Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

BENEFICIARY PERSPECTIVES OF MEDICARE RISK HMO'S

JUNE GIBBS BROWN
Inspector General

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Department of Health and Human Services

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EXECUTIVE SUMMARY

PURPOSE

This study describes beneficiaries' perspectives of the Medicare risk HMO experience.

BACKGROUND AND METHODOLOGY

Medicare beneficiaries may join a risk health maintenance organization (HMO) through the Medicare program. Under a risk contract, Medicare pays the HMO a predetermined monthly amount (capitated rate) per enrolled beneficiary. In return, excepting hospice care, the HMO must provide all Medicare covered services that are medically necessary. Once enrolled, beneficiaries are usually required to use HMO physicians and hospitals (lock-in) and to obtain prior approval from their primary care physicians for other than primary care.

As of July 1, 1994, the Health Care Financing Administration (HCFA) reported 136 risk-based HMO plans served 2,036,279 Medicare enrollees. The Office of Managed Care within HCFA has oversight responsibility for Medicare risk contracts with HMOs.

Using HCFA databases, we selected a stratified, random sample of 4,132 enrollees and disenrollees from 45 Medicare risk HMOs. Since our primary focus is Medicare beneficiaries' perceptions of their risk HMO experience, we collected information directly from beneficiaries in 1993. We surveyed both enrollees and disenrollees to compare their responses, and thus, to gain greater insight into HMO issues. We did not attempt to validate their responses through record review or HMO contact.

FINDINGS

Generally, beneficiary responses indicate Medicare risk HMOs provided adequate service access for most beneficiaries who had joined.

The majority of enrollees and disenrollees reported medical care that maintained or improved their health, timely appointments for primary and specialty care, good access to Medicare covered services and to hospital, specialty and emergency care, and sympathetic personal treatment by their HMOs and HMO doctors. In some instances, however, enrollees and disenrollees differed markedly in reporting their HMO experiences.

Beneficiary responses indicate Medicare risk HMOs generally adhered to Federal enrollment standards for informing beneficiaries about application procedures, lock-in and prior approval for specialty care.

However, compliance with Federal enrollment standards for health screening and informing beneficiaries of their appeal rights appeared to be problematic.

- 43% of beneficiaries, who could remember, said they were asked at application about their health problems, excluding kidney failure and hospice care; 3% were required to have a physical examination before joining the HMO.
- 25% of beneficiaries reported they did not know they had the right to appeal their HMOs' refusal to provide or pay for services.

Most beneficiaries reported timely doctor appointments for primary and specialty care, but some enrollees and disenrollees experienced noteworthy delays.

- 94% of enrollees and 85% of disenrollees got an appointment within 1 to 2 days when they believed they were very sick.
- Over 75% of beneficiaries usually waited 8 days or less for appointments with primary doctors and about two-thirds usually waited the same for appointments with specialists; however, 16% waited for 13 days or longer for a primary care visit and 25% waited this long to see specialists.
- 93% of enrollees and 80% of disenrollees typically waited an hour or less in the office to see their primary doctors.
- Most beneficiaries could reach the offices of their primary HMO doctors by telephone, but busy lines caused 11% of beneficiaries to say they sometimes gave up on trying to make appointments.

The great majority of enrollees believed they got the Medicare services they needed; disenrollees, however, reported more problems with access to primary and specialty care.

- 95% or more of enrollees had good access to primary, specialty, hospital and emergency care.
- While the majority of disenrollees also reported good access, 20% to 25% said they failed to receive primary care, referrals to specialists, and HMO coverage of emergency care, all services they believed they needed.
- Perceived, unmet service needs and lock-in problems led 22% of disenrollees and 7% of enrollees to seek out-of-plan care.

Most beneficiaries believed they were personally well-treated by their HMOs or primary doctors; however, disenrollees were more likely to perceive unsympathetic behaviors that potentially restrict service access.

- 12% of enrollees and 39% of disenrollees didn't feel their primary HMO doctors took their health complaints seriously; over one-third of both groups said this happened most to all of the time.

- Disenrollees were 3 times as likely as enrollees to believe that holding down the cost of care was more important to their primary HMO doctors and HMOs than giving the best medical care possible.

Overall, HMO beneficiaries seemed relatively healthy; however, disenrollees rated their health lower than enrollees and reported a much greater decline in health status during their HMO stay.

Analysis of smaller groups of enrollees and disenrollees revealed additional strengths and weaknesses of Medicare risk HMOs.

- Disenrollees without prior HMO experience were more critical of their HMOs than those with prior experience; however, the majority of both groups joined another HMO upon leaving.

- Disabled/ESRD disenrollees, more often than aged disenrollees, reported access problems in several crucial areas of their HMO care; 66% of disabled/ESRD enrollees wanted to leave their HMOs.

- 84% of enrollees intended to stay with their HMOs; the remaining 16% either planned to leave or wanted to leave, but felt they could not, primarily for reasons of affordability.

- Almost one-third of disenrollments were solely for administrative reasons, such as a beneficiary's moving or an HMO's clerical error; the remaining two-thirds voiced more criticism regarding their awareness of appeal rights, the effectiveness of HMO care and access to services.

Personal preferences in health care and service access problems were the two non-administrative categories of reasons for beneficiary disenrollments.

- HMO restrictions on providers and services, plus high beneficiary premiums/co-payments, were the leading disenrollment reasons based on personal preferences in health care delivery.

- Enrollees and disenrollees agreed the two most important reasons for leaving their HMOs were the choice of primary HMO doctors and high beneficiary premiums/co-payments.

RECOMMENDATIONS

As discussed, beneficiary responses indicate Medicare risk HMOs provide adequate service access for most beneficiaries who have joined. However, our survey results also indicate some serious problems with enrollment procedures and service access that we believe require HCFA's attention. Our intent is not to prescribe specific corrective actions, but to identify, based on information from beneficiaries, areas apparently needing improvement and to suggest techniques HCFA can use to further monitor these areas.

Three items need immediate exploration:

- Better informing of beneficiaries about their appeal rights as required by Federal standards.

- Carefully examining service access problems reported by disabled/ESRD beneficiaries, an especially vulnerable group.

- Monitoring HMOs for inappropriate screening of beneficiaries' health status at application.

Other service access issues meriting examination by HCFA in the near future concern beneficiaries' perceptions of problems with:

- Making routine appointments.

- Declining health caused by HMO care.

- HMOs' refusal to provide certain services.

Our experience with this survey also suggests some protocols HCFA may want to adopt for its instrument to survey disenrolling HMO beneficiaries.

AGENCY COMMENTS

HCFA concurred with the report's recommendations. The Assistant Secretary for Planning and Evaluation suggested the inclusion of other research, comparative data, and HCFA monitoring efforts in the report to provide context for our findings. However, we chose not to largely because such discussions would have over-extended an already lengthy report. Instead, we cautioned readers about the nature and limitations of the data presented, and have included the bibliography for those interested in more detail.

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

INTRODUCTION 1

FINDINGS 4

Overview 4

Health Status and Service Use 4

Federal HMO Requirements 7

Access: Appointments for Services 8

Access: Medical Services and Out-of-Plan Care 10

Access: Behavioral Barriers to Services 12

Problems and Differences Among Beneficiary Sub-Populations 13

Reasons for Leaving an HMO 18

RECOMMENDATIONS 23

AGENCY COMMENTS 25

ENDNOTES 27

BIBLIOGRAPHY 32

APPENDICES

A: Sample and Response Rates A-1

B: Sample Demographics B-1

C: Confidence Intervals C-1

D: Beneficiary Health Status D-1

E: Text of Agency Comments E-1

INTRODUCTION

PURPOSE

This study describes beneficiaries' perspectives of the Medicare risk HMO experience.

BACKGROUND

Medicare beneficiaries may join a risk health maintenance organization (HMO) through the Medicare program. When enrolling beneficiaries, HMOs may not deny or discourage enrollment based on a beneficiary's health status except for end-stage renal disease (ESRD) or hospice care. They must also adequately inform beneficiaries about lock-in to the HMO and grievance/appeal procedures. Under a risk contract, Medicare pays the HMO a predetermined monthly amount (capitated rate) per enrolled beneficiary. In return, excepting hospice care, the HMO must provide all Medicare covered services, that are medically necessary. Once enrolled, beneficiaries are usually required to use HMO physicians and hospitals (lock-in) and to obtain prior approval from their primary care physicians for other than primary care. The Office of Managed Care within the Health Care Financing Administration (HCFA) has oversight responsibility for Medicare risk contracts with HMOs. As of July 1, 1994, HCFA reported 136 risk-based HMO plans served 2,036,279 Medicare enrollees.[1]

METHODOLOGY

Definition of access

Beyond referencing medical necessity and an actual or likely adverse effect on the beneficiary, the law and regulations do not clearly delineate what full access to services through an HMO means. In order to construct a survey instrument that adequately covered access to services, we adapted a definition from literature.[2,3] Basically, it uses five dimensions (availability, accessibility, accommodation, affordability, and acceptability) that represent the degree of "fit" between the patient and the health care system, e.g. existing services and the patient's medical needs, or price of services and the patient's ability to pay. To tailor the survey for Medicare risk HMOs, we expanded the idea of service availability to include the role of gatekeepers, primary physicians or others associated with the HMO, in preventing or facilitating beneficiaries' receipt of covered services. Operationally, we divided access into four areas: appointments, including waiting time and administrative processes for making them; restrictions on medical services; incidence and reasons for out-of-plan care; and behavior of primary HMO doctors and other HMO personnel towards beneficiaries.

