

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**BENEFICIARY PERSPECTIVES OF  
MEDICARE RISK HMOs**

Summary Report



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# Beneficiary Perspectives of Medicare Risk HMOs

## Summary Report

### PURPOSE

This report describes beneficiaries' perspectives of the Medicare risk HMO experience. For a more detailed discussion, see the companion technical report entitled "Beneficiary Perspectives of Medicare Risk HMOs," OEI 06-91-00730.

### 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, HCFA reported 136 risk-based HMO plans served 2,036,279 Medicare enrollees.<sup>1</sup> The Office of Managed Care within the Health Care Financing Administration (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. We did not attempt to validate their responses through record review or HMO contact. (See Appendix A for details of methodology.)

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

### 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. When this happened, we describe the difference as a point of comparison.

*Overall, HMO beneficiaries seemed relatively healthy. However, disenrollees reported a much greater decline in health status during their HMO stay and were much more likely to blame their HMO care for their declining health.*

Enrollees and disenrollees self-reported similar health problems, but rated their health status differently. Two-thirds of both groups reported no serious health problems;<sup>2</sup> the majority of both rate their health as good to excellent. However, disenrollees tended to rate themselves in poorer health overall than the enrollees who had comparable health problems. Both groups also self-reported deteriorating health over time, but 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 when we surveyed them. HCFA data showed 65% of disenrollees and 77% of enrollees, who answered our survey, were enrolled in the sampled HMOs more than 12 months.<sup>3</sup>

Another important difference between enrollees and disenrollees was how they rated the effectiveness of the HMO care. Disenrollees (22%) were ten times more likely than enrollees (2%) to believe the medical care received through the HMO caused their health to worsen. Fully half of enrollees said HMO care improved their health compared to only one-third of disenrollees.

*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 that HMOs generally informed beneficiaries about application procedures, lock-in and prior approval for specialty care. However, their responses also indicate weaknesses in enrollment procedures and in beneficiary understanding of individual appeal/grievance rights. 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. Forty-three percent of 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.<sup>4</sup> 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. Also problematic is the fact that 25% didn't know they have the right to appeal the HMO's 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; busy telephone lines caused appointment difficulties for some beneficiaries.*

Timely appointments includes days elapsed before a scheduled appointment, time spent waiting in an office to see a doctor and the ease (or difficulty) of the process for scheduling appointments.

► **Appointments:** The great majority of beneficiaries reported they got appointments within 1 to 2 days when they believed they were very sick, but enrollees (94%) were more likely than disenrollees (85%) to get quick appointments. Fully 78% of beneficiaries usually waited 8 days or less for appointments with primary doctors and 63% usually waited the same for appointments with specialists. A substantial group (16% to 26%) of enrollees and disenrollees said they typically waited from 13 to more than 20 days for scheduled appointments for primary and specialty care. Moreover, the waiting times for scheduled appointments differed little between the self-reported healthier and sicker beneficiaries.

► **Office waiting time:** Disenrollees (20%) were almost 3 times as likely as enrollees (7%) to report waiting 1 hour or more in the office to see their primary HMO doctors.

► **Telephone access:** Busy telephone lines hindered some beneficiaries' access to services by affecting their ability to make appointments for care. Disenrollees (34%) encountered consistently busy telephone lines almost twice as often as enrollees (19%) and 11% of all beneficiaries said they sometimes gave up trying to make appointments.

*The great majority of beneficiaries believed they received the Medicare services they needed and were personally well-treated; however, disenrollees were more likely to perceive problems with access to primary and specialty care, to seek out-of-plan care and to report their HMOs' or primary doctors' unsympathetic behaviors.*

A large majority of enrollees and disenrollees believed their primary HMO doctors and HMOs provided the necessary care. They consistently reported good access to Medicare covered services and to hospital, specialty and emergency care.

► **Access to primary and specialty care:** Disenrollees reported more access problems in three categories. First, disenrollees said their primary HMO doctors failed to provide Medicare covered services nearly 5 times as often as enrollees. Second, disenrollees were much more likely than enrollees to report their doctors' failure to give the necessary referrals to specialists. In fact, disenrollees with self-reported serious illnesses were more than twice as likely to report this denial of referrals than disenrollees with none. Third, disenrollees more often reported HMOs' refusals to pay for emergency care compared to enrollees.<sup>5</sup>

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%), and medical equipment for home use (11%) -- all of which are Medicare covered services with some restrictions. Although based on a few responses, this may indicate a problem with HMO service provision and/or beneficiary understanding of available services.

