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FEDERAL OVERSIGHT OF MEDICARE HMOS: ASSURING BENEFICIARY PROTECTION

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BEFORE THE

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FEDERAL OVERSIGHT OF MEDICARE HMOS: ASSURING BENEFICIARY PROTECTION

THURSDAY, AUGUST 3, 1995

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room 628, Senate Dirksen Building, Hon. William S. Cohen [Chairman of the Committee] presiding.

Present: Senators Cohen, Grassley, Craig, Burns, Thompson, Pryor, Reid, and Kohl.

Also present: Mary Berry Gerwin, Staff Director; Helen M. Albert, Investigator; Priscilla H. Hanley, Professional Staff; Michael T. Townsend, Press Secretary; Sally Ehrenfried, Chief Clerk; Elizabeth Watson, System Administrator; Theresa M. Forster, Minority Staff Director; Kenneth R. Cohen, Investigator; and Stephen Propst.

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order.

Senator Pryor has advised me that he is on his way and will be here momentarily, so we will begin the proceedings on time.

Today, the Senate Special Committee on Aging is holding a hearing on the adequacy of federal oversight of Medicare Health Maintenance Organizations and whether more needs to be done to assure quality of care for Medicare beneficiaries who enroll in these HMOs.

The debate over whether more older Americans should shift from traditional Medicare fee-for-service coverage to managed care plans is being waged here in Washington and all across the country. The HMO debate here in Washington is sparked by the fiscal crisis now facing Medicare. Recently, the trustees of the Medicare Trust Fund issued a rather stark warning about the future of Medicare indicating that the program is on the path to the poorhouse, and that it will go bankrupt by the year 2002, less than 7 years from now. Unless major structural changes are made in the program, Medicare will go broke, leaving 36 million older Americans or disabled Americans without coverage to pay their medical bills.

There is much partisan fingerpointing on which political party is doing a better job of preserving Medicare. I think we have to realize, however, that the best way to preserve Medicare for current and future beneficiaries is to take on the task of making Medicare

more efficient and cost effective. When I think of voting on these issues under the guise of preserving the program, it seems rather short-sighted and unfair to the millions of Americans who want Medicare to be there for them when they retire when they need it.

According to Darwin, the ability to change is the key to survival. Managed care is one of the keys to the evolution and survival of Medicare. While private health care plans have moved toward managed care to control costs, most of the Medicare beneficiaries are still on the fee-for-service provision which offers few incentives for efficiency and encourages higher costs and overutilization of services.

Medicare costs are rising over 10 percent a year while private health care spending is growing at less than half that rate. I think it's time for the federal government to carefully assess how more of these savings can be captured for Medicare itself. Whether to join a Medicare HMO is far more than just a policy discussion here in Washington, distant from the lives of most Americans. There are discussions taking place across the breakfast tables and living rooms throughout this country.

Seventy-five percent of the Medicare beneficiaries now live in areas with a Medicare HMO plan available to them. While Medicare still lags behind the private sector in its use of managed care, there are now more than 150 Medicare HMOs with 2.6 million members and 70 more Medicare risk HMOs waiting for HCFA contract approval. As millions of older Americans face the decision of whether to join or stay in a Medicare HMO, the question of who is watching out for the beneficiary's quality of care and other rights becomes vitally important. We must do all we can to ensure beneficiaries that HMOs under contract with Medicare are financially solvent, provide quality care and treat enrollees fairly and that the federal government is vigilant in enforcing these protections.

For the past several months, the GAO, at the request of Senator Pryor and myself, has been investigating the adequacy of federal oversight of the Medicare HMOs. The focus of our investigation and this hearing today is Medicare risk HMOs. Under these arrangements, Medicare contracts with an HMO to provide a full range of Medicare benefits for a fixed or so-called "capitated" payment for each Medicare beneficiary enrolled. If the actual cost of the services provided to the beneficiary in the plan are higher than the fixed payment, the HMO bears the loss. If they are less, then the HMO makes a profit.

Under current law, the Health Care Financing Administration is charged with certifying and monitoring Medicare risk HMOs to ensure that they comply with federal requirements. HCFA also contracts with peer review organizations to monitor and assess the quality of care provided to beneficiaries. As we will hear today in testimony, serious questions exist about whether HCFA is doing enough to monitor and enforce beneficiary protections in Medicare HMOs.

Today, we are releasing a GAO report that makes some rather disturbing conclusions that HCFA is not doing enough to protect Medicare beneficiaries who enroll in risk HMOs. Particularly disturbing is the GAO's conclusion that HCFA has been reluctant to use sanctions and other enforcement tools against HMOs that have

been slow to correct deficiencies and that "serious improprieties by a few Medicare HMOs subjecting beneficiaries to abusive sales practices, unduly delaying their appeals, or exhibiting patterns of poor quality of care have taken years to resolve." GAO has also concluded that HCFA's quality assurance reviews are not comprehensive and that beneficiaries who appeal HMO denials of care often have to wait as much as 6 months or more for resolution. These delays can result in high out-of-pocket costs and prolonged uncertainty and worry for older Americans and their families.

These findings are especially troubling because it is not the first time that HCFA has been criticized for its failure to aggressively oversee quality assurance in Medicare HMOs. Here we have, for example, a stack of GAO, HHS Inspector General and Congressional hearings and reports, including some from this Committee, calling for changes in the oversight of Medicare HMOs. In 1987 and 1991, by way of example, this Committee, under the direction of the late Senator Jack Heinz, criticized HCFA for failing to adequately oversee Medicare HMOs. I think that while improvements have been made over the years in response to many of these criticisms, far too often these reforms have been adopted only in response to public criticism, investigations or press reports rather than through HCFA's own initiative. If we're going to encourage Medicare beneficiaries to have confidence in Medicare HMOs, they also have to have confidence that the Medicare Program itself is actively overseeing their plans.

This morning, we're going to hear about examples of abuses that have occurred in some Medicare HMOs in the areas of marketing, denial of care and appeals processes. Some of these cases involve high pressure marketing tactics by HMO sales forces, referrals of HMO enrollees to specialists who are not experienced in the type of surgery or medical procedures required by the patient, denials by some HMOs for appropriate skilled nursing facilities or rehabilitation, and long waiting periods for appeals for denials of care.

While many of these abuses have been corrected, and we must not condemn Medicare HMOs on the basis of anecdotes, these stories point clearly to the need for vigilant oversight of Medicare HMOs and strict enforcement of quality assurance standards to protect those who are enrolled in the plans. The purpose of the hearings, I want to emphasize, is not to discourage Medicare-managed care or to scare Medicare beneficiaries out of HMOs. To the contrary, there are countless cases of Medicare beneficiaries who are extremely pleased with the decision to join an HMO, enjoying additional benefits such as prescription drug coverage, dental or vision care, preventative health care, few out-of-pocket costs and little or no paperwork. These satisfied customers would never switch back to a fee-for-service health care plan.

As we will hear from testimony today, many efforts are underway in the private sector and in the managed care industry itself to ensure strong protections for members enrolled in HMOs. As the single, largest purchaser of HMO coverage in this country, Medicare should take advantage of these experiences and private sector initiatives.

I am hopeful that today's hearing will provide us with an important insight on where there are deficiencies in the oversight of

Medicare HMOs and what additional steps need to be taken by Congress, by HCFA, and the HMOs themselves, to ensure protection of Medicare beneficiaries who enroll in HMOs.

Finally, I want to point out that as is the case with many of the issues we address in this Committee, one of the best methods for protection for consumers, especially senior citizens when dealing with Medicare or making other major purchases or investment decisions, is simply education. Today, I hope that our witnesses will be able to shed some light on the types of information that Medicare beneficiaries and their families should have and questions they should be asking in making health care decisions such as whether to join, stay in, or leave an HMO.

Before turning to my colleague, Senator Pryor, who has yet to arrive, I'll keep talking until he gets here perhaps. Before turning to any of my colleagues, I want to once again reiterate that these hearings should not be used by opponents of managed care to derail the future of Medicare HMOs. Far from it, I believe that Medicare is going to collapse if we don't make serious, substantive changes. Managed care is one of the ways in which Medicare can get back on the track toward long-term solvency. In the rush towards managed care, however, we have an obligation to protect the quality of care and rights of senior citizens who move into HMOs and to ensure that quality of care goes hand-in-hand with changes in Medicare. That is the purpose of these hearings.

In a moment, I will commend Senator Pryor for his commitment and leadership in this issue because he has been a real leader on this issue. We will look forward to hearing from him in his opening statement. Pending that, I will yield to my colleague, Senator Grassley.

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Thank you very much.

First of all, the usual thank you for the outstanding work you do as Chairman of this Committee and particularly in something that is really going to be central to our work on health care reform and Medicare reform over the next several months as we go through reconciliation.

So as a followup, I understand that you are contemplating several other hearings on the Medicare program and how it serves beneficiaries now and how it will serve them in the future. Obviously, we all support your interest in this subject.

This hearing on Medicare HMOs is certainly timely. We're discussing major changes in the Medicare program. Among other things, it seems likely that we will see an acceleration of beneficiary enrollment in managed care plans. This increase in enrollment will probably continue even if we do not have major Medicare reforms. At this point, it does seem likely that we will introduce changes in the program that will give beneficiaries greater choice and greater choice obviously ought to be seen as a positive. The spectrum of available health plan types will become more varied as we have choice. This is a good development. First of all, we may be able to fix what is clearly—at least to some of us—unfair Medicare reimbursement. If we can do this, some of our States and communities will find themselves better off than they were before such

reforms, even in the context of a slowdown in overall Medicare spending.