Sample selection

We selected a stratified random sample from HCFA's Group Health Plan (GHP) data base. First, we sampled 45 HMOs from the 87 HMOs under a risk contract with HCFA as of February 1993.[4] Beginning with the GHP data, we counted the number of enrollments occurring within calendar years 1991 and 1992. For this cohort, we then calculated the proportion of disenrollments[5] within the following 12 months. Based on this disenrollment rate, we divided the 87 risk HMOs into three strata of 29 HMOs each. Within each strata, we selected 15 HMOs by simple random sampling.[6] Second, from each sampled HMO, we randomly selected 50 Medicare beneficiaries who were enrolled as of February 28, 1993 and 50 who had disenrolled between November 1992 and February 1993 inclusive (see Appendix A). When the total number per HMO for either group was less than 50, we selected them all. Using HCFA's Enrollment Data Base, we excluded, from the sampling universe, beneficiaries who had died or who appeared as current enrollees, but had actually disenrolled since the last update to the GHP file. This process resulted in 2,217 enrollees and 1,915 disenrollees for a total of 4,132 beneficiaries.

Scope and data collection

Since this study's primary focus is the Medicare beneficiaries' perceptions of a risk HMO experience, we only collected information from them. We did not contact HMOs or their staffs, nor did we attempt to assess the quality or propriety of medical care rendered by the HMOs to these beneficiaries. We initially mailed structured surveys to 4,132 beneficiaries in late April 1993.[7] In early May 1993, we mailed a follow-up letter and second survey to non-respondents; we closed data collection in July 1993. Both enrollees and disenrollees provided information on sample and demographic data, enrollment experience, past health status and service use, HMO environment, and HMO services available. Additionally, enrollees were asked about current health status and future plans for HMO membership while disenrollees were asked about health status at disenrollment and reasons for disenrollment. We surveyed both enrollees and disenrollees to compare their responses, and thus, to gain greater insight into HMO issues. We did not specifically ask beneficiaries about their satisfaction with the HMOs, as the concept of satisfaction is less objective than, and sometimes independent of, the issues of membership in a Medicare risk HMO. A total of 2882 surveys were deemed usable,[8] yielding an unweighted return rate of 70% overall, 77% for enrollees (N=1705) and 61% for disenrollees (N=1177).[9]

Weighting and interpretation

This study is a descriptive, exploratory analysis. We did not assume knowledge about non-respondents. We used tests for differences of means and proportions to discern significant differences between respondents and non-respondents by three demographic characteristics -- age, race, and sex. Significant differences were found based on

unweighted data. We decided to take the most conservative approach, weighting the sample to approximate 70% of the universe (see Appendix A). Also see Appendix B for respondent demographic profile which shows little difference between enrollees and disenrollees. Respondents were predominantly female, white, age 65 or older, and high school graduates or higher. We calculated from HCFA data provided for each respondent that the average length of enrollment in the sampled HMOs was 36 months for enrollees and 29 months for disenrollees.

When weighted, the sample approximates the disproportionate distribution of enrollees and disenrollees in the universe (97% vs. 3%). Because of this imbalance, we initially analyzed the two groups separately. Once proportions were computed per question for each group, answers from enrollees and disenrollees were then compared and are the basis for all Tables in this report except for Tables showing sub-populations.[10] Interpretation of these comparisons requires caution, however, since a small percentage of enrollees can represent many Medicare beneficiaries -- more beneficiaries, in fact, than a high percentage of disenrollees.

We also analyzed sub-populations of enrollees and disenrollees. Within each of these groups, we compared beneficiaries who are age 65 or older, disabled[11] or have ESRD, and beneficiaries with and without prior HMO experience. For enrollees only, we compared those who planned to stay in their HMOs to those who planned to leave or wanted to leave but felt they could not. For disenrollees only, we compared those who left for personal or service access reasons to those who left solely for administrative reasons. Administrative reasons for disenrollment were beneficiaries' moving out of the HMO service area, their HMOs no longer participating as a Medicare risk HMO or in their companies' retirement plan, or involuntary disenrollments such as late premium payments or clerical error. Data for the sub-populations are presented in Tables 12 to 15 and in Figure 1 and only cover survey questions that differentiated the sub-populations.

Throughout the report, percentages are based on the number of responses to each question. We calculated response rates based on the weighted value of the beneficiaries eligible to answer, which varies due to the use of contingency questions. Questions with response rates of less than 50% are not reported. The majority of questions had response rates of 80% to 99%. Additionally, we computed 95% confidence intervals for key questions (see Appendix C). A few of the confidence intervals are quite broad, particularly for disenrollees, due to the small number of responses for some questions.

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

FINDINGS

OVERVIEW

Generally, beneficiary responses indicate Medicare risk HMOs provided adequate service access for most beneficiaries who had joined.

The majority of enrollees and disenrollees reported medical care that maintained or improved their health, timely appointments for primary and specialty care, good access to Medicare covered services and to hospital, specialty and emergency care, and sympathetic personal treatment by their HMOs and HMO doctors. In some instances, however, enrollees and disenrollees differed markedly in reporting their HMO experiences. When this happened, we describe the difference as a point of comparison.

HEALTH STATUS AND SERVICE USE

Overall, HMO beneficiaries seemed relatively healthy, and few perceived themselves as potentially high users of medical services.

Based on beneficiary-reported incidence of acute or chronic medical conditions, the majority of enrollees and disenrollees appeared to be in relatively good health. Two-thirds of both groups reported they had no serious health problems while enrolled in the sampled HMOs. One-third had one or more serious problems such as, broken bones (9%), cancer (8%), heart attack (7%), pneumonia (7%) or a stroke (3%).[12] Reports on chronic ailments from both groups show about one-tenth had none and one-third had 1 to 3 chronic ailments of varying severity, e.g., high blood pressure only or joint pain and skin problems. Only 3% were nursing home patients in the last year.

Table 1: Beneficiaries' Health[13]

	All	Disenrollees	Enrollees
While in the HMO, reported no serious problems, e.g., broken bones or cancer.	**67%** (669,619)	**69%** (16,440)	**67%** (653,180)
While in the HMO, reported:			
▸ no chronic ailments	**10%** (97,674)	**12%** (3,043)	**10%** (100,717)
▸ 1 to 3 chronic ailments of varying severity	**32%** (317,887)	**31%** (7,584)	**32%** (310,304)
Were nursing home patients in the last year.	**3%** (27,363)	**3%** (816)	**3%** (26,547)
Had been admitted to the hospital while a member of the sampled HMO.	**49%** (492,668)	**42%** (10,334)	**49%** (482,334)

By our definition, few beneficiaries reported a high propensity to use services. Only 13% of enrollees and 10% of disenrollees both worried about their health the same as or more than other people their age and went to the doctor as soon as they started to feel bad. Their reported frequency of doctor visits and hospital admissions supports their self-evaluations of propensity to use services. During the last year, 91% of all beneficiaries saw their primary HMO doctors or specialists and 49% had been admitted to the hospital while a member of the sampled HMO. However, Table 2 shows that high propensity beneficiaries more often reported the higher rates of doctor visits and hospital admissions.

Table 2: Propensity Level and Service Use

	Enrollees' Propensity			Disenrollees' Propensity		
	Low	Medium	High	Low	Medium	High
1 to 6 total primary HMO doctor or specialist visits in the last year.	**83%** (204,527)	**73%** (145,428)	**65%** (72,403)	**87%** (5,581)	**83%** (4,256)	**60%** (1,281)
7 or more total primary HMO doctor or specialist visits in the last year.	**17%** (40,915)	**27%** (54,384)	**35%** (39,032)	**13%** (829)	**17%** (886)	**40%** (860)
Admitted to the hospital while a member of the sampled HMO.	**41%** (123,378)	**53%** (120,626)	**62%** (74,427)	**27%** (2,118)	**54%** (3,202)	**53%** (1,337)

Disenrollees rated their health lower than enrollees and reported a much greater decline in health status during their HMO stay.

Enrollees and disenrollees rated their health status differently. A comparison of the number and severity of acute/chronic health problems reported by beneficiaries indicates the enrollee and disenrollee groups are similarly distributed, ranging from no problems to multiple conditions (see Appendix D). However, disenrollees tended to rate themselves in poorer health overall than the enrollees who are comparable in the number and severity of health problems. Table 3 shows that most beneficiaries rated their health as good to excellent, both when they joined the HMO and when we surveyed them -- an average elapsed time of 36 months for enrollees and 29 months for disenrollees. Both groups also self-reported deteriorating health over time. However, at disenrollment, 19% fewer disenrollees rated their health as good to excellent compared to when they first joined their HMOs. This is more than double the 9% rate of decline from good to excellent health reported by enrollees.

