Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE RISK HMOs: BENEFICIARY ENROLLMENT AND SERVICE ACCESS PROBLEMS

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Specific details of problem extent and intensiveness among HMOs follow.

Federal Enrollment Procedures

Asking beneficiaries about their health problems during application was a fairly widespread and intensive problem.

Being required to take a physical examination before joining the HMO was relatively infrequent.

Understanding of HMOs

Lack of awareness of appeal rights was the most widespread and intensive problem, while beneficiary misunderstanding of other requirements was common but less severe.

Medical Appointments

In about two-thirds of HMOs, beneficiaries experienced moderate to minor difficulties with medical appointments.

Service Access

Perceived service access problems were fairly widespread and moderately intensive for disenrollees, but relatively infrequent for enrollees.

Personal Treatment

The most widespread and intensive personal treatment problems among HMOs were the failure of primary HMO doctors to take beneficiary complaints seriously and perceptions that holding down the cost of medical care was more important than giving the best medical care to their primary doctors and/or their HMO.

Beneficiaries' Responses Varied According to HMO Model Type and Profit Status.

Beneficiaries in group and staff model HMOs were more likely to report being required to have a physical examination at application, not being aware of appeal rights, and having problems with appointments.

Beneficiaries in non-profit HMOs were more likely to report being required to have a physical examination at application, not being aware of needing a referral to see a specialist, and having problems with appointments.

CONCLUSIONS

Beneficiary-level data linked with respective HMOs provides additional insights for examining HMO enrollment and service access problems. It may prove especially useful in focusing monitoring efforts. Determining a problem's distribution could either signal the need for program-wide monitoring or for targeting specific HMOs. A problem's degree of intensity can also be determined. However, to best utilize this knowledge, HCFA should establish acceptable tolerance ranges for these indicators, since a problem may be pervasive but not critical.

Additionally, certain structural factors, e.g., non-profit status and group and staff models, may affect beneficiaries' perceptions of HMO service. Such knowledge can help target monitoring efforts for HMOs with these characteristics.

For an HMO-level analysis, our experience suggests HCFA may want to stratify by Medicare enrollment size, as well as for selected structural characteristics, e.g. model type and profit status, when surveying HMO beneficiaries.

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INTRODUCTION

PURPOSE

To provide HMO-level data to identify distribution and intensity of enrollment and service access problems.

BACKGROUND

In a previous OIG report, "Beneficiary Perspectives of Medicare Risk HMOs" (OEI-06-91-00730), we reported results from a survey of beneficiaries enrolled in Medicare risk 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 was Medicare beneficiaries' perceptions, we collected information directly from them.[1] 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.

Generally, beneficiary responses indicated Medicare risk HMOs provide adequate service access for most beneficiaries who have joined. The majority of enrollees and disenrollees reported medical care that maintained or improved their health, timely appointments for primary and specialty care, good access to Medicare covered services and to hospital, specialty and emergency care, and sympathetic personal treatment by their HMOs and HMO doctors. In some instances, however, enrollees and disenrollees differed markedly in reporting their HMO experiences. When this happened, we described the difference as a point of comparison.

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

Our intent has been 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. In addition, we wanted to explore if linking beneficiary responses to their respective HMOs could show whether or not problem areas occurred program-wide or were only isolated within specific HMOs. Also, at the HMO-level, we wanted to determine problem intensity or degree of severity among HMOs.

METHODOLOGY

Construction of an HMO-level database

To construct an HMO-level database, we aggregated our original individual-level data[2] to link beneficiaries with their respective HMOs. For continuity and consistency with our first report, we separated the HMO-level data by enrollees and disenrollees. Also, since our individual-level data was a disproportionate sample of enrollees and disenrollees, we had to account for varying response rates per HMO. Enrollees were distributed among all 45 HMOs, but disenrollee representation was limited. Four HMOs had less than 20 of 50 disenrollees return their survey. Thus, for disenrollees only, these 4 HMOs were dropped from further analysis. Also, 5 other HMOs had less than 14 disenrollees in their total population when we sampled. Nevertheless, we still included these 5 HMOs in our analysis if 2 conditions were met. First, at least 75% of their disenrollees returned a usable survey. Second, for those remaining, at least 75% of their disenrollees answered on a question-by-question basis. It was not our intent to generalize our findings to all Medicare risk HMOs but, rather, to use our data to detect trends within our own sample, especially to illustrate the utility of HMO-level analyses.