We may be able to improve the benefits available to beneficiaries. Many experts point out that Medicare benefits already compare very well with the best benefit plans available in the private sector, so well-done Medicare reform could provide greater choices to beneficiaries and better benefits.

As we institute reforms and more beneficiaries choose managed care plans, we do have to be sure that they are adequately protected. I understand today's testimony indicates that there is at least some basis for being concerned about beneficiary consumer protections. This hearing examination of the way the current Medicare risk contracting program is working will help us get a realistic focus on the risk to beneficiaries that might be inherent in greater use of managed care plans with our elderly and retired population.

With that, Mr. Chairman, I'm sorry that I may not be able to stay for the entire meeting because of a markup in Judiciary, but I'll follow the issue very closely and as a member of the Finance Committee, with Medicare reform being central to a great part of my work, I will have to be very cognizant of what goes on here.

The CHAIRMAN. Thank you very much, Senator Grassley.

For the benefit of those in the audience, I wish to announce the obvious, I am not a candidate for the presidency. I yielded unfortunately to Senator Grassley out of order and I notice that Senator Burns held up a sign that said "Iowa." I am not running in the Iowa primary. I was preoccupied reading.

Senator BURNS. I wasn't sure that Grassley had moved to Nebraska. [Laughter.]

The CHAIRMAN. Senator Pryor.

STATEMENT OF SENATOR DAVID PRYOR

Senator PRYOR. Thank you.

I want to thank you and apologize for being late. I think there has never been a time when there was a more timely hearing than the one we're having now. I want to thank you for calling this hearing, Mr. Chairman. As you know, working together for years on health care issues, and in particular the Medicare program, we in this Committee have been very, very committed to quality of care for Medicare beneficiaries.

As the HMO program has evolved and we have watched it evolve, the monitoring of this program has been very, very critical to this Committee.

In the late 1980's, we were concerned about the problems related to startup, such as the small number of HMOs participating. When we looked at the HMO program again in the 1990's, just a few years later, our investigators from this Committee found that there were really a number of threats to beneficiary protection, including improper disenrollment and very questionable marketing practices by some of the HMOs.

Today, we've got a 30-year-old Medicare Program that is at a crossroads. We've debated the pros and cons of adding and subtracting onto the program. We're warned that the Medicare Trust Fund is going bankrupt. We're being told we must reduce Medicare spending in order to balance the federal budget.

Although Medicare and the HMO program have grown rapidly, more than 90 percent of the Medicare beneficiaries continue to receive care through the fee-for-service system. Many, many in the Congress today believe that moving more beneficiaries into HMOs may be our best solution to Medicare's financial woes. We're going to talk about how practical that is this morning.

Before we make this extremely high speed turn onto the HMO highway, I think we do have a responsibility to make certain the road is not full of potholes. I have read the recent GAO study, and the report by the Inspector General of HHS. They've raised questions and concerns about beneficiary protection within the HMO program. These reports cite a number of weaknesses in the federal oversight of Medicare HMOs, including a lack of basic data on utilization.

Mr. Chairman, I'm going to ask unanimous consent that my full statement be placed in the record and in view of the large number of witnesses and our colleagues who want to speak, I will yield the balance of my time.

[The prepared statement of Senator Pryor follows:]

PREPARED STATEMENT SENATOR DAVID PRYOR

I would like to thank you, Mr. Chairman, for holding this hearing today on the very important topic of assuring beneficiary protection within the Medicare HMO program. It has been my great pleasure to work with you on this and other important aging issues.

Since the Medicare HMO program began in the early 1980's, the Aging Committee has been deeply committed to ensuring the quality of care for Medicare beneficiaries. As the HMO program has evolved over the years, so have our concerns about the program. In the late 1980's, we were concerned about problems with the start-up of the program, such as the small number of HMOs participating in it. When we looked at the HMO program again in the early 1990's, Committee investigators found a number of threats to beneficiary protection, including improper disenrollments and questionable marketing practices by some HMOs.

Today, the 30-year-old Medicare program is at a crossroads. Daily, we are warned that the Medicare Trust Fund is going bankrupt. We are also told that we must reduce Medicare spending in order to balance the federal budget. Although the Medicare HMO program has been growing rapidly, more than 90% of Medicare beneficiaries continue to receive care through the fee-for-service system. Many in Congress believe that moving more beneficiaries into HMOs may be one of the best solutions Medicare's financial woes. Before we make this high-speed turn onto the HMO highway, I think we have a responsibility to make sure that the road is not full of pot-holes.

Alarmingly, recent studies conducted by the GAO and the Inspector General of HHS have raised serious concerns about beneficiary protection within the HMO program. These reports cite a number of weaknesses in the federal oversight of Medicare HMOs, including a lack of basic utilization data, weak enforcement of federal regulations, and flaws in the beneficiary appeals process.

A balanced discussion of these quality concerns is essential if Congress is to make an informed assessment of managed care's merits and weaknesses. I want to emphasize that it is not the intent of this hearing to criticize HCFA or the Medicare HMO program. In fact, I would like to sincerely commend Mr. Vladeck and others at HCFA for taking steps to improve their quality assurance efforts. Nor is it our intent today to criticize individual HMOs or the managed care industry in general. HMOs are already a vital part of our health care system, and they have the potential to provide cost-effective, quality care to Medicare beneficiaries. My only objective is to ensure that as we fight to restore the financial health of the Medicare program, we do not sacrifice the health of our nation's elderly.

Finally, I want to thank all of our witnesses for taking the time to be here with us today. By working together, we can strengthen the Medicare program and ensure that it provides high quality care for at least another 30 years.

The CHAIRMAN. Thank you very much, Senator Pryor.

The Senator from Montana, Senator Burns.

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you, Mr. Chairman, and thank you for holding this hearing.

I want to reiterate this morning that Senator Pryor, I'm very sad that you're not going to run for reelection next year and you will be missed on this Committee. I want to associate myself with your statement that this is probably the most timely hearing that we will have dealing with health care and this type of thing that we will have probably this year before we get into next year's activities. We appreciate your leadership and your insight on many things and you will be sorely missed on this Committee. I hate to see you go.

As you know, I've been a big proponent of making sure that people have the freedom to choose. There are choices to be made in health care plans, providers and services, and I honestly believe that if we give that freedom to choose to Medicare beneficiaries, they will make the right and wise choice. They consider cost, they will consider quality, they will make sure that whatever they sign up for is the best choice for them and their family. Managed care, or HMOs, is certainly a part of that array of choices.

As health care reform is being debated this year, we will discuss giving folks the choice between private insurance, managed care, medical savings accounts, the traditional Medicare, and I see all of those being appropriate for seniors depending on their needs. I think that is where we really run into problems, we try to get one size fits all and that doesn't always work.

Montana is not exactly the HMO capital of the world, we only have two, maybe three, that are in process now, only one of which is statewide which is the Blue Cross/Blue Shield Plan of Montana, and it's doing very well. In 1987, with 15 primary care physicians in that HMO and about 200 members, it now has 270 physicians and 18,000 members. On the other hand, with over 1,300 physicians in Montana and a population of around 800,000 people, it has certainly not permeated the market or penetrated the market either. The point is that they are competing for Montana health care dollars and they are growing. Folks are choosing managed care because the choice is available and it fits their needs.

When I go through that, I would be remiss if I didn't say that I have a daughter that I'm very proud of. I have a special interest in this because she is in medical school and I want to see her be able to pay back her loans to her father, so she can make a living.

I'm pleased that the GAO has done a study also of federal oversight in HMOs, and I found it particularly interesting that HCFA lags behind the private sector in ensuring quality, collecting information, making information available to the consumers.

On these last two points, I'm baffled. Medicare is the largest health care program in our Nation. Everything is automated, computerized and in this day and age of telecommunications, it seems to me that the gathering of information should be easily done. I would think it would be easier for the Government to collect data than the private sector.

While I'm usually the last one to say we need more federal involvement, in a program that is administered by the federal government and is as large as Medicare is, I would think that oversight would be paramount.

I want to congratulate the Chairman of this Committee on oversight as far as that is concerned. He's come up with many innovative ways and had many hearings on fraud and abuse and ways that we can make Medicare be more functional, work more efficiently, beyond the year 2002.

Think it behooves us to look into these areas where we can get to the bottom line because I think it is mandatory, given the report of the trustees of Medicare, that we preserve and we strengthen Medicare but also along the way, do some things that would probably make it a better program for our seniors.

As sponsor of the last session's Patient Protection Act which guaranteed patients the right to choose their health care provider, I'm particularly interested to hear whether the need for specialty services ever posed a problem. We know that the crux of managed care is reducing the cost by utilizing gatekeepers and thereby hoping to limit overuse of specialty care. Often specialty care is needed and sometimes that is not available within the network, so Medicare beneficiaries are unlikely to be able to afford paying out of their pockets for specialty care that is not covered. I'm interested to hear whether this was ever encountered.

This is a timely hearing and I appreciate the leadership of the Chairman and the ranking member. As you know, at this time in our debate as far as Medicare is concerned, we have to find ways to preserve, as I said before, and strengthen it and look at options down the line.

Mr. Chairman, thank you very much for your kind courtesy.

The CHAIRMAN. Thank you, Senator Burns.

Senator Kohl.

STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Thank you very much, Mr. Chairman.

We're pleased that you've called this hearing and we're particularly thankful to Senator Pryor and you for having requested this very important GAO report.