Table 3: Beneficiaries' Self-Reported Health Status			
	All	**Disenrollees**	**Enrollees**
Were enrolled in the sampled HMO more than 12 months.	**76%** (847,226)	**65%** (18,450)	**77%** (828,776)
Rated their health as good to excellent when they joined the HMO.	**79%** (854,295)	**70%** (18,627)	**79%** (835,668)
Rate their health as good to excellent now.	**69%** (756,428)	**51%** (12,905)	**70%** (743,523)
Change	**-10%**	**-19%**	**-9%**

While not conclusive, our data suggest that a beneficiary's self-reported health status and propensity to use services, which was discussed earlier, may be related.[14] Another study noted high users tend to have chronic conditions and multiple problems that make their greater use seem appropriate.[15] Generally, we found both enrollees and disenrollees were less likely to rate their health as good to excellent as their propensity to use services increased (see Table 4). However, while the enrollees' self-reported rate of declining health over time was about the same for each level of propensity to use services, disenrollees' self-reported rate of declining health increased as propensity to use services increased. Our data do not explain this difference between enrollees and disenrollees; perhaps more detailed research is required concerning the relationship between beneficiary access to services and perceived health status.

Table 4: Propensity to Use Services and Self-Reported Health Status						
	Enrollees' Propensity			Disenrollees' Propensity		
	Low	Medium	High	Low	Medium	High
Good to excellent health when HMO joined.	**90%** (290,009)	**84%** (217,096)	**62%** (78,867)	**77%** (6,824)	**71%** (4,726)	**56%** (1,576)
Good to excellent health now.	**80%** (263,243)	**72%** (184,336)	**55%** (75,743)	**62%** (5,309)	**49%** (3,134)	**31%** (835)
Change	**-10%**	**-12%**	**-7%**	**-15%**	**-22%**	**-25%**

Disenrollees were much more likely to blame their HMO care for their declining health.

Another important difference between enrollees and disenrollees is how they rated the effectiveness of the HMO care (see Table 5). Disenrollees (22%) were ten times more likely than enrollees (2%) to believe the medical care received through the HMO caused their health to worsen. While slightly more than 40% of both groups perceived that the

HMO medical care caused their health to stay about the same, fully half of enrollees said HMO care improved their health compared to only one-third of disenrollees.

Table 5: Effect of HMO Care on Beneficiaries' Health			
	All	**Disenrollees**	**Enrollees**
Medical care received through the HMO caused their health to:			
▸ improve	**50%** (505,538)	**32%** (7,239)	**50%** (498,298)
▸ stay the same	**43%** (432,605)	**41%** (9,335)	**43%** (423,270)
▸ worsen	**2%** (22,475)	**22%** (4,951)	**2%** (17,524)

FEDERAL HMO REQUIREMENTS

Beneficiary responses indicate HMOs generally adhered to Federal standards for enrollment procedures, but screening for health status at application and a lack of beneficiary awareness of appeal rights were apparent problem areas.

Beneficiaries' recollections and perceptions indicate weaknesses in enrollment procedures (P), and in beneficiary understanding of lock-in (L) and individual appeal/grievance rights (R). With the exceptions of ESRD and the election of hospice care, Federal regulations prohibit HMOs from denying or discouraging enrollment based on a beneficiary's health status. HMOs must also adequately inform beneficiaries about lock-in to the HMO and grievance/appeal procedures. Basically, the experiences of enrollees and disenrollees were similar (see Table 6). However, disenrollees were less likely than enrollees to have a good overall understanding of HMOs.[16]

Items 1 and 2 in Table 6 illustrate how HMOs may have improperly screened applicants based on their health status. More than 2 of 5 beneficiaries, who could remember, said they were asked at application about their health problems, excluding kidney failure and hospice care. Between 2% and 3% reported a physical examination was required before they could join the HMO, an event that should never occur.[17] We specifically asked beneficiaries about their experiences at application. However, some HMOs conduct a health assessment interview shortly after enrollment. If some of these responses refer to such health assessments, this may have inflated our data. However, the length of enrollment in the HMO did not seem to affect beneficiary responses. The proportion of beneficiaries reporting health questions and required physical examinations at application was nearly the same for beneficiaries who had been enrolled for more than 12 months and for 12 months or less.

Table 6: Enrollment Experience				
		All	Disenrollees	Enrollees
1. (P)	Were asked at application about health problems, excluding kidney failure and hospice care.	**43%** (322,502)	**48%** (9,442)	**43%** (313,060)
2. (P)	Were required to have a physical examination before joining the HMO.	**3%** (26,254)	**2%** (426)	**3%** (25,827)
3. (P)	Didn't know they could change their minds about enrolling in the HMO after they applied.	**8%** (78,631)	**15%** (3,446)	**8%** (75,186)
4. (L)	Didn't know, from the beginning, they:			
▸	needed a referral from their primary HMO doctors to see a specialist.	**11%** (115,197)	**17%** (4,566)	**10%** (110,631)
▸	could only use HMO doctors and hospitals (except for emergent care and urgent care outside the service area).	**4%** (40,637)	**6%** (1,665)	**4%** (38,972)
5. (R)	Didn't know they had the right to appeal an HMO's refusal to provide or pay for services.	**25%** (250,624)	**31%** (6,753)	**25%** (243,871)
6.	Overall, had a good knowledge from the beginning of how the HMO would operate.	**76%** (716,242)	**66%** (15,532)	**76%** (700,709)

Also problematic is the fact that at least 1 in 10 enrollees and disenrollees didn't know from the beginning they would need referrals from their primary HMO doctors to receive specialty care (item 4). Finally, 25% didn't know they have the right to appeal the HMO's refusal to provide or pay for services (item 5). Forty-four percent of disenrollees, who didn't know about their appeal rights, were most likely to say they had been denied and would have appealed if they had known compared to only 9% of enrollees in the same circumstances. In contrast, 71% of enrollees, who didn't know they had appeal rights, most often said their HMOs didn't refuse to provide or pay for services in the first place.

ACCESS: APPOINTMENTS FOR SERVICES

Most beneficiaries reported timely doctor appointments for primary and specialty care, but some enrollees and disenrollees experienced noteworthy delays.

Timely appointments can entail days elapsed before a scheduled appointment or time spent in an office waiting to see a doctor. Table 7 shows that the majority of enrollees and disenrollees said they got appointments within 1 to 2 days when they believed they were very sick, could schedule appointments with primary care doctors and specialists within 8 days or less, and usually waited less than an hour in the office to see the doctor. However, disenrollees did not fare as well as enrollees in two categories of timely appointments -- quickly scheduled appointments for very sick beneficiaries and time spent

waiting in the office to see the doctor. Of the enrollees and disenrollees who had been very sick, disenrollees were 2.5 times as likely to say they didn't get an appointment within a day or two. Disenrollees also reported longer waits in the office to see their primary HMO doctors; they were almost three times as likely to wait 1 hour or more compared to enrollees.

Table 7: Appointment Times

	All	Disenrollees	Enrollees
Were able to get a doctor's appointment in a day or 2 when they were very sick.	**94%** (651,199)	**85%** (14,579)	**94%** (636,620)
For a scheduled appointment with their primary HMO doctors, usually waited:			
▸ 1 to 4 days	**52%** (496,182)	**52%** (11,876)	**52%** (484,306)
▸ 5 to 8 days	**26%** (240,484)	**23%** (5,325)	**26%** (245,809)
▸ 9 to 12 days	**6%** (60,588)	**7%** (1,594)	**6%** (58,994)
▸ 13 to more than 20 days	**16%** (154,852)	**18%** (4,219)	**16%** (150,632)
For a scheduled appointment with specialists, usually waited:			
▸ 1 to 4 days	**34%** (268,781)	**43%** (7,194)	**34%** (261,588)
▸ 5 to 8 days	**29%** (229,112)	**24%** (4,018)	**29%** (225,094)
▸ 9 to 12 days	**12%** (94,202)	**7%** (1,239)	**12%** (95,441)
▸ 13 to more than 20 days	**24%** (189,212)	**26%** (4,464)	**24%** (184,748)
Usually waited in the office before seeing their primary HMO doctors:			
▸ less than 1/2 hour	**53%** (525,978)	**36%** (8,186)	**53%** (517,792)
▸ 1/2 hour to 1 hour	**40%** (400,354)	**44%** (10,006)	**40%** (390,348)
▸ more than 1 hour	**7%** (69,550)	**20%** (4,609)	**7%** (64,941)

A substantial group (16% to 26%) of enrollees and disenrollees reported waiting from 13 to more than 20 days for scheduled appointments for primary and specialty care. This wait is an important consideration for beneficiaries who have serious health problems and/ or multiple chronic ailments of varying severity. Moreover, when sorted by the number and severity of health problems, the reported waiting times for scheduled appointments differ little between the healthier and sicker beneficiaries. The sicker beneficiaries were just as likely as the healthier beneficiaries, or slightly more likely in some cases, to wait

13 days or longer for scheduled appointments.[18] An exception was disenrollees who are disabled or have ESRD; 81% of these waited 8 days or less for scheduled appointments with specialists.[19]

The data suggest that some enrollees and disenrollees may have had better access to physician care for more acute conditions than for health maintenance or preventive care. A high percentage of both groups were able to see a doctor quickly when they were very sick. Those with the more numerous or severe health problems were more likely to get appointments quickly when they felt very sick. This pattern for appointments contrasts with the one noted above concerning waiting time for scheduled appointments with primary HMO doctors and specialists.