► **Out-of-plan care:** Excluding dental, routine eye, and emergent/urgent care, 7% of all beneficiaries had sought out-of-plan care for Medicare covered services without prior approval from their primary HMO doctors or the HMO. Disenrollees (22%) went out-of-plan 3 times as often as enrollees (7%). Reasons most often given for seeking out-of-plan care were perceived access problems, such as needing the unapproved care, not getting services quickly enough, and not being helped by the primary HMO doctor. Another reason, not knowing they would have to pay for out-of-plan care, illustrates beneficiary misunderstanding of lock-in.

► **Unsympathetic behavior by doctors or HMOs:** Unsympathetic behavior of primary HMO doctors, their staffs and HMO office staff can directly or subtly restrict beneficiaries' access to medical services. We found only slight evidence (less than 1%) of beneficiaries being told their medical needs could not be accommodated. Overall, about 11% of beneficiaries perceived more subtle kinds of personal treatment problems that can indirectly restrict access.<sup>6</sup> Disenrollees (39%) were more than 3 times as likely as enrollees (12%) to believe their primary HMO doctors did not take their health complaints seriously. However, over one-third of these disenrollees and enrollees said they encountered this attitude most to all of the time. Disenrollees were also more likely than enrollees to believe that holding down the cost of care was more important to their primary HMO doctors (28% vs. 10%) or their HMOs (35% vs. 11%) than giving the best medical care possible.

*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 2,300 beneficiaries), highly critical group.<sup>7</sup> 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, 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. We also found discontent among disabled/ESRD enrollees with 66% saying they wanted to leave their HMOs.

*Almost one-third of disenrollees left solely for administrative reasons; the remainder voiced more criticism of their HMO experience; 16% of enrollees either planned to leave their HMOs, or wanted to leave but felt they could not.*

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

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. Two percent planned to move out of the HMO's service area, 4% planned to leave for non-administrative reasons, and the final 10% wanted to leave but felt they could not, primarily because of the relative affordability of HMO care.

*The leading disenrollment reasons based on personal preferences were discomfort with the restricted care choices and high beneficiary expenses, while top reasons related to service access are difficulties with timely appointments and with obtaining needed primary and specialty care.*

Beneficiaries' personal preferences in a health care delivery system and their perceptions of access to services through the HMOs constituted two non-administrative categories of reasons for leaving or wanting to leave the HMOs. 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. Perceived access problems showed some differences between disenrollees and enrollees as well as some similarities. A telling distinction was 19% of disenrollees reported they left because of getting sicker as a result of the care received through the HMO, compared to only 4% of enrollees. 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 they believed they very sick. 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.

*Choice of primary HMO doctors and high beneficiary expenses were the two most important reasons for leaving or wanting to leave the HMOs.<sup>3</sup>*

Five reasons for leaving an HMO were the most frequently given and were among those rated most important by both disenrollees and enrollees. Both groups said they:

- ▶ didn't like the choice of primary HMO providers;
- ▶ believed their 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; and
- ▶ were refused, by their primary HMO doctors, services they believed they needed.

The choice of primary HMO doctors and high beneficiary expenses were the two most important overall disenrollment reasons for both groups. 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. Enrollees' reasons for planning/wanting to leave were predominantly personal preferences for health care delivery.

## 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 recommendations based on our survey results.

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 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.<sup>9</sup>
- ▶ **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<sup>10</sup> 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**

HCFA concurred with the report's recommendations. The agency reports it is focusing on improved ways to communicate with beneficiaries, and specifically the Medicare HMO enrollee. The report findings and recommendations may also be part of its efforts to support action in certain areas of beneficiary access and education. Finally, HCFA will utilize the report as part of its data collection and information gathering efforts to assess beneficiary access to managed care services and the extent of beneficiary knowledge on how to use these services.