We all know that this is an epochal year in the history of Medicare and the future of Medicare, but we're all concerned about the talk about the need to cut the cost of Medicare by as much as $270 billion over the next several years. I don't agree with that number, I think it's too steep. Nevertheless, we all understand that if we're going to preserve Medicare, we're going to have to cut the rate of growth of Medicare. Everybody talks about managed care in one form or another as the way in which that has to be done.

We're also concerned about the timing of the budget cycle this year as it affects Medicare and new Medicare proposals. Some of us are concerned that at the very last minute or something close to the last minute, whether intentional or otherwise, we will be presented with a Medicare proposal that won't give us enough time to analyze it and understand all of its ramifications and its implications for the elderly population in our society.

So it is particularly appropriate, I think, that we are here today to talk about managed care, what it is and what it is intended to be and how we can improve it so that as managed care becomes more and more important in our society at all levels of medicine, but particularly at the Medicare level, we do the best possible job in seeing to it that managed care delivers to the people in our society the highest quality of medicine possible.

We're here today to look at the GAO report, to talk about managed care as it relates to Medicare, and I think it's an important hearing. I'm pleased to be a part of it. Again, I appreciate the fact that our Chairman, Senator Cohen, and Senator Pryor are calling this hearing.

Thank you very much.

The CHAIRMAN. Thank you, Senator Kohl.

Senator Craig.

STATEMENT OF SENATOR LARRY CRAIG

Senator CRAIG. Mr. Chairman, I too join in thanking you for holding this hearing at a time that I think all of us are beginning to focus, as we should, on Medicare and its problems, but more importantly, its expectations.

I think all of us are strongly committed to assuring that Medicare will be around 30 years from now and that the seniors of our country will have the kind of access to health care that they have grown to expect from the system.

The question is, how do we keep it there and that is what we will struggle with in the coming months. My guess is that as we all head for the August recess, this hearing is even more timely in adding to our understanding a broader group of options to be able to discuss with our constituents as we visit with them; because I'm quite confident the issue of Medicare will come up, as it should, in the town meetings that I will hold and other gatherings that I will attend while I'm in my home State of Idaho.

HMOs are a consideration that has to be on the table. However, Mr. Chairman, we have to go beyond that. Obviously, in a State like mine, HMOs hardly exist and so if that is the answer to senior access to health care, it won't work in a rural State like Idaho. We have to have diversity and flexibility in the program, and options and choices for those who are the recipients of Medicare, that will give access as we expect it, but also bring about the financial stability. My guess is if we don't accomplish that, we will all gather here 7 or so years from now to decide what went wrong and why the seniors of our country are not receiving the kind of health care that they should receive as participants in and recipients of this program.

Thank you very much, Mr. Chairman. I would ask unanimous consent that my entire statement become a part of the Committee record.

The CHAIRMAN. Thank you, Senator Craig. Your entire statement will be made a part of the record.

[The prepared statement of Senator Craig follows:]

PREPARED STATEMENT OF LARRY E. CRAIG

Mr. Chairman, this hearing on Medicare and managed care could not be more timely. As we head into the August recess, many of us will be speaking with constituents about how we can improve the Medicare System and short up the trust fund. As we look at options such as the expansion of access to HMO programs, we must also review the issues of access to care and quality of care.

As we consider proposals to reform Medicare, our goal is to give seniors more choices and better access to care, while controlling costs. This will be difficult to accomplish, but as we all know, something has to change. Otherwise, 7 years down the road, this committee may be conducting a hearing on how our senior constituents no longer have any Medicare benefits, no choice, and certainly no access to care.

Mr. Chairman, coming from Idaho, I understand some of the problems of our current Medicare System that arise from the lack of choices. In Idaho, we have a shortage of health care providers, and more are limiting the number of Medicare patients they will accept because of all the administrative hassles and low reimbursement rates. Therefore, simply cutting provider reimbursements isn't going to help the seniors in my State trying to get access to care. So when we look at creative ways of letting seniors have more flexibility and choices, other options such as medical savings accounts and managed care need to be addressed.

Managed care is not a concept that has fully hit Idaho. We have few HMO plans available in the State. Therefore, I look forward to the information our witnesses will be providing today. If managed care is going to be a more widely available option for seniors to choose in the Medicare program, then the issue of quality will need to be explored. Similarly, other options such as medical savings accounts need to be on the table for consideration.

Mr. Chairman, it is my understanding that as recently as 3 years ago, there were only 96 Medicare HMOs, covering 1.6 million people. Today, there are 165 Medicare HMOs with 2.6 million members. In addition, there are 70 HMOs awaiting HCFA contract approval. With that kind of rapid growth, and anticipated future growth, the Congress needs to ensure that the health care financing administration's oversight of the Medicare HMO Program is comprehensive and appropriate—especially given that while HMOs encourage prevention, they also have an incentive to underutilize services.

Mr. Chairman, I hope that this hearing can shed some light on these issues, and we can gain a better understanding of what is needed to ensure high quality and access to care in HMOs for Medicare beneficiaries as the Congress moves toward reforming the system.

The CHAIRMAN. I might point out that about 75 percent of the Medicare beneficiaries do, in fact, live in areas that are served by HMOs. Maine is not one of them since we don't have a single HMO. So Senator Craig's statement of the relationship between rural areas such as Idaho and Maine touch a particularly strong nerve.

We're going to have our first panel of witnesses today which will consist of: Sarah Jaggar, Director, Health Financing and Policy Issues for the GAO and the Honorable June Gibbs Brown, Inspector General, Department of Health and Human Services. Both Ms. Jaggar and Ms. Brown and their staffs have been very helpful to us in the examination of quality care and Medicare HMOs as well as many other Medicare issues that Senator Pryor and I have examined over the years.

I'm going to ask that both of you come forward and bring those who are going to accompany you, introduce them, and then Ms. Jaggar, I will call upon you to proceed first followed by Ms. Brown.

I would also ask that you try to summarize your statements. I believe we're looking at votes periodically throughout the morning on the defense authorization bill. We would like to try to get as much of the testimony in as possible.

Senator PRYOR. Mr. Chairman, before our distinguished witnesses proceed, may I have just a moment? I guess you'd say this is a moment of personal privilege.

I've been on the Aging Committee almost 17 years. This was one of the first Committees I became a member of when I came to the Senate. This issue that we are looking at today, in my opinion, is one of those issues that justifies the existence of the Senate Special Committee on Aging. I know of no other Committee—I'm on the Finance Committee, Governmental Affairs, that would take the time and use its resources to the extent this Committee has on the minority and majority sides to delve into an issue of this nature. This is precisely what this Committee is all about.

The second thing, Mr. Chairman, in these almost 17 years, never at any time on this Committee have I seen any partisanship, have I seen any deference to Republicans or Democrats, have I seen a partisan issue that was made more partisan by bringing it to the Committee, and I want to thank you for your continuing that principle.

With that said, we look forward to hearing our witnesses and thank you for coming.

The CHAIRMAN. Thank you, Senator Pryor.

Ms. Jaggar.

STATEMENT OF SARAH JAGGAR, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY ED STROPKO, LOURDES CHO, AND CHARLES WALTER

Ms. JAGGAR. Thank you.

The CHAIRMAN. Would you care to introduce who is accompanying you?

Ms. JAGGAR. Yes, sir.

Good morning, Mr. Chairman and Members of the Committee.

I am pleased to be here today to assist you in your efforts to ensure that Medicare beneficiaries have access to quality care from the HMOs in which they are enrolled. With me today is Ed Stropko who has been involved in this work for more than a decade for GAO and has a wealth of knowledge to share with you.

As you know, the Health Care Financing Administration contracts with HMOs to provide services to Medicare beneficiaries. As you mentioned, today, Mr. Chairman, we are issuing a report requested by this Committee entitled, "Medicare, Increased HMO Oversight Could Improve Quality and Access to Care." The report discusses problems HCFA has in monitoring HMOs and in ensuring that they comply with Medicare's performance standards. We focus on Medicare risk contract HMOs which currently enroll about 7 percent of Medicare beneficiaries.

HCFA is responsible for setting and enforcing standards for Medicare HMOs. In general, Medicare risk contract HMOs must meet three sets of standards. First, they must meet financial solvency requirements and provide adequate administration and management. Second, these HMOs must have quality assurance systems to detect and correct patterns of under-service and poor quality care, provide reasonable access to specialists and services, and not transfer excessive financial risk to providers. Third, they must use fair

marketing practices, provide Medicare coverage services, and follow equitable grievance and appeal procedures.

In this report and in prior reports, we looked at how HCFA oversees Medicare contract HMOs' compliance with these standards. We found that, although HCFA routinely reviews HMO operations for quality assurance and utilization management, these reviews are too limited to verify that these systems are effective. The review teams generally lack the specialized training and experience needed to adequately assess the HMO's quality assurance and utilization management. The review teams do not draw on the experience of Peer Review Organization (PRO) staff that could help in quality assurance assessment.

We also found that HCFA's enforcement actions are weak. We found that HCFA does not use its sanction authority to take strong enforcement actions to correct problems such as abusive sales practices, slow servicing of claims, delays in deciding appeals, and quality assurance deficiencies. Typically, HCFA seeks to document causes of problems and urges HMOs to implement a corrective action plan. Years can pass before an HMO corrects its problems.

Third, we found that the process for appealing HMO denials of care often is too slow to resolve disputes over services that beneficiaries believe they urgently need. HCFA allows up to 6 months before an appeal must be decided by an HMO's appeal board. If the appeal is denied, it is then reconsidered at HCFA. Although HCFA strives to decide these appeals within 30 days, most cases take 3½ months or more on average.