Busy telephone lines and misplaced medical records caused appointment difficulties for some beneficiaries.

Busy telephone lines and misplaced medical records can also affect beneficiaries' ability to make appointments for care. Busy telephone lines did hinder some beneficiaries' access to services (see Table 8). Disenrollees reported encountering consistently busy telephone lines almost twice as often as enrollees, and said they gave up trying to make appointments slightly more often. Problems with medical records were relatively uncommon. Of the 9% of all beneficiaries who reported lost or misplaced medical records, only 3% (N=2,977) reported they were kept from using HMO covered services as a result.

Table 8: Appointments by Telephone

	All	Disenrollees	Enrollees
Reported busy lines all to most of the time.	**19%** (116,784)	**34%** (5,093)	**19%** (111,691)
Sometimes gave up on making appointments due to the busy lines.	**11%** (67,768)	**17%** (2,627)	**11%** (65,141)

ACCESS: MEDICAL SERVICES AND OUT-OF-PLAN CARE

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

A large majority of enrollees and disenrollees believed their primary HMO doctors and HMOs provided the necessary care. Their responses consistently indicated good access to Medicare covered services, hospital care and specialty care (see Table 9). However, disenrollees reported more access problems in three categories. First, disenrollees (22%) said their primary HMO doctors failed to provide Medicare covered services 7 times as

often as enrollees (3%). Second, disenrollees (23%) were much more likely than enrollees (5%) to report their doctors' failure to give the necessary referrals to specialists. In fact, disenrollees who reported 1 or more serious illnesses (40%) were more than twice as likely to cite this denial of referrals than disenrollees who reported no serious illnesses (17%). Third, disenrollees (16%) more often reported HMOs' refusals to pay for emergency care compared to enrollees (3%). As with referrals to specialists, disenrollees with serious conditions (25%) were more likely to report these refused payments than disenrollees with none (11%). A complication of payment for emergency care is that beneficiaries, understandably, don't always differentiate between emergency care and urgent care. While HMOs will generally pay for any required emergency care, they will only pay for unauthorized urgent care outside the service area.

Only 4% of all beneficiaries reported being told by medical or office staffs that a needed medical service was not covered by the HMO. The most frequently mentioned services were chiropractors (37%), laboratory tests and x-rays (14%), medical equipment for home use (11%), and skilled nursing home care (10%) -- all of which are Medicare covered services with some restrictions. Although based on a few responses, they may indicate a problem with service provision by the HMOs and/or beneficiary misunderstanding of available services.

Table 9: Service Access

	All	Disenrollees	Enrollees
Primary HMO doctor never failed to provide Medicare covered services that were needed.	**94%** (943,083)	**77%** (18,494)	**95%** (924,590)
Primary HMO doctor never failed to admit to hospital when needed.	**98%** (931,995)	**91%** (20,742)	**98%** (911,253)
Primary HMO doctor never failed to refer to a specialist when needed.	**94%** (914,121)	**75%** (17,666)	**95%** (896,459)
HMO never refused to approve a Medicare covered service that primary HMO doctor wanted.	**96%** (931,001)	**92%** (20,681)	**96%** (910,320)
HMO never refused to pay a doctor or hospital for emergency care	**94%** (910,975)	**80%** (18,067)	**94%** (892,908)

Perceived unmet service needs and factors related to lock-in lead some beneficiaries to out-of-plan care.

Excluding dental, routine eye, and emergent/urgent care, 7% of all beneficiaries reported they had sought out-of-plan care for Medicare covered services without prior approval from the primary HMO doctor or the HMO (see Table 10). Disenrollees went out-of-plan 3 times as often as enrollees. Four out of 5 of the most mentioned reasons for seeking out-of-plan care relate to service access problems and misunderstanding of lock-in, and were of greater importance to disenrollees.

Perceived access problems (and the implied impact on quality of care) are exemplified as needing the unapproved care, not getting services quickly enough, and not being helped by the primary HMO doctor (reasons 1, 2 and 5). Not wanting to go through the HMO for specialty care (reason 4) can also indicate access problems and/or beneficiaries' discomfort with HMO control of utilization through lock-in. Not knowing they would have to pay for out-of-plan care (reason 3) illustrates beneficiary misunderstanding of lock-in. The majority of beneficiaries who sought out-of-plan care had done so 1 to 3 times in the last year (78% of disenrollees and 87% of enrollees).

Table 10: Seeking Out-of-Plan Care

WHO?	All	Disenrollees	Enrollees
Beneficiaries who went out-of-plan	7% (70,817)	22% (5,187)	7% (65,629)
WHY?			
1. Needed care even if HMO would not approve	**42%** (27,708)	**51%** (2,368)	**41%** (25,340)
2. Couldn't get HMO services quickly enough	**21%** (13,501)	**46%** (1,946)	**19%** (11,555)
3. Didn't know they would have to pay	**18%** (11,285)	**36%** (1,774)	**16%** (9,511)
4. Didn't want to go through HMO to see specialist	**12%** (8,009)	**15%** (700)	**12%** (7,310)
5. Primary HMO doctor wasn't helping beneficiary	**12%** (7,987)	**42%** (2,094)	**10%** (5,892)

ACCESS: BEHAVIORAL BARRIERS TO SERVICES

Most beneficiaries believed they were personally well-treated by their HMOs or primary doctors; however, disenrollees were more likely to perceive unsympathetic behaviors that potentially restrict service access.

Unsympathetic behavior of primary HMO doctors, their staffs and HMO office staff can directly or subtly restrict beneficiaries' access to medical services. Actually telling beneficiaries that their medical needs could not be accommodated is a direct approach for which we found only slight evidence, i.e., less than 1% of all beneficiaries noted a problem. However, about 4% of disenrollees, an estimated 900 beneficiaries, said they had been told by primary HMO doctors, their staffs or HMO office staff that the HMO couldn't afford the medical care that the beneficiary needed or that they would receive better care outside the HMO.[20] In addition, medical professionals can subtly curtail access to services by not taking health complaints seriously or by showing undue concern

about treatment costs. Overall, 10% to 12% of beneficiaries perceived these kinds of personal treatment problems that can indirectly restrict access (see Table 11).[21]

Disenrollees were more than 3 times as likely as enrollees to believe their primary HMO doctors did not take their health complaints seriously. However, substantial portions of both enrollees (36%) and disenrollees (44%), who didn't feel they were taken seriously, said they encountered this attitude most to all of the time. Disenrollees were about 3 times as likely to believe that holding down the cost of care was more important to their primary HMO doctors or their HMOs than giving the best medical care possible. Disenrollees were also more likely than enrollees to say they didn't know what was most important to their doctors and HMOs. Enrollees were comparatively more definite, with over two-thirds saying that giving the best medical care possible is most important to their doctors and HMOs.

Table 11: Personal Treatment of Beneficiaries

	All	Disenrollees	Enrollees
Primary HMO doctor did not take health complaints seriously.	**12%** (117,723)	**39%** (8,868)	**12%** (108,855)
Didn't take complaints seriously all to most of the time.	**36%** (36,434)	**44%** (3,675)	**36%** (32,760)
Most important to your primary HMO doctor is:[22]			
▸ holding down the cost of care	**10%** (101,155)	**28%** (6,460)	**10%** (94,695)
▸ giving the best medical care possible	**72%** (727,550)	**47%** (10,927)	**73%** (716,623)
▸ don't know	**13%** (126,383)	**24%** (5,564)	**12%** (120,819)
Most important to your HMO is:[22]			
▸ holding down the cost of care	**11%** (116,436)	**35%** (8,071)	**11%** (108,364)
▸ giving the best medical care possible	**66%** (676,073)	**39%** (9.016)	**67%** (667,057)
▸ don't know	**12%** (125,318)	**20%** (4,609)	**12%** (120,709)

PROBLEMS AND DIFFERENCES AMONG BENEFICIARY SUB-POPULATIONS

Disabled/ESRD disenrollees most often reported access problems in several crucial areas of their HMO care; many disabled/ESRD enrollees wanted to leave.