Problem Distribution and Intensity

First, for each question, we determined if an HMO had at least one beneficiary report an incidence. This process counted the number of involved HMOs and established how widely distributed the problem was among them. Second, we calculated the proportion of negative responses per question for all beneficiaries within each HMO. Third, we constructed frequency ranges which provided a common descriptive framework to compare problem intensity or degree of severity among HMOs. The ranges included no beneficiaries (0%) in each HMO reporting the problem, 1% to 10% of beneficiaries, 11% to 25% of beneficiaries, 26% to 50% of beneficiaries, or more than 50% of beneficiaries. Fourth, we counted, per question, how many HMOs fell into each of these ranges. Tables showing specific distribution and degree of intensity are categorized in Appendix A as health screening, understanding of HMOs, medical appointment problems, perceived service access problems, and perceived personal treatment problems.

Definition of Structural Factors

We selected 5 structural factors to examine how beneficiaries' perceptions may be affected: HMO model type[3], profit status, contracted services[4], location in multiple States, and Medicare enrollment size. We used several sources to identify these characteristics. HMO model type was obtained from the HCFA monthly report of Medicare prepaid health plans for February 1993. Profit status, contract services, and location in 1 or multiple States were found in the "1992-1993 Managed Care Report" section of Business Insurance (December 18, 1992). We also used the HCFA's Group Health Plan (GHP) database as of February 28, 1993 to obtain information on Medicare enrollment size[5] (See Appendix C for a profile of HMOs). To determine the significance of these structural factors, we conducted various statistical analyses.[6]

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

FINDINGS

OVERVIEW

Our analysis of beneficiary problems with Federal enrollment procedures, understanding of HMOs, medical appointments, service access, and personal treatment suggested two general findings:

Most Reported Problems are Widespread Among the Sampled Medicare Risk HMOs, but at Varying Degrees of Intensity.

Disenrollees Generally Experienced these Problems at a Higher Degree of Intensity than Enrollees.

Specific details of problem extent and intensiveness among HMOs follow.

Federal Enrollment Procedures[7]

Asking beneficiaries about their health problems during application was a fairly widespread and intensive problem. (See Appendix A, Table 1.)

Health Screening (37% of enrollees and 39% of disenrollees)[1]

- In over two-thirds of the HMOs, between 26% to more than 50% of both enrollees and disenrollees said they were asked about health problems during application.

Being required to take a physical examination before joining the HMO was relatively infrequent.

Required a physical exam (4% of enrollees and 2% of disenrollees)

- Enrollees in a little over one-half of the HMOs and disenrollees in slightly more than one-third of the HMOs said a physical was required to join. Usually such reports were of minor intensity ($\leq 10\%$).

[1] The percentage of enrollees and disenrollees who responded negatively to each issue.

Understanding of HMOs

Lack of awareness of appeal rights was the most widespread and intensive problem, while beneficiary misunderstanding of other membership requirements was present but less severe. (See Appendix A, Table 2.)

Appeal rights (26% of enrollees and 32% of disenrollees)

- From 11% to over 50% of beneficiaries in more than 90% of the HMOs reported they were not aware they had a right to appeal their HMO's refusal to provide or pay for services.

Specialist referral (11% of enrollees and 15% of disenrollees)

- Not being aware of needing a primary doctor referral to see a specialist was more intensive for disenrollees. From 11% to 50% in over two-thirds of the HMOs reported a lack of awareness of this process.

Ability to back-out (11% enrollees and 18% of disenrollees)

- More disenrollees were not aware of their ability to back-out of enrollment after application. Eleven percent to 50% of disenrollees in nearly two-thirds of the HMOs reported this lack of knowledge.

Lock-in (4% of enrollees and 7% of disenrollees)

- Beneficiaries in over two-thirds of HMOs reported they were not aware of being restricted to HMO doctors and hospitals. However, this situation represents $\leq$10% of beneficiaries in each HMO.

Medical Appointments

In about two-thirds of HMOs, beneficiaries experienced moderate to minor difficulties with medical appointments. (See Appendix A, Table 3.)

Appointment when very sick (6% of enrollees and 12% of disenrollees)

- Not being able to get an appointment within 2 days when very sick was found in two-thirds of the HMOs. However, it was worse for disenrollees, of which 11% to 50% in about half of the HMOs reported the problem.