HCFA's current regulatory approach to ensuring good HMO performance lags behind the private sector. The private sector has developed strategies for ensuring quality and value in HMO selection, including collecting more information on HMO performance, providing the information to consumers, and demanding accreditation reviews before contracting with HMOs or plans.

HCFA has taken and continues to develop a number of positive steps in this area. For example, HCFA has progressively improved its collection and summarization of comparative performance indicators on individual HMOs, making these available to contract monitoring staff. Also, three regional offices, accounting for about three-quarters of Medicare HMO enrollment, have implemented an automatic tracking system for complaints. Importantly, HCFA has announced that in fiscal year 1996, it plans to begin conducting site visits to HMOs annually.

Nonetheless, we believe that as the primary sponsor of Medicare beneficiaries' interests when they enroll in HMOs, HCFA has a responsibility to assert their interests by acting quickly and firmly when it has indications of poor care or abusive practices. Preliminary evidence on the success of private sector approaches, coupled with the long history of weaknesses in HMO monitoring and enforcement, suggests that HCFA needs to make its compliance approach more consumer oriented. This would entail using qualified personnel to do routine monitoring and including PRO findings in HCFA's evaluations of HMO compliance; using the option of discontinuing enrollment to minimize beneficiary exposure to noncompliant HMOs; providing Medicare beneficiaries such basic information as disenrollment data, complaint rates and HMO com-

pliance status to help them in choosing health care providers; and streamlining the process for appealing coverage decisions to minimize beneficiaries' risk of incurring high, out-of-pocket costs.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions you may have.

[The prepared statement of Ms. Jaggar follows:]

United States General Accounting Office

GAO

Testimony

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United States Senate

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MEDICARE

Increased Federal Oversight of HMOs Could Improve Quality of and Access to Care

Statement of Sarah F. Jaggar, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-95-229

Mr. Chairman and Members of the Committee:

We are pleased to be here to assist in the Committee's continuing efforts to ensure that Medicare beneficiaries have access to quality care and fair treatment in their health maintenance organizations, or HMOs. Today we are issuing a report requested by this Committee entitled Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155). The report discusses problems that the Health Care Financing Administration (HCFA) has had monitoring HMOs it contracts with to provide services to Medicare beneficiaries, and ensuring that they comply with Medicare's performance standards.[1] Many of these problems are long-standing and have been the subject of continuing congressional oversight and GAO reports. (See app. I for a list of related GAO products.)

Today I would like to focus my remarks on HCFA's (1) monitoring of Medicare contract HMOs' compliance with quality-related standards, (2) enforcement actions when an HMO has failed to comply with these standards, and (3) implementation of beneficiaries' right to appeal HMO denials of care. In addition, I would like to highlight emerging private sector methods used to ensure quality and value in HMOs. To develop this information, we interviewed HCFA officials, reviewed internal HCFA policies and reports, analyzed three cases in which HCFA was taking special enforcement actions against individual HMOs, and documented HMO accreditation and performance measurement practices used in the private sector.

In brief, we found weaknesses in HCFA's quality assurance monitoring, enforcement measures, and appeal processes. Specifically, we found that, although HCFA routinely reviews HMO operations for quality, these reviews are generally perfunctory and do not assess the financial risks HMOs transfer to providers. Moreover, HCFA collects virtually no data on services received through HMOs to enable HCFA to identify providers who may be underserving beneficiaries.

In addition, HCFA's HMO oversight has two other significant limitations: enforcement actions are weak, and the beneficiary appeal process is slow. In enforcing Medicare standards, HCFA has been reluctant to take strong action against HMOs that fail to comply. For the cases we reviewed, deficiencies persisted for years. In its appeal process, HCFA allows 6 months or more for

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[1]When we discuss HCFA's monitoring of HMOs in this testimony, we are referring to both HMOs and Competitive Medical Plans holding Medicare risk contracts for prepaid care. Competitive Medical Plans are subject to regulatory requirements similar to those for HMOs, but they have more flexibility in how they set premiums and services for commercial members. Currently, there are about 164 Medicare risk contract HMOs.

resolution, which can create uncertainty or high out-of-pocket costs for beneficiaries.

HCFA's current regulatory approach to ensuring good HMO performance appears to us to lag behind the private sector. The private sector has developed strategies for ensuring quality and value in HMO selection, including collecting more information on HMO performance, providing the information to consumers, and demanding accreditation reviews. These strategies provide models for improving federal oversight of Medicare HMOs.

BACKGROUND

Although less than 10 percent of Medicare beneficiaries are now in HMOs, recent growth in enrollment and in HMO applications for Medicare contracts has accelerated. In addition, the Congress is considering ways to attract more beneficiaries to HMOs and other forms of managed care in the hope of containing cost growth while preserving quality and access to care.

To encourage commercial and Medicare use of HMOs, in the early 1970s the Congress authorized standards and oversight to ensure reasonable care and service to beneficiaries. As the government gained experience with HMOs, federal standards were strengthened. HCFA is responsible for setting standards for Medicare HMOs' financing, quality of care, and fair treatment of beneficiaries. HCFA is also responsible for enforcing compliance with these standards.

First, HMOs must meet financial solvency requirements, have minimum enrollments necessary to assume the financial risks, and provide adequate administration and management. Second, the plans must have quality assurance systems to detect and correct patterns of underservice and poor-quality care, provide reasonable access to specialists and services, and not transfer excessive financial risk to providers. Third, HMOs must use fair marketing practices that do not mislead or confuse enrollees, provide necessary and covered services, and follow equitable grievance and appeal procedures.

HCFA monitors for continued compliance with requirements by reviewing an HMO's operations every 2 years and through collection and review of performance indicators such as complaints and disenrollments. In addition, HCFA contracts with state-based medical peer review organizations (PRO), which employ local doctors and nurses to assess the quality of care provided in HMOs. The PROs review both care provided to a sample of beneficiaries and all quality of care complaints. Currently, HCFA is revising the PROs' mission to emphasize assessment of patterns of medical practices for treating or preventing specific conditions.

To enforce HMO compliance with federal standards, HCFA is authorized to impose a number of sanctions, including stopping

enrollment, assessing monetary penalties, and terminating a contract. HCFA also has administrative ways to encourage compliance, such as withholding an HMO's request to expand its service area.

PERFUNCTORY MONITORING MAY NOT DETECT QUALITY ASSURANCE DEFICIENCIES

We found that HCFA's monitoring process is insufficient to verify HMO compliance with critical quality assurance standards. Every 2 years, HCFA reviews Medicare HMO systems for monitoring and controlling quality of care. However, these on-site reviews are too limited and are conducted by staff who lack the skills required to verify that the HMO systems actually meet federal standards. In addition, HCFA has not required the HMOs to provide information on their beneficiaries' encounters with doctors and therefore lacks the data to assess patterns of utilization of care. HCFA also has not assessed the financial risks that HMOs place on their providers.

Reviews Lack Depth and Expertise

HCFA's routine on-site reviews check only that an HMO has procedures and staff capable of quality assurance and utilization management--they do not check for effective operation of these processes. In addition, we found that the reviews focus largely on Medicare requirements for administration, management, and beneficiary services. About one-third of each review does examine quality assurance issues, but HCFA's review teams generally lack the specialized training and experience that would enable them to adequately assess the HMO's quality assurance and utilization management. Moreover, HCFA review teams do not draw on the specialized training and experience of PRO staff that could help to verify that HMOs' quality assurance programs work.

In some cases, these routine reviews have failed to detect deficiencies. In the South Florida case we reviewed, the PRO found significant quality of care problems at the same time that routine HCFA on-site visits identified no problems in HMO quality assurance practices. PRO findings included cases of incorrect diagnoses, inappropriate treatment plans, and delayed treatment. Only after years of negative PRO findings did HCFA comprehensively investigate the quality assurance practices of the South Florida and other HMOs.

Little Information on Patient-Provider Encounters

HCFA's lack of patient-provider encounter data, which are vital to assessing beneficiary use of services, also limits the effectiveness of HCFA's monitoring. Federal standards require that HMOs have information and management systems to collect and monitor

these data. Yet HMOs often lack encounter data, and HCFA has not required that such data be standardized or submitted to it and to the PROs. HCFA has been reluctant to impose uniform data requirements on HMOs.

Little Attention Paid to Risk-Sharing Arrangements

HCFA's HMO quality assurance monitoring also does not assess whether financial risks transferred to HMO providers create significant incentives to underserve. The Congress gave the Department of Health and Human Services (HHS) authority, effective April 1991, to limit arrangements that it judged too risky. However, HCFA officials noted that defining acceptable risks has proven complex, and as of July 1995, HHS had not issued implementing regulations and standards. This leaves reviewers with no standard by which to assess a deficiency.

One HMO whose financial-risk arrangements with providers had been of concern to HCFA reviewers for several years also had a high number of quality of care problems. The HMO uses about 23 percent of its Medicare payment for ambulatory care to administer the program; the remaining 77 percent of the payment is used to make fixed, per-enrollee payments to providers. The providers--often individual physicians or small physician groups--are responsible for providing HMO enrollees all needed ambulatory services from these payments. Several providers have lost money on care they provided to HMO patients, which could give providers incentives to withhold services.

HCFA RELUCTANT TO USE ENFORCEMENT AUTHORITY

In the three enforcement cases we reviewed and in our past reviews, we found that HCFA has not used its sanction authority to take prompt and strong enforcement actions to correct problems such as abusive sales practices, slow servicing of claims, delays in deciding appeals, and quality assurance deficiencies.