Disenrollees who are disabled or who have ESRD are a small (an estimated 2300 beneficiaries), highly critical group.[23] As shown in Table 12, they were twice as likely as aged disenrollees and 41 times as likely as disabled/ESRD enrollees to say that medical care received through the HMO caused their health to worsen. In addition, more than all

the aged beneficiaries and disabled/ESRD enrollees, these disenrollees reported having limited access to some medical services. They were the most likely to report that their primary HMO doctors restricted access to needed Medicare covered services, didn't refer them to specialists when necessary, and didn't take their health complaints seriously. They were also the most likely to seek out-of-plan care while still enrolled in the HMO and to believe that holding down the cost of care was more important to primary HMO doctors and the HMOs than providing the best medical care possible.

Table 12: Beneficiary Perspectives by Medicare Categories of Aged or Disabled/ESRD

	Disenrollees		Enrollees	
	Aged	Disabled/ ESRD	Aged	Disabled/ ESRD
Medical care received through the HMO caused beneficiary's health to get worse.	20% (4,094)	41% (858)	2% (17,294)	1% (231)
For a scheduled appointment with their primary HMO doctors, usually waited:				
▸ 1 to 4 days	49% (10,[illegible]	78%		
▸ 5 to 8 [illegible]				

[illegible] and disabled/ESRD enrollees, these disenrollees reported having [illegible] access to some medical services. They were the most likely to report that their primary HMO doctors restricted access to needed Medicare covered services, didn't refer them to specialists when necessary, and didn't take their health complaints seriously. They were also the most likely to seek out-of-plan care while still enrolled in the HMO and to believe that holding down the cost of care was more important to primary HMO doctors and the HMOs than providing the best medical care possible.

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	Aged	Disabled/ ESRD	Aged	Disabled/ ESRD
Medical care received through the HMO caused beneficiary's health to get worse.	20% (4,094)	41% (858)	2% (17,294)	1% (231)
For a scheduled appointment with their primary HMO doctors, usually waited:				
▸ 1 to 4 days	49% (10,246)	78% (1,630)	51% (468,557)	68% (15,749)
▸ 5 to 8 days	24% (5,011)	15% (314)	26% (237,936)	11% (2,549)
▸ more than 8 days	27% (5,654)	8% (158)	23% (204,855)	21% (4,771)
For a scheduled appointment with specialists, usually waited:				
▸ 1 to 4 days	40% (5,976)	69% (1,218)	35% (258,235)	12% (3,353)
▸ 5 to 8 days	25% (3,797)	13% (222)	29% (213,086)	42% (12,00[illegible]
▸ more than 8 days	36% (5,370)	19% [illegible]	[illegible]	
Primary HMO doctor failed [illegible] Medic[illegible]				

Concerning waits for scheduled appointments with their primary HMO doctors and specialists, the pattern is reversed in favor of disabled/ESRD disenrollees. The majority of them waited the shortest times (1 to 4 days). In contrast, disabled/ESRD enrollees were the most likely to wait from 5 to 8 days or longer for appointments with specialists. Sixty-six percent (an estimated 18,000) of these enrollees reported wanting to leave their HMOs, but felt they couldn't.

Disenrollees without prior HMO experience were more critical of their HMOs than those with prior experience; the majority of both groups joined another HMO upon leaving.

While most beneficiaries (86%) were not HMO members immediately before joining the sampled HMO, this lack of prior experience with HMOs seems to have had more influence on disenrollees' perceptions of service access than on enrollees'. Enrollees with and without prior HMO experience responded similarly about the various aspects of service access. On the other hand, disenrollees who had not been HMO members previously (an estimated 20,000 beneficiaries) reported access problems more often. As Table 13 shows, disenrollees with no prior HMO experience were 1.5 to 3 times as likely to perceive longer waits in doctors' offices, service restrictions by primary HMO doctors, the need for out-of-plan care, difficulty with HMO payment for emergency care, and trouble with personal care by their primary HMO doctors and the HMOs.

Table 13: Disenrollee Perceptions By Prior HMO Experience

	Prior	**None**
Usually waited more than an hour in office before seeing their primary HMO doctors.	**9%** (459)	**24%** (4,069)
Primary HMO doctor failed to provide Medicare covered services that were needed.	**10%** (526)	**25%** (4,258)
Sought out-of-plan care while in the HMO.	**11%** (533)	**27%** (4,626)
HMO refused to pay for emergency care.	**7%** (338)	**17%** (2,834)
Primary HMO doctor did not take their health complaints seriously all to half the time.	**48%** (801)	**62%** (3,908)
Holding down the cost of care was <u>most</u> important to:		
their primary HMO doctor.	**17%** (866)	**32%** (5,458)
the HMO.	**26%** (1,303)	**40%** (6,614)

The majority of disenrollees, both with and without prior HMO experience, joined another HMO after leaving the sampled HMO, but at different rates. Most disenrollees (77%)

were not HMO members immediately before joining the sampled HMOs. Those with no prior experience came into the HMO from care in a doctor's office (73%) or in no regular place (14%). By definition, all disenrollees with prior HMO experience (23%) were members of another HMO immediately before joining the sampled HMO. However, a notably larger proportion of those with prior HMO experience (81%) than those without prior HMO experience (51%) went on to another HMO. The remainder of disenrollees without prior HMO experience turned for care to a doctor's office (32%), a community clinic or health center (9%), or a hospital emergency room (6%).

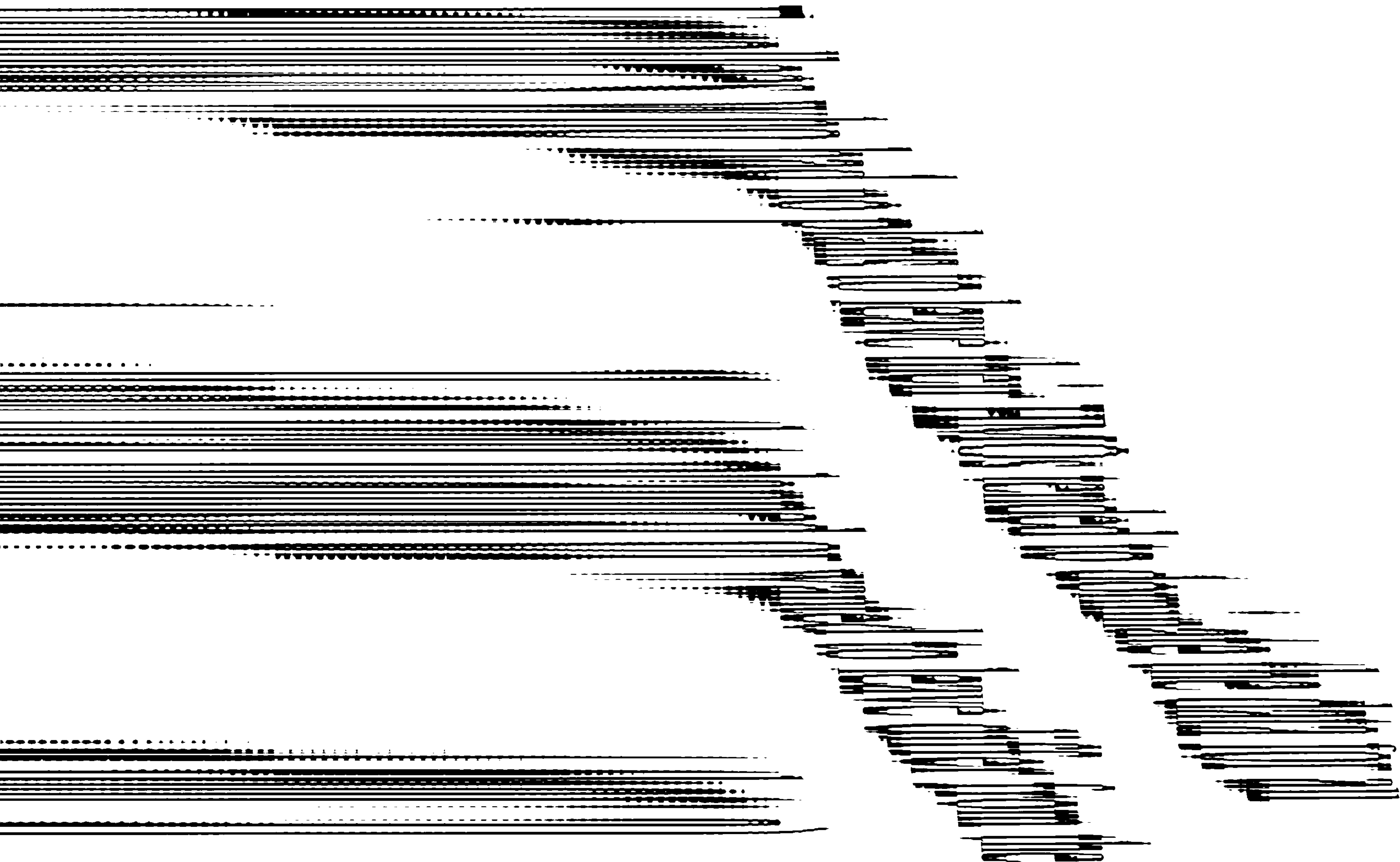
The data do not explain the difference between the two groups of disenrollees. One possibility is that beneficiaries are seeking a certain level of comfort with a health care delivery system. A substantial portion of disenrollees who began in fee-for-service, may try an HMO, not like it conceptually and return to fee-for-service settings. Other disenrollees may be at ease with the HMO concept and/or cost, and try various ones until they find a particular one that meets their needs. An appropriate area for further study may be the extent to which the Medicare population can or will adapt to the HMO form of managed care after extensive experience with fee-for-service. Another important research question is to learn more about how able or willing HMOs are to accommodate the special health care needs of an aging population.