Appointments with primary HMO doctors and specialists (Doctor appointment, 15% of enrollees and 18 percent of disenrollees; specialist appointment, 19% of enrollees and 24% of disenrollees)

- In at least 58% of the HMOs, from 11% to over 50% of beneficiaries said they waited more than 12 days for a scheduled appointment with their primary HMO doctor. For scheduled appointments with a specialist, disenrollees indicated longer waits. In half of the HMOs, from 26% to over half of the disenrollees reported this situation.

Wait in doctor's office (5% of enrollees and 13% of disenrollees)

- More disenrollees waited longer than an hour in the office to see their primary HMO doctor. In about half of the HMOs, from 11% to 50% of disenrollees reported waits this long.

Busy telephone lines (10% of enrollees and 13% of disenrollees)

- In more than one-third of the HMOs, from 11% to 50% of beneficiaries said consistently busy telephone lines caused them sometimes to give up scheduling an appointment.

Service Access

Perceived service access problems were fairly widespread and moderately intensive for disenrollees, but relatively infrequent for enrollees. (See Appendix A, Table 4.)

Sought out-of-plan medical care (7% of enrollees and 15% of disenrollees)

- In 68% of the HMOs, from 11% to 50% of disenrollees said they sought out-of-plan medical care, excluding dental, routine eye, and emergent/urgent care.

Not referred to a specialist (4% of enrollees and 14% of disenrollees)

- In 52% of the HMOs, from 11% to 50% of disenrollees said their doctor sometimes failed to refer them to a specialist when needed.

Failed to get needed Medicare services (4% of enrollees and 12% of disenrollees)

- Almost half of the HMOs had from 11% to 50% of their disenrollees saying their primary HMO doctors failed to provide needed Medicare services.

Health Status Worsened (2% of enrollees and 11% of disenrollees)

- More disenrollees reported a decline in health status. In 40% of the HMOs, from 11% to 50% of disenrollees reported the medical care they received from their HMO caused their health to worsen.

Personal Treatment

The most widespread and intensive personal treatment problems among HMOs were the failure of primary HMO doctors to take beneficiary complaints seriously and perceptions that primary doctors and HMOs sometimes place too much emphasis on holding down the cost of care. (See Appendix A, Table 5.)

Complaints not taken seriously (12% of enrollees and 25% of disenrollees)

- In over 80% of the HMOs, from 11% to more than 50% of disenrollees, as compared to 11% to 25% of enrollees in over half of the HMOs, reported their complaints were not taken seriously by their primary HMO doctor.

Doctor holding down the cost of medical care (7% of enrollees and 25% of disenrollees)

- In over 80% of the HMOs, from 11% to more than 50% of disenrollees, as compared to 11% to 25% of enrollees in more than a third of the HMOs, thought holding down the cost of care was most important to their primary HMO doctor.

HMOs holding down the cost of medical care (15% of enrollees and 35% of disenrollees)

- In over 90% of the HMOs, from 11% to more than 50% of disenrollees, as well as 11% to 50% of enrollees in over two-thirds of the HMOs, indicated that holding down the cost of medical care was more important than giving the best medical care to their HMOs.

Beneficiaries' Responses Varied According to Model Type and Profit Status.

Beneficiaries in group and staff model HMOs were more likely to report being required to have a physical at application, not being aware of appeal rights, and having difficulties with appointments. (See Appendix B.)

Required a physical exam. Enrollees in staff model HMOs were more than 2.5 times more likely than enrollees in other models to say a physical was required prior to enrollment.

Disenrollees in group model HMOs were 3 times more likely than disenrollees in other models to say they were required to take a physical.

Appeal rights. More disenrollees in group model HMOs were almost twice as likely to say they were not aware of their appeal rights.

Appointment with primary HMO doctor. Enrollees and disenrollees in a group model were almost 2 to over 3 times more likely than their counterparts in other models to indicate waiting longer than 12 days for a scheduled primary doctor appointment.

Appointment with specialist. Enrollees in group models were more likely than enrollees in other models to say they waited longer than 12 days for an appointment with a specialist. For disenrollees, those in a group model were 2 times more likely than other disenrollees to report such a wait.

Appointment when very sick. Disenrollees in a group model were twice as likely as disenrollees in other models to report having difficulties getting an appointment within 2 days when very sick.