HCFA officials have stated that pursuing sanctions against noncompliant HMOs can be cumbersome and require many staff. Instead, HCFA seeks to document the causes of an HMO's problems and urges the HMO to develop and implement a corrective action plan. If the HMO does not implement the corrective action or the action is inadequate, HCFA staff investigate the HMO's operations and further document the problems. An investigation could result in HCFA finding noncompliance and requesting a new corrective action plan.

Without prompt and forceful HCFA action, years can pass before an HMO corrects identified problems. For example, in the South Florida case we reviewed, in which a PRO had raised concerns about the quality of care provided by the HMO in 1991 and again in 1992,

HCFA did not probe into the problem until 1994, when it formed a special investigation team that found the HMO's quality assurance and utilization management systems did not meet federal standards. From 1988 to 1994, the HMO enrolled over 336,000 beneficiaries, while about 269,000 disenrolled; in 1994, the HMO had Medicare revenues of over $1 billion.

SLOW APPEAL PROCESS PLACES BENEFICIARIES AT RISK

Weaknesses in HCFA's monitoring and enforcement actions increase the importance of the appeal process for resolving disputes about HMO denials of care. The appeal process, however, often has been too slow to effectively resolve disputes over services that beneficiaries believe they urgently need. To receive such care, some beneficiaries disenroll and return to fee-for-service Medicare. Others remain in HMOs but incur substantial out-of-pocket costs with little certainty of repayment.

Under Medicare rules, beneficiaries may appeal HMO denials of service, including refusals to pay for services obtained outside the plan when there was an emergency or urgent need for care. If an HMO appeal panel rules against a beneficiary, it must forward the case to HCFA. Under current HCFA standards, this first level in the appeal process--from the initial denial of care to the forwarding of the appealed case to HCFA--can take up to 6 months. Although HCFA strives to resolve appeals it receives within 30 days, most cases took longer. In 1993, only 38 percent of the cases were decided within 30 days, and 45 percent required about 3-1/2 months. More complex cases, where medical information was missing or Medicare coverage rules were unclear, took over 6 months.

Some beneficiaries who obtain out-of-plan services that they believe are needed may be liable for those costs. In 1994, 80 percent of the 3,100 appeals reviewed by HCFA involved denied claims for reimbursement of services obtained from providers not affiliated with the HMO. The average claim was about $4,300, totaling over $15 million in disputed claims. HCFA decided against beneficiaries 64 percent of the time, leaving them liable for more than $11 million in claims.

HCFA has taken steps toward improving the appeal process. In November 1994, HCFA clarified its rules to permit appeal without a written denial notice from the plan. HCFA also issued a rule in November 1994 extending to beneficiaries in HMOs the right to expedited PRO review of HMO decisions to discharge them from a hospital when they believe they should remain hospitalized--a right that fee-for-service Medicare beneficiaries have had since 1986. In addition, HCFA operations officials recognize the potential for further improvements.

PRIVATE SECTOR DEVELOPMENTS SUGGEST ALTERNATIVE STRATEGIES TO ENSURE QUALITY

Private sector employers, as sponsors in selecting their employees' health plans, have developed strategies for ensuring quality and value in HMO selection, including demanding accreditation reviews, collecting more information on HMO performance, and providing the information to consumers. HCFA is the Medicare beneficiaries' sponsor in certifying and overseeing Medicare contract HMOs. HCFA, however, does not routinely provide beneficiaries the results of its monitoring reviews or other performance-related information it collects, such as HMO disenrollment rates or beneficiary complaints. Private sector strategies provide models for improving federal oversight of Medicare HMOs.

Some large employers, as sponsors of their employees, have begun to use accreditation and performance data in deciding whether to accept an HMO into their plan. By the end of 1995, nearly half the HMOs in the country will have undergone National Committee for Quality Assurance (NCQA) accreditation review. NCQA accreditation focuses primarily on HMO quality assurance practices that are related to medical operations--the area in which federal certification reviews are relatively weak. NCQA's accreditation review teams typically include physicians and other clinicians or administrators experienced in HMO operations

In addition, a group of large employers and HMOs working with NCQA have developed the Health Plan Employer Data and Information Set (HEDIS), a standardized information database that can enable consumers--both group and individual--to compare different HMOs. HEDIS includes data on various plans' quality of care, access to care, member satisfaction, utilization of services, and financial stability. HCFA recently embraced this approach and proposes to develop, in cooperations with NCQA, HEDIS-type HMO performance measures geared to elderly Medicare beneficiaries.

The private sector also disseminates quality-related information to purchasers and users. NCQA publicizes its accreditation decisions for employers and employees to consider in their HMO selection. Consequently, HMOs that do not obtain accreditation can lose business. For example, when a Florida HMO failed to get NCQA accreditation, a consortium of employers elected to exclude the HMO from new business with their employer-sponsored health plans.

CONCLUSIONS

Over the past two decades the federal government's leadership position regarding HMOs and quality assurance has declined relative to the private sector. In the early 1970s, the federal government encouraged the growth of HMOs and developed the standards for

assuring quality of care. Since the mid-1980s, however, HCFA's approach to quality assurance and other beneficiary protections in Medicare contract HMOs has been unresponsive. Quality assurance problems have gone undetected or, when detected, have not been acted on promptly. By contrast, the private sector has become more active in monitoring quality assurance and holding HMOs accountable for their performance.

Preliminary evidence on the success of private sector approaches--coupled with the long history of weaknesses in HCFA's monitoring and enforcement of HMOs--suggests that HCFA could and should become a more active, consumer-oriented sponsor for Medicare beneficiaries enrolled in HMOs. This would entail

-- using qualified personnel to do routine monitoring, and including PRO findings in HCFA's evaluations of HMO compliance;

-- using the option of discontinuing enrollment to minimize beneficiary exposure to noncompliant HMOs;

-- providing Medicare beneficiaries such basic information as disenrollment data, complaint rates, and HMO compliance status to help them in choosing health care providers; and

-- streamlining the process for appealing coverage decisions to minimize beneficiaries' risk of incurring high out-of-pocket costs.

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This concludes my prepared statement. I will be happy to answer any questions that you may have.

For more information on this testimony, please call Edwin Stropko, Assistant Director, at (202) 512-7108. Other major contributors included Charles A. Walter, Lourdes R. Cho, and Karen Sloan.

RELATED GAO PRODUCTS

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/HEHS-T-95-81, Feb. 10, 1995).

Health Care: Employers Urge Hospitals to Battle Costs Using Performance Data Systems (GAO/HEHS-95-1, Oct. 3, 1994).

Health Care Reform: "Report Cards" Are Useful But Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (GAO/HRD-91-54, Sept. 5, 1991).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed (GAO/HRD-87-113, July 22, 1987).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, Mar. 8, 1985).

(101365)

The CHAIRMAN. Thank you very much, Ms. Jaggar, and for summarizing your statement.

Ms. Brown.

STATEMENT OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY GEORGE GROB

Ms. BROWN. Good morning, Mr. Chairman and members of the committee.

With me today is George Grob who has done a great deal of work in this area. Mr. Grob is our Deputy Inspector General for Evaluations and Inspections.

Managed care is now a prominent feature of the Medicare and Medicaid programs—10 million Medicare and Medicaid beneficiaries are now enrolled in such plans. Enrollment rates are increasing faster than ever. While these plans promise medical care at lower cost, some worry that quality may be sacrificed to keep down costs.

In this regard, I'd like to share with you three lessons we have learned from our investigations, audits, evaluations, and the prosecutions we have undertaken since the early 1980's.

First, the quality of care is not the only thing at risk; so is our money. For example, we recently found that more than $70 million in improper payments to Medicare HMOs for individuals falsely identified as eligible for Medicaid. Medicare HMOs receive an additional $200 a month for each such dually eligible person. Even more grave are the fraud and mismanagement which confront the very stability of the plans.

The first HMO we investigated declared insolvency after we found improper payments and violations of enrollment criteria. The chief officer fled the country when we pursued criminal and civil actions against him. There are numerous and novel ways to defraud HMOs and other kinds of managed care plans. I have summarized the main categories of vulnerabilities on the first chart we have displayed. Much more detail is provided in my written statement.

Second, there is much that is good as well as questionable in these plans. In a recent survey, summarized on the second chart, we found that 95 percent of the current Medicare HMO enrollees thought they had good access to primary, specialty, hospital and emergency care; 94 percent reported getting an appointment within 1 or 2 days when they believed they were very sick. At the same time, we found some problems, including possible prescreening, busy telephone lines, and misplaced medical records. The most disturbing was the fact that two-thirds of the disabled and kidney disease patients wanted to leave their HMOs.

This survey is one of the most recent reports and goes to the heart of this hearing. With your permission, I would like to submit the report for the record.

The CHAIRMAN. It will be included in full, Ms. Brown.

[The report follows:]

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

BENEFICIARY PERSPECTIVES OF MEDICARE RISK HMOs

JUNE GIBBS BROWN
Inspector General

MARCH 1995
OEI-06-91-00730

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.