Sixteen percent of enrollees either planned to leave their HMOs, or wanted to leave but felt they could not.

Eighty-four percent of enrollees had no plans to leave their HMOs, but the remaining 16%, an estimated 150,000 beneficiaries, either planned to leave or wanted to leave but felt they could not (see Table 14). The plans of 2% were predicated on an anticipated move out of the HMO's service area. These would fall into the administrative category discussed in the next section. Another 4% planned to leave for non-administrative reasons. The final 10% wanted to leave but felt they could not, primarily because of the relative affordability of HMO care.

Table 14: Enrollees' Future HMO Plans

	Number	Percent
Planned to leave the HMO because of anticipated move	22,317	**2%**
Planned to leave the HMO for other reasons	37,021	**4%**
Wanted to leave the HMO, but felt they couldn't because:[24]	93,774	**10%**
▸ HMO is the only way to afford all the health care needed	71,845	**89%**
▸ Medicine is too expensive outside the HMO	67,634	**86%**
▸ Enrollee can't afford non-HMO doctors	66,220	**83%**
▸ Enrollee can't afford private health insurance	68,843	**78%**
▸ Enrollee isn't eligible for Medicaid	33,532	**44%**



Enrollees who had no plans to leave their HMOs tended to dominate the data for all enrollees. In some areas though, enrollees that planned or wanted to leave differ from the main group of enrollees (see Figure 1). While not conclusive, our data suggest that: a) enrollees who planned to leave appear less well informed about HMOs and more displeased with service delivery, and b) those who wanted to leave, but couldn't seem less healthy and compelled to stay because of financial considerations.

Figure 1: Enrollees who planned to remain in their HMOs compared to enrollees who planned to leave and to enrollees who wanted to leave, but couldn't.

Enrollees Who Plan to Leave Are:

More Likely to:

- perceive doctors don't take their complaints seriously
- wait more than 12 days for doctor appointments
- wait more than 1 hour in the doctor's office
- say they hadn't been very sick
- perceive doctors didn't provide all needed services
- complain their doctors wouldn't refer them to specialists
- not know what is most important to their doctors or their HMOs
- seek out-of-plan care

Less Likely to:

- report good to excellent health when they joined the HMO and now
- be fully informed about HMO lock-in
- have received services while an HMO member
- believe giving the best medical care possible is most important to their doctors and HMOs

Enrollees Who Want to Leave But Can't Are:

More Likely to:

- worry about their health
- report health questions at application
- wait more than 12 days for doctor appointments
- wait more than 1 hour in the doctor's office
- not get quick appointments when they were very sick
- wait from 13 days to more than 20 days for an appointment with a specialist
- report appointment lines were busy all to most of the time

Less Likely to:

- report good to excellent health when they joined the HMO and now
- say they hadn't been very sick
- believe giving the best medical care possible is most important to their HMO
- say their health improved due to their HMO care

Almost one-third of disenrollees left solely for administrative reasons; the remainder voiced more criticism of their HMO experience.

Responses from the 29% of disenrollees who left their HMOs for administrative reasons[25] tended to dilute the criticism of other disenrollees. Administrative reasons refer to business or procedural actions rather than to beneficiary choice. Table 15 shows

non-administrative disenrollees were substantially more negative than administrative disenrollees regarding their experience with appeal rights, effectiveness of HMO care, waiting time for appointments, and personal treatment received from the primary HMO doctor and the HMO. It also illustrates the moderating effect that the responses from administrative disenrollees have on the disenrollee data as a whole.

Table 15: Administrative and Non-Administrative Disenrollments

	All Disenrollees	Admin. Disenrollees	Non-Admin. Disenrollees
Would have appealed HMO's refusal to provide/pay for services if had known about rights.	**43%** (2,603)	**22%** (474)	**55%** (2,129)
HMO did not refuse to pay/provide for services	32% (1,917)	**42%** (886)	**26%** (1,031)
Medical care received through the HMO caused their health to:			
▸ become worse	21% (4,365)	12% (721)	25% (3,642)
▸ improve	33% (6,747)	52% (3,153)	25% (3,593)
Usually waited more than an hour in the office before seeing their primary HMO doctors.	22% (4,369)	14% (811)	25% (3,557)
Usually waited 13 to more than 20 days for appointment with specialist.	27% (4,092)	19% (848)	31% (3,244)
Primary HMO doctor did not take health complaints seriously.	36% (7,288)	26% (1,549)	40% (5,740)
Holding down the cost of care was most important to:			
▸ primary HMO doctor	26% (5,445)	8% (463)	34% (4,982)
▸ the HMO	34% (6,928)	14% (818)	42% (6,110)

REASONS FOR LEAVING AN HMO

Both disenrollees and enrollees provided their reasons for leaving an HMO. Their personal preferences in a health care delivery system and their perceptions of access to services through the HMO constituted two non-administrative categories of reasons for leaving (see Table 16). As previously mentioned, 29% of disenrollees mentioned administrative reasons,[26] such as moving out of the HMO service area (25%), their HMOs no longer participating as a Medicare risk HMO or in their companies' retirement plan (6%), or involuntary disenrollments such as late premium payments or clerical error (3%). Eighteen percent of disenrollees left for administrative reasons only; 7% left for administrative reasons first, but would have left anyway for other reasons.[27] Disenrollees citing administrative reasons only are not included in the following analysis.

Enrollees described disenrollment reasons because they either planned to leave their HMOs or wanted to leave, but felt they could not (see Table 14).

Before a detailed discussion of beneficiaries' reasons for leaving an HMO, a summary of the overall pattern is helpful. Five reasons for leaving an HMO were the most frequently given and were among those rated most important by both disenrollees and enrollees (see Table 16).[28] Both groups:

- didn't like the choice of primary HMO providers;
- believed premiums and/or co-payments were too expensive;
- wanted to use the doctors they had before they joined the HMO;
- were not allowed to see the specialists they believed they needed to see;
- were refused, by their primary HMO doctors, services they believed they needed.

Ten items represented the most important disenrollment reasons for 79% of disenrollees; 8 items represented them for 81% of enrollees. While disenrollees' most important reasons for leaving were divided between personal preferences and perceived access problems, enrollees' reasons for planning/wanting to leave were predominantly personal preferences. Both groups perceived problems with service access, but disenrollees seemed to feel a greater impact on their health as a result, i.e., they were getting sicker.

HMO restrictions on providers and services, plus high beneficiary expenses, were the leading disenrollment reasons based on personal preferences for health care delivery.

Within the personal preference category, enrollees and disenrollees most frequently cited discomfort with the HMO restrictions on providers and services, plus high beneficiary premiums/co-payments, as reasons for leaving an HMO. Among the top four reasons for both groups were:

- not liking the choice of primary HMO doctors,
- their premiums and/or co-payments were too expensive,
- a dislike of going through the primary HMO doctor to get medical services,
- a desire to use the doctor the beneficiary had before joining the HMO.

The most frequent choice for disenrollees (44% - choice of primary HMO doctors) and enrollees (37% - going through the primary HMO doctor for services) clearly stood out, but the other ranked reasons are less differentiated. Also among disenrollees' top four reasons was wanting to use another hospital (23%). Personal preferences regarding the physical aspects of HMOs were chosen by a small percentage of beneficiaries -- difficulty getting to the HMO (6%), not liking the HMO building (2%), and not liking the HMO's location (5%). Encouragement of friends or family to leave was, in fact, a more frequent choice (7%) than these.