Busy telephone lines. Enrollees in a group model were at least twice as likely as enrollees in other models to report sometimes giving up making an appointment because of consistently busy telephone lines.

Beneficiaries in non-profit HMOs were more likely to report being required to have a physical examination at application, not being aware of needing a specialist referral, and having problems with appointments. (See Appendix B, Table 2.)

Required a physical. Disenrollees in non-profit HMOs were at least twice as likely as disenrollees in for-profit HMOs to say they were required a physical examination for application.

Understanding of HMOs. Both enrollees and disenrollees in non-profit HMOs were over 1.5 times more likely than beneficiaries in for-profit HMOs to say they were not aware of the need for a specialist referral.

Enrollees in non-profit HMOs were almost 2 times more likely as enrollees in for-profit HMOs to say they were not aware they could back-out of enrollment.

Appointment with primary HMO doctor. Both enrollees and disenrollees in non-profit HMOs were almost twice as likely as those in for-profit HMOs to say they usually waited more than 12 days for a scheduled appointment with their primary HMO doctor.

Appointment with a specialist. Both enrollees and disenrollees in non-profit HMOs were over 1.5 times more likely as beneficiaries in for-profit HMOs to say they waited more than 12 days for a specialist appointment.

Busy telephone lines. Enrollees in non-profit HMOs were at least 2 times more likely as enrollees in for-profit HMOs to say they sometimes gave up on making an appointment because of busy telephones lines.

CONCLUSIONS

We found that using beneficiary-level data linked back to the HMO provides additional insights for examining HMO enrollment and service access issues. This type of information may prove especially useful in focusing monitoring efforts. For example, most of the problem areas we found were distributed throughout the sampled HMOs and were not just isolated incidences. This pervasiveness could signal the need for program-wide monitoring efforts. Additionally, this level of data could be used to pinpoint specific problematic HMOs and indicate when corrective actions should be initiated.

HMO-level analysis can also show a problem's degree of intensity. For example, for our sampled HMOs, we would focus program-wide attention on screening for health status at application, not making beneficiaries aware of their appeal rights, and not taking complaints seriously. Also, for disenrollees only, we would focus program-wide attention on service access problems. However, to best utilize knowledge of problem intensity, we suggest HCFA establish acceptable tolerance ranges for these indicators, since a problem may be pervasive but still not be seen as critical.

Additionally, our analysis suggests that certain structural factors also impact beneficiaries' perceptions of HMO service. For example, of the structural factors we examined, group and staff model, as well as non-profit status, made a significant difference in how beneficiaries experienced certain problems. This type of knowledge could help target monitoring efforts for HMOs with these characteristics.

For an HMO-level analysis, our experience suggests HCFA may want to stratify by Medicare enrollment size, as well as for selected structural characteristics, e.g. model type and profit status, when surveying HMO beneficiaries.

Additional Office of Inspector General Work

Using our beneficiary survey data, we also plan to produce a report exploring the value and use of disenrollment rates as an HMO performance indicator, including an analysis of the most significant reasons for beneficiary disenrollments.

ENDNOTES

1. 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. Additionally, 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.

2. We selected a stratified random sample from HCFA's Group Health Plan (GHP) data base. First, we sampled 45 HMOs from the 87 HMOs under a risk contract with HCFA as of February 1993. Beginning with the GHP data, we counted the number of enrollments occurring within calendar years 1991 and 1992. For this cohort, we then calculated the proportion of disenrollments within the following 12 months. Based on this disenrollment rate, we divided the 87 risk HMOs into three strata of 29 HMOs each. Within each strata, we selected 15 HMOs by simple random sampling. Second, from each sampled HMO, we randomly selected 50 Medicare beneficiaries who were enrolled as of February 28, 1993 and 50 who had disenrolled between November 1992 and February 1993 inclusive. When the total number per HMO for either group was less than 50, we selected them all. Using HCFA's Enrollment Data Base, we excluded, from the sampling universe, beneficiaries who had died or who appeared as current enrollees, but had actually disenrolled since the last update to the GHP file. This process resulted in 2,217 enrollees and 1,915 disenrollees for a total of 4,132 beneficiaries. A total of 2,882 surveys were deemed usable, yielding an unweighted return rate of 70% overall, 77% for enrollees (N=1,705) and 61% for disenrollees (N=1,177).