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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% (10,246)	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% (12,008)
▸ more than 8 days	36% (5,370)	19% (332)	36% (265,888)	46% (13,061)
Primary HMO doctor failed to provide Medicare covered services that were needed.	20% (4,366)	39% (823)	3% (30,648)	4% (1,285)
Primary HMO doctor failed to refer to a specialist when needed.	21% (4,431)	50% (1,054)	5% (42,743)	6% (1,725)
Sought out-of-plan care while a member of the HMO.	20% (4,160)	49% (1,027)	7% (63,392)	7% (2,237)
Primary HMO doctor didn't take their health complaints seriously.	38% (7,892)	48% (976)	11% (104,185)	20% (4,671)
Holding down the cost of care was most important to:				
▸ primary HMO doctor	26% (5,471)	48% (989)	10% (94,109)	2% (586)
▸ the HMO	34% (7,042)	50% (1,030)	11% (105,041)	11% (3,324)

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.

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 all 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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APPENDIX A

SAMPLE AND RESPONSE RATES

UNWEIGHTED SAMPLE OF ENROLLED AND DISENROLLED BY DISENROLLMENT RATE STRATUM				
STRATUM	UNIVERSE OF 45 SAMPLED HMOs (N =773,975)		FINAL SAMPLE (N = 4132) USABLE RESPONSES (N = 2882)	
	ENROLLED	DISENROLLED	ENROLLED	DISENROLLED
STRATUM 1 (11.8%-47.5%)	356,187	16,526	740 (Response = 551)	695 (Response = 398)
STRATUM 2 (6.1%-11.3%)	285,102	7,795	737 (Response = 564)	741 (Response = 454)
STRATUM 3 (0%-5.9%)	107,353	1,012	740 (Response = 590)	479 (Response = 325)
TOTAL	748,642	25,333	2,217 (Response = 1705)	1,915 (Response = 1177)

WEIGHTED RESPONSES BY DISENROLLMENT STRATUM AND STATUS			
STRATUM	ENROLLED	DISENROLLED	TOTAL/RATE
STRATUM 1 (11.8%-47.5%)	509,176	16,921	526,097 (47%)
STRATUM 2 (6.1%-11.3%)	414,969	9,947	424,916 (38%)
STRATUM 3 (0%-5.9%)	159,905	1,336	161,242 (15%)
TOTAL/RATE	1,084,051 (97%)	28,203 (3%)	1,112,254 (100%)

WEIGHTED DATA PROJECTED TO APPROXIMATELY 70 PERCENT OF THE UNIVERSE OF ENROLLED/DISENROLLED			
STATUS	UNIVERSE	SAMPLE	RESPONSE RATE
ENROLLED	1,447,000	1,084,051	75%
DISENROLLED	48,900	28,203	58%
TOTAL	1,495,900	1,112,254	74%

APPENDIX B

DEMOGRAPHIC PROFILE OF RESPONDENTS
(Weighted Data)

	TOTAL POPULATION	DISENROLLEES	ENROLLEES
GENDER			
Female	60% (666,049)	53% (15,065)	60% (650,984)
Male	40% (446,205)	47% (13,139)	40% (433,067)
RACE/ETHNICITY			
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)
AVERAGE AGE	74 Years	73 Years	74 Years
EDUCATION			
< 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)
MEDICARE CATEGORY			
Aged	97% (1,078,445)	92% (25,907)	97% (1,052,538)
Disabled/ESRD	3% (33,809)	8% (2,296)	3% (31,513)
COMPETITIVE AREA			
Competitive[1]	63% (700,103)	53% (14,878)	63% (685,225)
Noncompetitive	37% (412,152)	47% (13,325)	37% (398,826)
HMO EXPERIENCE			
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)
AVERAGE LENGTH OF TIME IN HMO	36 Months	29 Months	36 Months
SERIOUS HEALTH CONDITIONS[2]			
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)

[1] 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.

[2] Health conditions are self-reported, and are for example, broken bones, cancer, heart attack, pneumonia or stroke.

APPENDIX C

ESTIMATES AND CONFIDENCE INTERVALS

The chart below summarizes the estimated proportions and the 95% confidence intervals for key statistics presented in this report. This stratified sample required using SUDAAN[3] to compute the correct standard errors for the point estimates, based on weighted data.

Statistic		
	Point Estimate	**95% Confidence Interval**
Proportion of beneficiaries with no serious health problems		
	Enrollees 67.2% Disenrollees 68.9%	62.7% - 71.6% 61.6% - 76.2%
Proportion of beneficiaries reporting no chronic ailments		
	Enrollees 10.1% Disenrollees 12.3%	7.2% - 13.1% 7.4% - 17.2%
Proportion of beneficiaries reporting 1 to 3 chronic ailments of varying severity		
	Enrollees 32.1% Disenrollees 30.7%	28.0% - 36.3% 25.1% - 36.3%
Proportion of beneficiaries that were nursing home patients in the last year		
	Enrollees 2.7% Disenrollees 3.4%	1.1% - 4.3% 1.0% - 5.9%
Proportion of beneficiaries admitted to the hospital while a member of sampled HMO		
	Enrollees 49.2% Disenrollees 42.1%	43.9% - 54.5% 35.9% - 48.3%
Proportion of beneficiaries with a high propensity for service		
	Enrollees 19.0% Disenrollees 15.8%	12.6% - 25.3% 10.4% - 21.1%
Proportion of beneficiaries who saw their primary HMO doctor or specialist by referral during the last year		
	Enrollees 91.2% Disenrollees 90.6%	88.6% - 93.9% 87.2% - 94.0%

[3] SUDAAN - Release 6.34, Research Triangle Park, North Carolina: Research Triangle Institute, 1993.

Statistic	Point Estimate	95% Confidence Interval
Proportion of beneficiaries visiting primary HMO doctor or specialist 1 to 6 times in the last year		
	Enrollees	
	Low Propensity 83.3%	76.7% - 90.0%
	Medium Propensity 72.8%	57.3% - 88.3%
	High Propensity 65.0%	51.6% - 78.3%
	Disenrollees	
	Low Propensity 87.0%	78.8% - 95.2%
	Medium Propensity 82.8%	73.6% - 91.9%
	High Propensity 59.8%	36.6% - 83.1%
Proportion of beneficiaries visiting primary HMO doctor or specialist 7 or more times in the last year		
	Enrollees	
	Low Propensity 16.7%	10.0% - 23.3%
	Medium Propensity 27.2%	11.7% - 42.7%
	High Propensity 35.0%	21.7% - 48.4%
	Disenrollees	
	Low Propensity 13.0%	4.8% - 21.2%
	Medium Propensity 17.2%	8.1% - 26.4%
	High Propensity 40.2%	16.8% - 63.5%
Proportion of beneficiaries rating their health as good or excellent when they joined the HMO		
	Enrollees 79.4%	75.7% - 83.1%
	Disenrollees 70.4%	64.2% - 76.6%
Proportion of beneficiaries rating their health as good or excellent at the current time		
	Enrollees 69.7%	66.1% - 73.3%
	Disenrollees 50.9%	44.0% - 57.8%
Proportion of beneficiaries claiming the medical care received through HMO caused their health to improve		
	Enrollees 50.3%	45.5% - 55.0%
	Disenrollees: 32.1%	26.1% - 38.0%
	Administrative 51.7%	38.5% - 65.0%
	Non-administrative 25.1%	17.7% - 32.5%
Proportion of beneficiaries claiming the medical care received through HMO caused their health to get worse		
	Enrollees: 1.8%	0.5% - 3.0%
	Aged 1.8%	0.6% - 3.1%
	Disabled/ESRD 0.7%	0.1% - 2.2%
	Disenrollees: 21.9%	12.8% - 31.1%
	Administrative 11.6%	2.7% - 20.5%
	Non-administrative 25.4%	13.7% - 37.1%
	Aged 20.0%	12.0% - 28.0%
	Disabled/ESRD 41.0%	11.2% - 70.9%

Statistic		
	Point Estimate	95% Confidence Interval
Proportion of beneficiaries asked at application about health problems, excluding kidney failure and hospice care		
	Enrollees 42.9% Disenrollees 48.3%	35.4% - 50.4% 39.5% - 57.1%
Proportion of beneficiaries required to have a physical examination before joining the HMO		
	Enrollees 2.9% Disenrollees 1.9%	1.0% - 4.8% 0.4% - 3.3%
Proportion of beneficiaries not knowing they could change their minds about enrolling in the HMO after they applied		
	Enrollees 8.2% Disenrollees 14.7%	5.5% - 10.9% 10.2% - 19.2%
Proportion of beneficiaries not knowing, from the beginning, they needed a referral from their primary HMO doctors to see a specialist		
	Enrollees 10.4% Disenrollees 17.2%	7.7% - 13.1% 12.1% - 22.4%
Proportion of beneficiaries not knowing, from the beginning, they could only use HMO doctors and hospitals (except for emergent care and urgent care outside the service area)		
	Enrollees 3.7% Disenrollees 6.3%	1.7% - 5.6% 3.3% - 9.3%
Proportion of beneficiaries not knowing they had the right to appeal an HMO's refusal to provide or pay for services		
	Enrollees 25.3% Disenrollees 31.0%	21.4% - 29.1% 24.9% - 37.0%
Proportion of beneficiaries with good knowledge from the beginning of how the HMO would operate		
	Enrollees 76.3% Disenrollees 66.2%	70.6% - 82.0% 60.6% - 71.7%
Proportion of beneficiaries who would have appealed if they had known their right to appeal the HMO's refusal to provide or pay for services		
	Enrollees 43.7% Disenrollees: 8.9% Administrative 22.4% Non-administrative 54.6%	31.5% - 55.9% 3.8% - 13.9% 6.1% - 38.8% 33.3% - 75.8%
Proportion of beneficiaries whose HMO did not refuse to provide or pay for services		
	Enrollees 70.9% Disenrollees: 31.9% Administrative 41.9% Non-administrative 26.4%	57.7% - 84.1% 21.8% - 42.0% 22.2% - 61.6% 12.0% - 40.8%