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. All things considered, though, we still 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. Serious health problems such as, broken bones, cancer, heart attack, pneumonia or a stroke.
3. The average length of enrollment in the sampled HMOs was 36 months for enrollees and 29 months for disenrollees.
4. 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.
5. 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.
6. Some literature indicates this attitude toward the older patient is a problem generally and is not necessarily confined to one particular care setting.
7. 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.
8. The disenrollees (18%) who cited administrative reasons only are not included in the following analysis. Administrative reasons for disenrollment were 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%). Disenrollees could select more than 1 reason. Enrollees described disenrollment reasons because they either planned to leave their HMOs or wanted to leave, but felt they could not.
9. 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)
10. 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.

11. 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.

12. 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.

## APPENDIX A

### Methodology and Demographic Profile

#### Methodology

This study's primary focus is the Medicare beneficiaries' perceptions of a risk HMO experience. Thus, we collected information directly from beneficiaries but not from HMOs, their staffs or their medical records. We also 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. Since the law and regulations do not clearly delineate what full access to services through a Medicare risk HMO means, we adapted a definition from literature.<sup>11,12</sup> We expanded this definition to include the role of HMO gatekeepers, primary physicians or others, in preventing or facilitating beneficiaries' receipt of covered services. Operationally, we divided access into: timeliness of appointments; service restrictions; incidence of out-of-plan care; and behavior of HMO personnel towards beneficiaries.

Using HCFA databases, we selected a stratified, random sample of 4,132 enrollees and disenrollees from 45 Medicare risk HMOs. Of the structured surveys mailed to each sampled beneficiary, a total of 2,882 surveys (1,705 enrollees and 1,177 disenrollees) were returned and deemed usable. The weighted sample approximates the distribution of enrollees and disenrollees in the universe (97% vs. 3%). Because of this imbalance, we initially analyzed the two groups separately and then compared their responses. Throughout the report, percentages are based on the number of responses to each question. We also analyzed sub-populations of enrollees and disenrollees. (See Table on next page for demographic profile of respondents.)

**Demographic Profile of Respondents  
(Weighted Data)**

	TOTAL POPULATION	DISENROLLEES	ENROLLEES
<b>GENDER</b>			
Female	60% (666,049)	53% (15,065)	60% (650,984)
Male	40% (446,205)	47% (13,139)	40% (433,067)
<b>RACE/ETHNICITY</b>			
White	90% (991,084)	88% (24,872)	90% (966,213)
Non-White	7% (83,684)	12% (3,332)	7% (80,352)
Unknown	3% (37,486)	0	3% (37,486)
<b>AVERAGE AGE</b>	74 Years	73 Years	74 Years
<b>EDUCATION</b>			
< Than High School	24% (274,156)	20% (5,683)	25% (268,473)
High School Diploma	29% (318,440)	22% (6,238)	29% (312,201)
> Than High School	43% (474,317)	49% (13,778)	42% (460,539)
No Response	4% (45,342)	9% (2,504)	4% (42,838)
<b>MEDICARE CATEGORY</b>			
Aged	97% (1,078,445)	92% (25,907)	97% (1,052,538)
Disabled/ESRD	3% (33,809)	8% (2,296)	3% (31,513)
<b>COMPETITIVE AREA</b>			
Competitive <sup>1</sup>	63% (700,103)	53% (14,878)	63% (685,225)
Noncompetitive	37% (412,152)	47% (13,325)	37% (398,826)
<b>HMO EXPERIENCE</b>			
Prior Experience	14% (154,069)	21% (5,997)	14% (148,072)
No Experience	82% (906,961)	71% (19,905)	82% (887,056)
No Response	4% (51,226)	8% (2,302)	4% (48,923)
<b>AVERAGE LENGTH OF TIME IN HMO</b>	36 Months	29 Months	36 Months
<b>SERIOUS HEALTH CONDITIONS<sup>2</sup></b>			
2+ conditions	6% (61,003)	5% (1,254)	6% (59,749)
1 condition	24% (265,866)	22% (6,153)	24% (259,713)
None	60% (669,619)	58% (16,440)	60% (653,180)
No Response	10% (115,767)	15% (4,357)	10% (111,410)

<sup>1</sup> A competitive area is a county in which 2 or more of all Medicare risk HMOs, not just sampled HMOs, provide services. Beneficiaries were then matched to counties by zip codes of their mailing address.

<sup>2</sup> Health conditions are self-reported, and are for example, broken bones, cancer, heart attack, pneumonia or stroke.