3. HMO model types are divided into three categories. Group models contract with independent, multispecialty physician groups. Individual practice associations (IPAs) contract with independent physicians or small, single specialty physician groups who also maintain private practices co-jointly with their HMO contract. Staff models directly employ salaried physicians to serve patients.

4. Contract services refers to whether or not an HMO formalizes an agreement with another established HMO to provide services.

5. We categorized Medicare enrollment size as: 1) very small, with a total enrollment of less than 1000; 2) small or medium, with a total enrollment between 1000 and 15,000; 3) large, enrollment between 16,000 and 31,000; and 4) very large, greater than 31,000.

6. To test significant differences for each structural factor per question, as well as between enrollees' and disenrollees' responses per question, we used one or more of the following programs from SPSS for Windows (SPSS, Inc. 1993): 1) MEANS which calculates a standard analysis of variance table; 2) Independent-Samples T TEST which computes Student's *t*; and 3) CHAID (Chi-square Automatic Interaction Detection) which finds statistically significant subgroups.

7. Using Federal regulations, we measured beneficiaries' enrollment experience with health screenings and understanding of HMO membership. Strictly speaking, HMOs should have no negative experiences reported in these areas. Possibly, some HMOs conduct health assessment interviews shortly after enrollment and some beneficiary responses may refer to such assessments. If so, our data may be somewhat inflated.

APPENDIX A

PROBLEM DISTRIBUTION AND INTENSITY

TABLE 1. Health Screening

Beneficiaries Responding	Distribution Among HMOs*				
	0% of Beneficiaries in... ↓	1% to 10% of Beneficiaries in... ↓	11% to 25% of Beneficiaries in... ↓	26% to 50% of Beneficiaries in... ↓	>50% of Beneficiaries in... ↓
▸ ***Were asked at application about health problems, excluding kidney failure and hospice care.***					
Enrollees 37% (N=418)		2 HMOs (4%)	12 HMOs% (27%)	19 HMOs (42%)	12 HMOs (27%)
Disenrollees 39% (N=276)		1 HMO (3%)	8 HMOs (21%)	15 HMOs (39%)	14 HMOs (36%)
▸ ***Were required to have a physical examination before joining the HMO.***					
Enrollees 4% (N=57)	20 HMOs (44%)	20 HMOs (44%)	4 HMOs (9%)	1 HMO (2%)	
Disenrollees 2% (N=20)	24 HMOs (62%)	14 HMOs (36%)	1 HMO (2%)		

**Note:* N=45 HMOs for enrollees; "N" varies for disenrollees (see Methodology section, page 2 of this report). Also, percentages may not equal 100% due to rounding.

TABLE 2. Understanding of HMOs

Beneficiaries Responding	Distribution Among HMOs*				
	0% of Beneficiaries in... ↓	1% to 10% of Beneficiaries in... ↓	11% to 25% of Beneficiaries in... ↓	26% to 50% of Beneficiaries in... ↓	>50% of Beneficiaries in... ↓
▸ ***Did not know they had a right to appeal an HMO's refusal to provide or pay for services.***					
Enrollees 26% (N=381)		1 HMO (2%)	26 HMOs (58%)	18 HMOs (40%)	
Disenrollees 32% (N=250)	1 HMO (3%)	2 HMOs (5%)	11 HMOs (29%)	19 HMOs (50%)	5 HMOs (13%)
▸ ***Did not know they needed a referral from their primary HMO doctor to see a specialist.***					
Enrollees 11% (N=176)	3 HMOs (7%)	22 HMOs (49%)	18 HMOs (40%)	2 HMOs (4%)	
Disenrollees 15% (N=151)	4 HMOs (10%)	9 HMOs (23%)	22 HMOs (55%)	4 HMOs (10%)	1 HMO (2%)
▸ ***Did not know they could change their minds about enrolling in the HMO after they applied (back-out).***					
Enrollees 11% (N=133)	2 HMOs (4%)	21 HMOs (47%)	20 HMOs (44%)	1 HMO (2%)	1 HMO (2%)
Disenrollees 18% (N=135)	4 HMOs (11%)	9 HMOs (24%)	13 HMOs (34%)	12 HMOs (31%)	
▸ ***Did not know they could only use HMO-designated doctors and hospitals (lock-in).***					
Enrollees 4% (N=63)	15 HMOs (33%)	27 HMOs (60%)	3 HMOs (7%)		
Disenrollees 7% (N=68)	11 HMOs (28%)	19 HMOs (47%)	9 HMOs (23%)	1 HMO (2%)	

**Note:* N=45 HMOs for enrollees; "N" varies for disenrollees (see Methodology section, page 2 of this report). Also, percentages may not equal 100% due to rounding.