Statistic		
	Point Estimate	95% Confidence Interval
Proportion of beneficiaries able to get an doctor's appointment in a day or 2 when they were very sick		
	Enrollees 93.8% Disenrollees 85.1%	89.9% - 97.8% 79.5% - 90.6%
Proportion of beneficiaries waiting 1 to 4 days for a scheduled appointment with their primary HMO doctor		
	Enrollees: 51.8% Aged 51.4% Disabled/ESRD 68.3% Disenrollees: 51.7% Aged 49.1% Disabled/ESRD 77.6%	42.8% - 60.6% 45.5% - 57.3% 41.5% - 95.0% 46.0% - 57.6% 40.7% - 57.4% 57.4% - 97.7%
Proportion of beneficiaries waiting longer than 12 days for a scheduled appointment with their primary HMO doctor		
	Enrollees 16.1% Disenrollees 18.2%	12.2% - 20.0% 12.0% - 24.4%
Proportion of beneficiaries waiting 1 to 4 days for a scheduled appointment with specialists		
	Enrollees: 34.2% Aged 35.0% Disabled/ESRD 11.8% Disenrollees: 42.6% Aged 39.6% Disabled/ESRD 68.7%	27.5% - 40.8% 27.8% - 42.3% 0.1% - 26.8% 31.8% - 53.5% 30.6% - 48.5% 37.3% - 100.0%
Proportion of beneficiaries waiting longer than 12 days for a scheduled appointment with specialists		
	Enrollees 24.1% Disenrollees: 26.2% Administrative 18.6% Non-administrative 30.5%	18.3% - 30.0% 19.1% - 33.4% 5.7% - 31.4% 21.3% - 39.7%
Proportion of beneficiaries usually waiting in their primary HMO doctor's office for less than 1/2 hour		
	Enrollees 53.2% Disenrollees 36.0%	46.7% - 59.7% 29.2% - 42.7%
Proportion of beneficiaries usually waiting in their primary HMO doctor's office for more than 1 hour		
	Enrollees 6.7% Disenrollees: 20.3% Prior HMO exp. 9.3% No prior HMO exp. 24.2% Administrative 13.9% Non-administrative 25.3%	4.0% - 9.4% 12.8% - 27.7% 2.4% - 16.1% 14.4% - 33.9% 4.1% - 23.8% 15.0% - 35.5%

Statistic			
	Point Estimate		95% Confidence Interval
Proportion of beneficiaries reporting busy lines all to most of the time			
	Enrollees	18.8%	13.2% - 24.4%
	Disenrollees	34.2%	24.3% - 44.0%
Proportion of beneficiaries giving up on making appointments due to busy phone lines			
	Enrollees	10.9%	6.6% - 15.1%
	Disenrollees	17.4%	10.2% - 24.5%
Proportion of beneficiaries whose primary HMO doctor never failed to provide Medicare covered services that were needed			
	Enrollees:	94.8%	92.7% - 96.9%
	Aged	94.8%	92.4% - 97.2%
	Disabled/ESRD	95.3%	88.2% - 100.0%
	Disenrollees:	76.7%	69.1% - 84.2%
	Aged	78.9%	72.3% - 85.5%
	Disabled/ESRD	53.3%	26.0% - 80.5%
Proportion of beneficiaries whose primary HMO doctor failed to admit to hospital when needed			
	Enrollees	3.4%	1.8% - 4.9%
	Disenrollees:	21.6%	13.5% - 29.6%
	Prior HMO exp.	9.9%	3.2% - 16.5%
	No prior HMO exp.	24.5%	14.2% - 34.9%
Proportion of beneficiaries whose primary HMO doctor never failed to admit to hospital when needed			
	Enrollees	97.8%	96.3% - 99.3%
	Disenrollees	90.5%	84.7% - 96.3%
Proportion of beneficiaries whose primary HMO doctor never failed to refer to specialist when needed			
	Enrollees:	94.7%	92.6% - 96.7%
	Aged	94.7%	92.6% - 96.8%
	Disabled/ESRD	93.3%	84.0% - 100.0%
	Disenrollees:	75.1%	67.2% - 83.1%
	Aged	77.7%	70.6% - 84.8%
	Disabled/ESRD	49.1%	23.2% - 75.0%
Proportion of beneficiaries whose HMO never refused to approve a Medicare covered services that primary HMO doctor wanted			
	Enrollees	96.0%	94.2% - 97.8%
	Disenrollees	91.9%	88.6% - 95.1%
Proportion of beneficiaries whose HMO never refused to pay a doctor or hospital for emergency care			
	Enrollees	94.3%	92.2% - 96.4%
	Disenrollees:	79.6%	72.5% - 87.7%
	Prior HMO exp.	7.3%	0.7% - 14.0%
	No prior HMO exp.	16.7%	8.0% - 25.3%

Statistic			
	Point Estimate		95% Confidence Interval
Proportion of beneficiaries who went out-of-plan for care			
	Enrollees:	6.8%	4.6% - 9.1%
	Aged	6.8%	4.6% - 9.1%
	Disabled/ESRD	7.3%	0.1% - 19.4%
	Disenrollees:	22.1%	15.5% - 28.7%
	Prior HMO exp.	10.5%	3.9% - 17.0%
	No prior HMO exp.	27.0%	17.4% - 36.5%
	Aged	19.5%	13.8% - 25.2%
	Disabled/ESRD	48.9%	21.7% - 76.1%
Proportion of beneficiaries who went out-of-plan because they needed care even if HMO wouldn't approve			
	Enrollees	41.1%	19.8% - 63.1%
	Disenrollees	51.0%	33.3% - 68.7%
Proportion of beneficiaries who went out-of-plan because they couldn't get HMO services quick enough			
	Enrollees	18.8%	6.5% - 31.0%
	Disenrollees	45.8%	28.6% - 63.1%
Proportion of beneficiaries who went out-of-plan because they didn't know they would have to pay			
	Enrollees	16.1%	2.6% - 29.6%
	Disenrollees	35.8%	20.9% - 50.8%
Proportion of beneficiaries who went out-of-plan because they didn't want to go through HMO to see specialist			
	Enrollees	12.2%	0.1% - 24.7%
	Disenrollees	15.3%	4.4% - 26.1%
Proportion of beneficiaries who went out-of-plan because their primary HMO doctor wasn't helping beneficiary			
	Enrollees	9.7%	1.9% - 17.4%
	Disenrollees	42.4%	24.3% - 60.5%
Proportion of beneficiaries told they would probably receive better care if they left the HMO			
	Enrollees	4.1%	1.5% - 6.6%
	Disenrollees	0.9%	0.2% - 1.5%
Proportion of beneficiaries whose primary HMO doctor did not take their health complaints seriously			
	Enrollees:	11.6%	8.6% - 14.5%
	Aged	11.4%	8.4% - 14.4%
	Disabled/ESRD	20.2%	0.1% - 41.4%
	Disenrollees:	38.8%	27.6% - 50.1%
	Administrative	26.2%	13.9% - 38.6%
	Non-administrative	39.9%	28.3% - 51.5%
	Aged	38.1%	27.4% - 48.8%
	Disabled/ESRD	47.5%	20.5% - 74.5%

Statistic		
	Point Estimate	95% Confidence Interval
Proportion of beneficiaries who didn't take complaints seriously all to most of the time		
	Enrollees 35.9%	21.8% - 50.0%
	Disenrollees: 44.3%	32.4% - 56.2%
	Prior HMO exp. 47.5%	22.9% - 72.1%
	No prior HMO exp. 63.6%	50.0% - 77.3%
Proportion of beneficiaries who believe holding down the cost of care is most important to their primary HMO doctor		
	Enrollees: 9.6%	5.9% - 13.3%
	Aged 9.9%	6.0% - 13.8%
	Disabled/ESRD 2.0%	1.1% - 5.2%
	Disenrollees: 27.6%	17.6% - 37.5%
	Prior HMO exp. 17.4%	6.7% - 28.2%
	No prior HMO exp. 31.8%	19.2% - 44.5%
	Administrative 7.6%	2.1% - 13.2%
	Non-administrative 33.6%	20.0% - 47.2%
	Aged 25.6%	16.4% - 34.8%
	Disabled/ESRD 47.9%	21.3% - 74.5%
Proportion of beneficiaries who believe giving the best medical care possible is the most important to their primary HMO doctor		
	Enrollees 72.9%	66.0% - 79.8%
	Disenrollees 46.6%	35.9% - 57.3%
Proportion of beneficiaries feeling holding down the cost of care is most important to their HMO		
	Enrollees: 10.8%	8.3% - 13.4%
	Aged 10.9%	8.2% - 13.5%
	Disabled/ESRD 10.6%	0.1% - 22.7%
	Disenrollees: 35.0%	25.5% - 44.4%
	Prior HMO exp. 26.0%	14.6% - 37.5%
	No Prior HMO exp. 39.6%	26.7% - 52.4%
	Administrative 13.5%	5.3% - 21.8%
	Non-administrative 42.3%	28.1% - 56.5%
	Aged 33.5%	24.7% - 42.3%
	Disabled/ESRD 49.9%	24.1% - 75.6%
Proportion of beneficiaries feeling giving the best medical care possible is the most important to their HMO		
	Enrollees 66.8%	62.4% - 71.2%
	Disenrollees 38.9%	30.6% - 47.2%
Proportion of beneficiaries leaving HMO because they didn't like the choice of primary HMO doctors		
	Enrollees 28.0%	18.0% - 38.0%
	Disenrollees 44.4%	31.9% - 56.8%