Table 16: Reasons for Leaving by Disenrollees and Enrollees Who Plan/Want to Leave[29]				
	Disenrollees		**Enrollees**	
	Frequency (Rank)	**Most Important (Rank)**	**Frequency (Rank)**	**Most Important (Rank)**
Personal Preferences[30]				
Didn't like the choice of primary HMO doctors.	**44%** (1) (9,173)	**10%** (2) (1,650)	**28%** (2) (47,060)	**15%** (2) (14,309)
Premium and/or co-payments were too expensive.	**29%** (2) (5,895)	**20%** (1) (3,221)	**25%** (4) (39,140)	**18%** (1) (17,087)
Didn't like going through the primary HMO doctor to get medical services.	**23%** (3) (4,639)	*	**37%** (1) (59,332)	**5%** (6) (4,986)
Wanted to use another hospital.	**23%** (3) (4,709)	**7%** (4) (1,122)	**12%** (7) (16,996)	*
Wanted to use the doctor beneficiary had before (s)he joined the HMO.	**22%** (4) (4,576)	**7%** (4) (1,192)	**27%** (3) (42,095)	**14%** (3) (12,930)
Couldn't see the same primary HMO doctor every time.	**16%** (5) (3,331)	*	**17%** (6) (26,970)	**10%** (5) (9,508)
Primary HMO doctor left the HMO.	**14%** (6) (2,833)	**5%** (5) (751)	**10%** (8) (15,951)	*
HMO services changed.	**14%** (6) (2,914)	*	**18%** (5) (27,946)	**4%** (7) (3,479)
Friend or relative encouraged beneficiary to leave.	**13%** (7) (2,646)	*	**7%** (9) (10,580)	*
Access to Services[31]				
Had to wait too long for scheduled appointments.	**22%** (1) (4,291)	**5%** (5) (747)	**15%** (3) (20,355)	*
Not allowed to see specialists needed.	**21%** (2) (3,956)	**8%** (3) (1,338)	**19%** (1) (26,265)	**11%** (4) (10,318)
Had to wait too long at the office to see the doctor.	**19%** (3) (3,631)	*	**11%** (4) (14,765)	*
Was getting sicker because of the care received through the HMO.	**19%** (3) (3,663)	**7%** (4) (1,145)	**4%** (7) (5,471)	*
Couldn't get services fast enough when very sick.	**19%** (3) (3,530)	**5%** (5) (871)	**11%** (4) (14,136)	*
Making appointments by telephone was too difficult.	**16%** (4) (3,055)	*	**8%** (6) (11,367)	*
Primary HMO doctor refused to provide needed services.	**15%** (5) (2,946)	**5%** (5) (885)	**16%** (2) (21,368)	**4%** (7) (4,022)
Couldn't see primary HMO doctor or specialist as often as needed.	**14%** (6) (2,670)	*	**9%** (5) (12,557)	*
Too many of needed medical services are not covered.	**8%** (7) (1,569)	*	**9%** (5) (12,965)	*

Difficulties with timely appointments and restricted primary and specialty care were the top disenrollment reasons related to service access.

Perceived access problems, as reasons for leaving, showed some differences between disenrollees and enrollees as well as some similarities. A telling distinction was 19% (rank 3) of disenrollees reported they left because of getting sicker as a result of the care received through the HMO compared to only 4% (rank 7) of enrollees. However, four reasons were listed among the top five by both groups:

- waiting too long for scheduled appointments,
- not being allowed to see the necessary specialists,
- waiting too long at the office to see the doctor, and
- being unable to get services fast enough when they were very sick.

Disenrollees were 1.5 to 2 times as likely as enrollees to choose the reasons of long office waits and lack of fast service when very sick. Sixteen percent (rank 2) of enrollees cited, as a reason for leaving, their primary HMO doctors' refusals to provide needed services. Fifteen percent of disenrollees also chose doctors' refusals to provide services, but, because of greater concerns they had in other areas, this reason only ranks fifth for them.

Choice of primary HMO doctors and high beneficiary expenses were the two most important overall disenrollment reasons for enrollees and disenrollees; the two groups differed on other most important reasons.

Disenrollees varied more in selecting their one most important reason for leaving an HMO, while enrollees chose fewer reasons, predominantly from the personal preference category. Both groups chose the same four reasons for leaving (rank 1 to 4) as their one most important reason:

- not liking the choice of primary HMO doctors,
- premiums and/or co-payments that were too expensive,
- a desire to use the doctor the beneficiary had before joining the HMO, and
- not being allowed to see the necessary specialists.

The first three reasons reflect personal preferences, i.e., discomfort with the HMO way of providing care and financial concerns of the beneficiaries; the fourth, perceived problems with access to services. Also at rank 4 (7%) among the most important reasons were disenrollees' wanting to use another hospital and saying they were getting sicker because of the care received through the HMO. Of the other most important reasons for leaving an HMO, disenrollees cited three perceived access problems (long waits for scheduled appointments, no quick appointments when very sick, and primary HMO doctors refusing to provide services) and one personal preference concerning a primary HMO doctor (all rank 5). Enrollees, on the other hand, cited the reverse -- three personal preference reasons (rank 5 to 7) and one perceived access problem (also rank 7).

While beneficiaries may identify high premiums/co-payments as a reason for leaving, the reason may really be high expenses in combination with other areas of dissatisfaction. A recently published study[32] of Medicare risk HMOs reported that more than 90% of both HMO enrollees and fee-for-service beneficiaries rated various dimensions of their care[33] as good or excellent. On virtually every dimension examined except cost, however, enrollees were significantly less likely than non-enrollees to rate their care as excellent. Yet, these same enrollees were much more likely to rate their satisfaction with out-of pocket costs as excellent and identified significantly fewer instances of needing various types of health care for which they did not have coverage. The study concludes that "Most enrollees ... seemed to feel that HMOs' lower costs and wider set of benefits more than compensated for their lower level of satisfaction with care received." When applied to our data, this finding may mean that as beneficiaries perceive HMO costs are too expensive, they may become less willing to tolerate other features of HMO care that they do not like.

RECOMMENDATIONS

As the health care reform debate continues and a means to control health care costs is sought, the HMO form of managed care has received increased attention. To provide further information for the ongoing debate and to assist HCFA in its management of Medicare risk HMOs, we present these conclusions based on our survey results.

As discussed, beneficiary responses indicate Medicare risk HMOs provided adequate service access for most beneficiaries who had joined. However, our survey results also indicate some serious problems with enrollment procedures and service access that we believe require HCFA's attention. Our intent here, and in subsequent reports based on the same survey data, is not to prescribe specific corrective actions. Instead, we want to identify for HCFA, based on information from beneficiaries, areas of the Medicare risk HMO program apparently needing improvement and to suggest techniques HCFA can use to further monitor these areas.

Three items need immediate exploration:

- **Beneficiaries should be better informed about their appeal rights as required by Federal standards.** Fully 25% of beneficiaries did not know they could appeal their HMOs' refusals to provide or pay for services. We believe knowledge of appeal rights is an extremely important issue when viewed in combination with lock-in to the HMOs and the fact that 12% of all HMO beneficiaries perceived their primary HMO doctors did not take their health complaints seriously.

- **Service access problems reported by disabled/ESRD beneficiaries need to be carefully examined, as they are an especially vulnerable group.** Moreover, the problems cited in their survey responses parallel February 1994 Congressional testimony regarding HMO care of the disabled.[34]

- **Medicare risk HMOs should be monitored for inappropriate screening of beneficiaries' health status at application.** More than 2 of 5 beneficiaries, who could remember, said they were asked at application about their health problems. A recently published study[35] of Medicare risk HMOs found that these plans attract healthier-than-average beneficiaries. While the study concludes this "appears to be due primarily to self-selection of enrollees, since HMOs must enroll an interested Medicare beneficiary," our data suggest the possibility of health screening and selective enrollment by HMOs, as an alternate explanation.

Several other beneficiary-reported issues of access to services through HMOs merit examination by HCFA in the near future for possible cause and resolution. The access issues concern:

- **Routine Appointments** -- Some beneficiaries reported having difficulty making appointments for services in terms of the days waited for scheduled appointments,

apparently without regard to their health status. Others said they sometimes gave up trying to make appointments because of consistently busy telephone lines.

- **Health Maintenance** -- Some beneficiaries reported being unable to see their primary HMO doctors within 1 or 2 days when they felt they were very sick. Some also believed their HMO medical care caused their health to worsen.

- **Refusal of Services** -- Some beneficiaries reported they were refused referrals to specialists, payments to a doctor or hospital for emergency care, or Medicare covered services because the HMO purportedly did not cover them.

Based on our experience with this survey, we suggest consideration of three items as HCFA conducts field tests of its survey instrument for disenrolling HMO beneficiaries.

- **Allow disenrollees to communicate as many reasons for leaving the HMO as are applicable to their situation.** Confining a beneficiary to only one reason may mask underlying problems of which HCFA needs to be aware.

- **Distinguish between administrative and non-administrative disenrollments.** Because of the major differences between administrative and non-administrative disenrollees, it appears advisable to treat them separately when monitoring managed care settings. Also, if disenrollment rates are to be a performance indicator, HCFA may want to exclude administrative disenrollments or treat them separately.

- **Conduct these exit surveys by mail with computer generated forms, either exclusively or in conjunction with other methods.** In this way, as the GHP or other data base is updated with disenrollment information, HCFA could routinely and systematically collect information from all or a portion of disenrollees.

Additional Office of Inspector General Work

Other Inspector General reports, either in progress or planned, are also intended to assist HCFA in its examination and management of HMO issues. From this survey data we plan to complete an HMO level report showing the distribution, frequency and characteristics of HMOs relative to the enrollment and access issues reported by beneficiaries. We also plan to produce a report that explores the value and use of disenrollment rates as an HMO performance indicator and that analyzes the most significant reasons for beneficiary disenrollments. Other subjects of future HMO reports are a determination of how physicians and beneficiaries view their relationship in an HMO setting and how well Medicare beneficiaries enrolled in HMOs understand their appeal rights and have them protected.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE). The full text of their comments is in Appendix E.