TABLE 3. Medical Appointment Problems

Beneficiaries Responding	Distribution Among HMOs*				
	0% of Beneficiaries in... ↓	1% to 10% of Beneficiaries in... ↓	11% to 25% of Beneficiaries in... ↓	26% to 50% of Beneficiaries in... ↓	>50% of Beneficiaries in... ↓
▸ ***When very sick, was not able to get a doctor's appointment within 1 to 2 days.***					
Enrollees 6% (N=63)	17 HMOs (38%)	19 HMOs (42%)	6 HMOs (13%)	3 HMOs (7%)	
Disenrollees 12% (N=60)	10 HMOs (28%)	8 HMOs (22%)	14 HMOs (39%)	4 HMOs (11%)	
▸ ***For scheduled appointments with primary HMO doctors, usually waited more than 12 days.***					
Enrollees 15% (N=225)	4 HMOs (9%)	15 HMOs (33%)	18 HMOs (40%)	7 HMOs (16%)	1 HMO% (2%)
Disenrollees 18% (N=149)	5 HMOs (13%)	8 HMOs (20%)	17 HMOs (44%)	7 HMOS (18%)	5% (N=2 HMOs)
▸ ***For scheduled appointments with specialists, usually waited more than 12 days.***					
Enrollees 19% (N=222)	1 HMO (2%)	11 HMOs (24%)	22 HMOs (49%)	9 HMOs (20%)	2 HMOs (4%)
Disenrollees 24% (N=153)	1 HMO (3%)	6 HMOs (16%)	9 HMOs (24%)	19 HMOs (51%)	2 HMOs (5%)
▸ ***Usually waited 1 hour or more in the office to see primary HMO doctor.***					
Enrollees 5% (N=80)	11 HMOs (24%)	27 HMOs (60%)	7 HMOs (16%)		
Disenrollees 13% (N=108)	8 HMOs (22%)	10 HMOs (27%)	13 HMOs (35%)	5 HMOs (14%)	1 HMO (2%)
▸ ***Consistently busy telephone lines sometimes hindered bene's making appointments.***					
Enrollees 10% (N=85)	13 HMOs (29%)	16 HMOs (36%)	10 HMOs (22%)	6 HMOs (13%)	
Disenrollees 13% (N=62)	12 HMOs (33%)	10 HMOs (28%)	8 HMOs (22%)	6 HMOs (17%)	

**Note:* N=45 HMOs for enrollees; "N" varies for disenrollees (see Methodology section, page 2 of this report). Also, percentages may not equal 100% due to rounding.

TABLE 4. Service Access

Beneficiaries Responding	Distribution Among HMOs*				
	0% of Beneficiaries in... ↓	1% to 10% of Beneficiaries in... ↓	11% to 25% of Beneficiaries in... ↓	26% to 50% of Beneficiaries in... ↓	>50% of Beneficiaries in... ↓
▸ ***Thought needed to seek out-of-plan care, excluding dental, routine eye, and emergent/urgent care.***					
Enrollees 7% (N=108)	2 HMOs (4%)	34 HMOs (76%)	9 HMOs (20%)		
Disenrollees 15% (N=120)	3 HMOs (7%)	10 HMOs (25%)	24 HMOs (60%)	3 HMOs (8%)	
▸ ***Primary HMO doctor sometimes failed to refer to a specialist when needed.***					
Enrollees 4% (N=66)	11 HMOs (24%)	30 HMOs (67%)	4 HMOs (9%)		
Disenrollees 14% (N=115)	8 HMOs (20%)	11 HMOs (28%)	16 HMOs (40%)	5 HMOs (12%)	
▸ ***Primary HMO doctor sometimes failed to provide needed Medicare services.***					
Enrollees 4% (N=60)	13 HMOs (29%)	31 HMOs (69%)	1 HMO (2%)		
Disenrollees 12% (N=105)	5 HMOs (12%)	16 HMOs (40%)	16 HMOs (40%)	3 HMOs (8%)	
▸ ***Medical care received through the HMO caused beneficiaries' health to improve.***					
Enrollees 53% (N=772)				19 HMOs (42%)	26 HMOs (58%)
Disenrollees 39% (N=296)		1 HMO (3%)	3 HMOs (8%)	28 HMOs (72%)	7 HMOs (17%)
▸ ***Medical care received through the HMO caused beneficiaries' health to stay about the same.***					
Enrollees 45% (N=649)			1 HMO (2%)	31 HMOs (69%)	13 HMOs (29%)
Disenrollees 50% (N=383)			3 HMOs (7%)	17 HMOs (44%)	19 HMOs (49%)
▸ ***Medical care received through the HMO caused beneficiaries' health to worsen.***					
Enrollees 2% (N=32)	24 HMOs (53%)	20 HMOs (44%)	1 HMO (2%)		
Disenrollees 11% (N=86)	13 HMOs (33%)	10 HMOs (26%)	12 HMOs (31%)	4 HMOs (10%)	

