knowledge and interest in joining Health Maintenance Organizations (HMOs) in 1995 includes some useful information. However, the inclusion of beneficiaries who lived in geographic areas not served by risk contracting HMOs makes some of the results and comparisons in trends presented in the study very difficult to interpret. For example, the report mentions that 35% of all Medicare beneficiaries would be interested in joining an HMO if one were available. But if one of the goals of the study is to see if beneficiaries are informed about their health care options and propensity to join an HMO, it would be preferable to focus on the responses of beneficiaries who actually have the option of joining an HMO.

The inclusion of all beneficiaries in the analyses also confounds the discussion of trends in beneficiaries' knowledge. For example, the report mentions that seventy percent of beneficiaries surveyed in 1995 were aware that they could join an HMO under the Medicare program; this represents an eight percentage point increase from a year previously. An interesting question is whether the increase in beneficiaries' knowledge of HMOs is the result of greater outreach by HCFA and the HMOs themselves, or increases in the market penetration of HMOs (or both?). The report mentions HCFA projects designed to educate Medicare beneficiaries about their health care options and the updating of the Medicare and Managed Care Plans Brochure as possible reasons for this increase, but does not discuss the effect of increasing market penetration on changes in beneficiaries' knowledge of HMOs. The number of plans participating in the risk contracting program increased by nearly thirty from 1994 to 1995, and the percentage of beneficiaries enrolled in HMO rose from 8.1% (2.3 million beneficiaries) to 10.1% (3.1 million). Some of the increase in the knowledge of beneficiaries about their health care options is no doubt the result of greater market penetration by HMOs and competition.

JAN -2 P 4:03

To summarize, we have three broad recommendations that will hopefully improve the report:

(1) Clarify the study population. The Executive Summary mentions that 942 Medicare beneficiaries were surveyed, but does not indicate that HMO enrollees were excluded in the analyses (see p. I).

(2) Discuss the implications of including all beneficiaries--both those in managed care market areas and those who are not--in the analyses.

(3) Discuss the importance of HMO market penetration as a possible reason for the increase in beneficiaries' knowledge of Medicare managed care. This should be included in the Executive Summary and Conclusion section of the report.

Three additional recommendations not discussed above include:

(4) Add caveats regarding the absence of nonresponse bias. The fact that the respondents and nonrespondents to the survey did not differ significantly with respect to either age or gender does not warrant the conclusion that the survey results are probably not biased (p. 2). Health and disability are likely to be stronger predictors of response than either age or gender, and we know from several studies that health status is an important predictor of Medicare managed care enrollment and hence knowledge of Medicare HMOs.

(5) Discuss the new Point of Service (POS) options that HMOs are developing (under HCFA guidelines) to allow enrollees to have access to providers outside of the HMO's network. This could have an impact on enrollment since, as reported in the study, beneficiaries' greatest objection to joining an HMO stems from their inability to choose their own physician.

(6) Address the following specific problems:

- On p. 1, the report states "For physician and most other outpatient services, Medicare pays 80 percent of the amount allowable for a covered service. Beneficiaries pay the remaining 20 percent of allowable charges, plus Medicare premiums and deductibles for inpatient and outpatient care." The last sentence is very confusing and mixes up the premiums, deductibles, and co-pays under Medicare Part A and Part B.

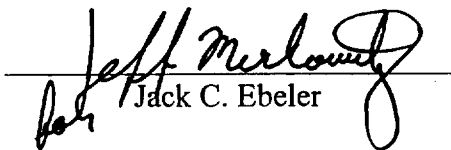
- On p. 2, the report states "Beneficiaries are required to obtain all their medical care through providers affiliated with the HMO they joined, except for emergency and urgently needed care when they are out of the HMO service area." As discussed above, this ignores POS options that some HMOs may adopt.

- Again on p. 2, the report states "The HMOs agree to provide a beneficiary's total medical care for a set amount paid monthly by Medicare." The HMO is not required to provide a beneficiary's total medical care, but rather health care that is equivalent to the Medicare covered services available in fee-for-service.

- The report states that "Beneficiaries continue to pay Medicare premiums (p. 2)." This statement needs to be clarified--HMO enrollees only pay Medicare Part B premiums.

An additional recommendation is that future surveys should either collect data exclusively from beneficiaries living in areas serviced by HMOs, or if data are to be collected from all beneficiaries, the results should distinguish between the two populations.

If you have any additional comments or questions, please contact William Marton of my staff at (202) 690-6443.



Jack C. Ebeler