Health Care Financing Administration

HCFA concurred with the report's recommendations. However, it noted an apparent inconsistency between sections of this report and our Summary Report on the same subject (OEI 06-91-00736) that discuss personal treatment of beneficiaries by their HMOs or primary HMO doctors. The finding is that 39% of disenrollees and 12% of enrollees believed their primary HMO doctors did not take their health complaints seriously. Of these beneficiaries, 44% of disenrollees and 36% of enrollees said they encountered this attitude most to all of the time. We have amended the Summary Report to clarify this finding.

Assistant Secretary for Planning and Evaluation

ASPE was concerned that our using beneficiary reported data only did not present a complete picture of Medicare risk HMO operations, and thus, did not put the report findings in perspective. ASPE suggests that the report should include comparative data from HCFA monitoring and other research, and an examination of the HMO plans' brochures and the *Medicare Handbook* to determine what information is available to beneficiaries.

Our primary purpose for conducting the beneficiary survey was to develop another tool HCFA could use to monitor HMO performance through systematic beneficiary feedback. Further, our study's scope was narrowly focused on beneficiaries' perceived access to services only, as opposed to beneficiary satisfaction or quality of care. We had previously considered including more discussion of other available information to provide context for beneficiary responses, as ASPE suggests. However, we chose not to largely because such discussions would have over-extended an already lengthy report. Instead, we cautioned readers about the nature and limitations of the data presented, and included the bibliography for those interested in more detail.

We believe that beneficiary reported information is a valuable indicator of where the Medicare risk HMO program is working well, or in need of improvement. For example, 25% of beneficiaries reported that they did not know they had appeal rights. As ASPE notes, HCFA has taken steps to make beneficiaries aware of these rights, e.g. review of marketing materials and distribution of the *Medicare Handbook*. Nevertheless, the beneficiaries themselves, the primary users of that information, have indicated that the message isn't getting through.

We agree that further explortion of our findings and recommendations is needed before final action is taken. For example, our recommendation for the disabled/ERSD population is that HCFA should carefully examine the reported access problems. Part of this examination would include, as ASPE suggests, reviewing data from other sources (such as HCFA's own monitoring efforts) to determine the extent to which such other sources similarly identify this as a problem area.

All things considered, though, we believe that the three problem areas we identified deserve further examination.

ENDNOTES

1. "Medicare Managed Care Contract Report," July 1, 1994, prepared by Office of Managed Care, HCFA.

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

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

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

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

4. Actually, 91 HMOs had risk contracts when the sample was drawn; however, 4 HMOs did not have any Medicare enrollees during 1991 and 1992.

5. Disenrollments for reasons other than the beneficiary's death.

6. Of the 45 HMOs, the model types were 9 group HMOs, 6 staff HMOs, and 30 individual practice associations (IPA) from 22 States. The distribution of the model types among the strata were: Group - 2 group HMOs in Strata 1, 4 in Strata 2, and 2 in Strata 3; Staff - 2 staff HMOs in Strata 1, 1 in Strata 2, and 3 in Strata 3; IPA - 10 IPAs in Strata 1, 10 in Strata 2, and 10 in Strata 3.

7. All sampled beneficiaries received a survey in English; 409 also received one in Spanish.

8. Surveys were usable if beneficiaries answered a minimum set of questions or were willing to complete the minimum set by telephone. All usable surveys had responses for enrollment status as of the sample's timeframe, receipt of services from the sampled HMO, and plans/reasons for leaving the HMO. In addition, if beneficiaries had received HMO services, their surveys had to include 5 additional responses about their HMO experience from any of the survey's sections. We made 143 follow-up telephone calls to beneficiaries whose surveys were potentially usable if we could complete/clarify enrollment status and other key questions.

9. Using weighted data, the response rate is 74% overall, 75% for enrollees and 58% for disenrollees. (See Appendix A.)

10. For example, suppose 25% of disenrollees answered "yes" to a particular question while 50% of enrollees answered "yes." The interpretation would be that enrollees were twice as likely as disenrollees to respond "yes" (i.e., 50% enrollees vs. 25% disenrollees). However, because of the disproportionate distribution of enrollees and disenrollees, this difference does not necessarily indicate significant statistical differences between the groups.

11. Determined disabled in accordance with the Medicare definition.

12. Beneficiaries could select more than one serious condition.

13. To calculate the approximate N for each cell in the Tables, divide the number in parentheses by the percent above it.

14. The Table below shows that the beneficiaries who have had 1 or more serious illnesses, e.g., heart attack, cancer, pneumonia, are more likely to be admitted to the hospital and to have higher numbers of doctor visits in a year. This information combined with the data in Table 3 suggest that beneficiaries' perceived propensity to use services is influenced by their health status, i.e., the sicker they are, the more likely to use services, and their need for the services is real.

Service Use by Beneficiaries with Serious Illnesses				
	Disenrollees		Enrollees	
	None	1 or more	None	1 or more
1 to 6 total primary HMO doctor or specialist visits in the last year.	**83%** (10,792)	**65%** (3,747)	**81%** (420,228)	**62%** (165,902)
7 or more total primary HMO doctor or specialist visits in last year.	**17%** (2,207)	**35%** (2,039)	**19%** (97,689)	**38%** (103,180)
Was admitted to hospital while member of sampled HMO.	**29%** (4,804)	**74%** (5,170)	**34%** (215,812)	**79%** (239,100)

15. Freeborn, Donald, Clyde Pope, and Bentson McFarland, "Consistently High and Low Elderly Users of Medical Care: Executive Summary," Center for Health Research, Kaiser Permanente, Northwest Region, NCHSR Grant No. HS 05316-02, March, 1988.

16. A composite score calculated for items 3 and 4 in Table 6.

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

18. Thirty-nine percent (N=1906) of disenrollees who had 1 or more serious illnesses waited from 13 to more than 20 days for a scheduled appointment with a specialist compared to 22% (N=2390) of disenrollees who had no serious illnesses. There were no differences among enrollees for this.

19. See this Report's section on analysis of sub-groups for more details on these beneficiaries.

20. Projected numbers of 3,138 and 8,158 enrollees respectively also had perceived this direct encouragement to leave the HMO.

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

22. The column does not total 100% as a small portion of beneficiaries answered that both cost of care and giving the best medical care were most important.

23. Disabled/ESRD disenrollees also seem to be disproportionately represented in their stratum. In the entire sample and in the enrollee stratum, the weighted proportion of disabled/ESRD beneficiaries is 3%. Disabled/ESRD disenrollees account for 8% of their stratum.

24. Percents are the proportion of all enrollees who want to leave their HMOs but feel they can't.

25. Administrative reasons for leaving included moving out of the HMO service area, HMOs no longer participating as a Medicare risk HMO or in the companies' retirement plan, and involuntary disenrollments such as late premium payments or clerical error.

26. Disenrollees could select more than 1 reason.

27. The remaining 4% of disenrollees did not say whether or not they left for administrative reasons only.

28. When discussing the most frequently mentioned or the most important reasons for leaving an HMO, we rank them in descending order by percents. If two or more reasons have the same percents, they also have the same rank. Thus, for example, the top 4 items, by rank, in a category may actually be more than 4 reasons.

29. Frequency is ranked within each of the 2 categories of reasons for leaving -- personal preferences and access to services. The most important reason for leaving is ranked among <u>all</u> the reasons of both categories. Reasons marked with an asterisk were mentioned frequently within their categories, but were not among the most important reasons.

30. Personal preference options chosen by too few beneficiaries to include were: 1) getting to the HMO is too difficult, 2) I don't like the HMO building, 3) I don't like where the HMO is located.

31. Access to services options chosen by too few beneficiaries to include were: 1) I am not allowed to go to the hospital when I need to, 2) the HMO won't approve Medicare covered services that my primary HMO doctor wants me to have, 3) my primary HMO doctor, his staff or HMO office staff have encouraged me to leave, 4) prescription drugs are not covered.

32. Brown, Randall S., Dolores Clement, Jerrold Hill, Sheldon Retchin, and Jeanette Bergeron, "Do Health Maintenance Organizations Work for Medicare?" *Health Care Financing Review*, Fall 1993, 15:1:7-23.

33. Measures of the care process (for example, explanations given by their physicians or attention they received as a patient), the structure of care (ease of obtaining care, waiting times, and ease of seeing the physician of their choice), and the perceived quality and outcomes of care (thoroughness of examinations and overall results of care received).

34. Before the House Select Subcommittee on Education and Civil Rights by a representative from the National Council on Independent Living. *Medicare and Medicaid Guide*, No. 789, Commerce Clearing House, February 17, 1994, p. 5.

35. Brown, Randall S., et al., Fall, 1993.

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