**Note:* N=45 HMOs for enrollees; "N" varies for disenrollees (see Methodology section, page 2 of this report). Also, percentages may not equal 100% due to rounding.

TABLE 5. Personal Treatment

Beneficiaries Responding	Distribution Among HMOs*				
	0% of Beneficiaries in... ↓	1% to 10% of Beneficiaries in... ↓	11% to 25% of Beneficiaries in... ↓	26% to 50% of Beneficiaries in... ↓	>50% of Beneficiaries in... ↓
▸ ***Primary HMO doctor sometimes failed to take beneficiary's health complaints seriously.***					
Enrollees 12% (N=175)		22 HMOs (49%)	23 HMOs (51%)		
Disenrollees 25% (N=219)	2 HMOs (5%)	4 HMOs (10%)	14 HMOs (35%)	19 HMOs (48%)	1 HMO (2%)
▸ ***Most important to primary HMO doctor was giving the best medical care possible.***					
Enrollees 86% (N=1197)					45 HMOs (100%)
Disenrollees 73% (N=471)				5 HMOs (13%)	34 HMOs (87%)
▸ ***Most important to primary HMO doctor was holding down the cost of care.***					
Enrollees 7% (N=120)	4 HMOs (9%)	25 HMOs (56%)	16 HMOs (35%)		
Disenrollees 25% (N=162)	2 HMOs (5%)	5 HMOs (13%)	16 HMOs (41%)	13 HMOs (33%)	3 HMOs (8%)
▸ ***Most important to the HMO was giving the best medical care possible.***					
Enrollees 74% (N=1036)					45 HMOs (100%)
Disenrollees 57% (N=387)			2 HMOs (5%)	12 HMOs (31%)	25 HMOs (64%)
▸ ***Most important to the HMO was holding down the cost of care.***					
Enrollees 15% (N=213)		13 HMOs (29%)	27 HMOs (60%)	5 HMOs (11%)	
Disenrollees 35% (N=230)		2 HMOs (5%)	10 HMOs (26%)	20 HMOs (51%)	7 HMOs (18%)

**Note:* N=45 HMOs for enrollees; "N" varies for disenrollees (see Methodology section, page 2 of this report). Also, percentages may not equal 100% due to rounding.

APPENDIX B

SIGNIFICANT STRUCTURAL FACTORS

TABLE 1: Model Types -- Significant Differences in Mean Responses*

	Enrollees			Disenrollees		
Beneficiary Responses	**IPA****	**Group**	**Staff**	**IPA****	**Group**	**Staff**
HEALTH SCREENING						
Physical exam was required before joining.	3%	4%	11%	2%	6%	2%
UNDERSTANDING OF HMOs						
Did not know they had the right to appeal an HMO's refusal to provide/pay for services.				29%	45%	24%
APPOINTMENTS						
For scheduled appointments with primary HMO doctors, usually waited more than 12 days.	9%	33%	18%	11%	39%	15%
For scheduled appointments with specialists, usually waited more than 12 days.	14%	31%	23%	21%	42%	21%
When very sick, was not able to get a doctor's appointment within 1 to 2 days.				10%	21%	9%
Consistently busy telephone lines sometimes hindered bene's making appointments.	7%	19%	11%			

**Note:* Only statistically significant differences at $p \leq .05$ are shown. Percentages are rounded.
**Individual Practice Association

TABLE 2: Profit Status -- Significant Differences in Mean Responses*

Beneficiary Responses	Mean Enrollee Response		Mean Disenrollee Response	
	For-Profit	Non-Profit	For-Profit	Non-Profit
ENROLLMENT PROCEDURES				
Were required to have a physical before joining the HMO.			2%	5%
UNDERSTANDING OF HMOs				
Did not know, from the beginning, they must be referred to a specialist by their primary HMO doctors.	9%	17%	14%	22%
Did not know they could change their minds about enrolling after they applied.	10%	18%		
APPOINTMENTS				
For scheduled appointments with primary HMO doctors, usually waited more than 12 days.	16%	27%	14%	30%
For scheduled appointments with specialists, usually waited more than 12 days.	13%	23%		
Consistently busy telephone lines sometimes hindered bene's making appointments.	8%	17%	8%	20%

**Note:* Only statistically significant differences at $p \leq .05$ level are shown. Percentages are rounded.

APPENDIX C

PROFILE OF HMOs -- STRUCTURAL FACTORS

	ENROLLEES in 45 HMOs	DISENROLLEES in 41 HMOs*
MODEL TYPE		
• IPA	30 HMOs	27 HMOs
• Group	9 HMOs	9 HMOs
• Staff	6 HMOs	5 HMOs
FOR-PROFIT/NON-PROFIT		
• For-Profit	34 HMOs	30 HMOs
• Non-profit	11 HMOs	11 HMOs
ENROLLMENT SIZE		
• Very Small (<1K)	6 HMOs	5 HMOs
• Small to Medium (1K - 15K)	28 HMOs	26 HMOs
• Large (16K - 31K)	6 HMOs	5 HMOs
• Very Large (>31K)	5 HMOs	5 HMOs
COMPETITIVE/NON-COMPETITIVE AREA		
• Competitive	36 HMOs	32 HMOs
• Non-Competitive	9 HMOs	9 HMOs
CONTRACTED/NOT CONTRACTED SERVICES		
• Contracted	14 HMOs	14 HMOs
• Not Contracted	31 HMOs	27 HMOs
LOCATION		
• 1 State	14 HMOs	14 HMOs
• Multiple States	31 HMOs	27 HMOs

**Note:* See Methodology section, page 2 of this report.

APPENDIX D

Key Questions: Significant Differences between Enrollees and Disenrollees*

	Enrollees		Disenrollees	
	# of HMOs	Mean Response	# of HMOs**	Mean Response
UNDERSTANDING OF HMOs				
Did not know they could change their minds about enrolling in the HMO after application.	45	12%	38	18%
Were not aware they needed a referral from their primary HMO doctor to see a specialist.	45	11%	40	16%
Were not aware they could only use HMO-designated doctors and hospitals.	45	4%	40	7%
Did not know they had a right to appeal an HMO's refusal to provide or pay for services.	45	26%	38	32%
MEDICAL APPOINTMENTS				
When very sick, was not able to get a doctor's appointment within 1 to 2 days.	45	7%	36	12%
Usually waited 1 hour or more in the office to see primary HMO doctor.	45	5%	37	14%
SERVICE ACCESS				
Primary HMO doctor sometimes failed to provide needed Medicare services.	45	4%	40	12%
Primary HMO doctor sometimes failed to refer to a specialist when needed.	45	4%	40	12%
Sought out-of-plan care, excluding dental, routine eye, and emergent/ urgent care.	45	7%	40	14%

Key Questions: Significant Differences between Enrollees and Disenrollees*

	Enrollees		Disenrollees	
–	# of HMOs	Mean Response	# of HMOs**	Mean Response
Medical care received through the HMO caused beneficiaries' health to improve.	45	53%	39	40%
Medical care received through the HMO caused beneficiaries' health to worsen.	45	2%	39	11%
PERSONAL TREATMENT				
Primary HMO doctor sometimes failed to take beneficiary's health complaints seriously.	45	12%	40	24%
Most important to primary HMO doctor was giving the best medical care possible.	45	86%	39	71%
Most important to primary HMO doctor was holding down cost of care.	45	9%	39	27%
Most important to the HMO was giving the best medical care possible.	45	74%	39	57%
Most important to the HMO was holding down cost of care.	45	15%	39	37%

**Note:* Only questions statistical significant at $p \leq .05$ (two-tailed) are shown. Percentages are rounded.
**See Methodology section, page 2 of this report.