Statistic		
	Point Estimate	95% Confidence Interval
Proportion of beneficiaries leaving HMO because the premium &/or co-payments were too expensive		
	Enrollees 24.6% Disenrollees 28.8%	13.3% - 35.9% 19.4% - 38.3%
Proportion of beneficiaries leaving HMO because they had to wait too long for scheduled appointments		
	Enrollees 14.9% Disenrollees 21.9%	4.9% - 24.9% 14.9% - 28.9%
Proportion of beneficiaries leaving HMO because they were not allowed to see specialists needed		
	Enrollees 19.0% Disenrollees 20.5%	6.1% - 31.9% 14.1% - 26.8%

APPENDIX D

BENEFICIARY HEALTH STATUS BY SELF-REPORTED HEALTH CONDITIONS AND BY SELF-RATED HEALTH LEVELS

Table D-1: Level of Chronic Health Conditions by Present Self-Reported Health Status

	Disenrollees' Health						Enrollees' Health					
	Excellent	Good	Fair	Poor	Very Poor	% All D	Excellent	Good	Fair	Poor	Very Poor	% All E
None	24% (720)	56% (1,650)	7% (220)	1% (17)	12% (350)	13% (2,957)	35% (32,854)	52% (48,311)	12% (11,428)	0% (386)	0% (0)	10% (92,279)
Low level	12% (878)	50% (3,025)	31% (4,208)	7% (500)	0% (3)	31% (7,189)	24% (69,545)	57% (169,164)	18% (51,763)	1% (3,604)	0% (533)	32% (294,608)
Medium level	6% (490)	34% (3025)	47% (4,208)	11% (999)	2% (150)	38% (8,872)	9% (35,361)	53% (200,182)	32% (122,186)	4% (16,429)	1% (2,732)	41% (376,890)
High level	2% (70)	27% (1,145)	48% (2,015)	20% (823)	4% (153)	18% (4,205)	3% (5,223)	43% (69,423)	35% (56,767)	11% (18,260)	7% (11,890)	17% (161,563)
Self-rating of current health	9% (2,158)	41% (9,414)	37% (8,657)	10% (2,340)	3% (655)	100% (23,223)	15% (142,983)	53% (487,080)	26% (242,144)	4% (38,678)	2% (15,155)	100% (926,040)

Notes: The percents in the "All" columns show the distribution of disenrollees and enrollees among the levels of self-reported health conditions. The percents for "excellent to very poor" total 100% and show the distribution of beneficiaries' self-rated health within each level of the self-reported physical conditions. The bottom row of each chart is the overall distribution of self-rated health levels for disenrollees and enrollees.

These two Tables illustrate that, by self-reported health conditions, disenrollees and enrollees appear similar, but by self-rated health levels, disenrollees tend to rate their health lower than enrollees do.

Table D-2: Level of Serious Health Conditions by Present Self-Reported Health Status

	Disenrollees Health						Enrollees' Health					
	Excellent	Good	Fair	Poor	Very Poor	% All D	Excellent	Good	Fair	Poor	Very Poor	% All E
None	12% (1,856)	45% (6,813)	34% (5,108)	7% (1,110)	2% (367)	68% (15,254)	17% (104,381)	56% (349,555)	25% (155,105)	3% (18,590)	0% (241)	67% (627,873)
1 condition	3% (192)	35% (2,075)	40% (2,349)	20% (1,179)	4% (220)	27% (6.015)	13% (33,739)	54% (134,884)	27% (67,975)	3% (8,625)	2% (5,808)	27% (251,030)
2+ conditions	2% (23)	11% (138)	79% (991)	3% (33)	5% (68)	6% (1,254)	8% (4,173)	28% (15,156)	24% (13,199)	20% (10,831)	20% (10,826)	6% (54,184)
Self-rating of current health	9% (2,071)	40% (9,026)	38% (8,448)	10% (2,322)	3% (655)	100% (22,523)	15% (142,293)	54% (499,595)	25% (236,279)	4% (38,046)	2% (16,875)	100% (933,087)

APPENDIX E

TEXT OF AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JAN 17 1995

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Reports: "Beneficiary Perspectives of Medicare Risk HMOs" (OEI-06-91-00730) and "Beneficiary Perspectives of Medicare Risk HMOs: Executive Report" (OEI-06-91-00736)

To June Gibbs Brown
Inspector General

We reviewed the above-referenced draft reports which describe beneficiaries' perspectives of the Medicare risk HMO experience.

We concur with the recommendations in the reports, and compliment OIG for the thoughtful and constructive revision of the first report. These drafts more accurately present the study findings; we greatly appreciate the fact that OIG took into consideration and responded to our comments on the working draft.

Our detailed comments are attached for your review. Thank you for the opportunity to review and comment on this draft report. Please advise us at your earliest convenience if you would like to discuss our position on the recommendations.

Attachment

Health Care Financing Administration (HCFA) Comments on Office of Inspector General (OIG) Draft Report: "Beneficiary Perspectives of Medicare Risk HMOs" (OEI-06-91-00730) and "Beneficiary Perspectives of Medicare Risk HMOs: Executive Report" (OEI-06-91-00736)

Recommendation 1

Three items need immediate exploration:

Beneficiaries should be better informed about their appeal rights as required by Federal standards.

Service access problems reported by disabled/ESRD beneficiaries need to be carefully examined, as they are an especially vulnerable group.

Medicare risk HMOs should be monitored for inappropriate screening of beneficiaries' health status at application.

Response

We concur. It is extremely important that Medicare beneficiaries enrolled in risk HMOs know their appeal rights, especially since the rights of HMO enrollees are very different from those in fee-for-service. Currently, HCFA is focusing on improved ways to communicate with our beneficiaries. A beneficiary outreach steering committee was formed to improve effectiveness of beneficiary communication by coordinating planning and implementation of beneficiary targeted information activities among HCFA and Peer Review Organizations (PROs). Specifically, in the HMO area, we are reviewing various options to educate the Medicare enrollee, e.g., a national hotline to field beneficiary complaints and generate program information, and a clearinghouse for outreach materials developed by PROs and other agencies.

We also agree that service access problems reported by beneficiaries need to be carefully examined. HCFA contracts nationwide with End Stage Renal Disease (ESRD) Networks to ensure effective and efficient administration of the benefits provided for individual with ESRD. ESRD Networks are also responsible for promoting internal quality assurance programs within ESRD facilities and providers, for ensuring quality in service delivery, identifying uncooperative facilities and providers and reporting to HCFA. Attached is a listing of the ESRD Networks that may be contacted regarding any problems with receiving ESRD services.

The findings and recommendations may also be part of our efforts to support action in certain areas of beneficiary access and beneficiary education.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

SAIG
PDIG
DIG-AS
DIG-EI
DIG-OI
AIG-CFAA
AIG-MP
GGC/IG
EXSEC
DATE SENT 2/3

FEB 1 1995

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: "Beneficiary Perspectives of Medicare Risk HMOs," OEI-6-91-00730

Thank you for sharing the draft report in which you recommend that HCFA explore three recommendations:

- Beneficiaries should be better informed about their appeal rights as required by Federal standards.
- Service access problems reported by disabled/ESRD beneficiaries need to be carefully examined, as they are an especially vulnerable group.
- Medicare risk HMOs should be monitored for inappropriate screening of beneficiaries' health status at application.

I understand that these recommendations about operational aspects of the Medicare HMO risk program are based only on results of surveys of beneficiaries' perspectives. I am concerned that comparative data that at least describe the extent to which information is available to beneficiaries and HCFA's monitoring are not included in the report. The bibliography includes prior research, such as the evaluations of the risk-contracting program and studies on biased selection, that would place these findings in perspective.

In addition, an examination of plans' brochures would reveal the extent to which appeal rights are actually explained. The Medicare Handbook also explains appeal rights, prohibitions against pre-screening, and procedures for beneficiaries' complaints about the quality of care. Data from HCFA's compliance monitoring efforts would show access problems reported by disabled/ESRD beneficiaries.

Again, thank you for the opportunity to comment on the draft report. Perhaps the final report can incorporate comparative data, where available.

David T. Ellwood

Prepared by: Evelyn King 690-7808

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FEB 1995
OFFICE OF INSPECTOR GENERAL

Recommendation 2

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.

Distinguish between administrative and non-administrative disenrollments.

Conduct these exit surveys by mail with computer generated forms, either exclusively or in conjunction with other methods.

Response

We concur, and will utilize the report as a part of our data collection and information gathering efforts to assess beneficiary access to managed care services and extent of beneficiary knowledge on how to use these services.

Technical Comments

The third paragraph on page 4 of the Executive Report states that, "Disenrollees were more than three times as likely as enrollees to believe their primary HMO doctors did not take their health complaints seriously. However over one third of both groups said they encountered this attitude most to all of the time." This is a serious issue. By contrast, it also noted that the language on page 13 of the full report dealing with the same point reads differently. It says, "Substantial portions of both enrollees and disenrollees, who didn't feel they were taken seriously said they encountered this attitude most to all of the time." This does not appear to be consistent with the original point on the same subject because it is only those people who felt they were taken seriously that felt it happened often. If this interpretation is correct, then page 4 of the Executive Report should be modified to conform with page 13 of the full report.

Ms. BROWN. Finally, we get to the benefits of managed care while protecting enrollees and taxpayers. I believe we need a multifaceted approach, and that is summarized on the third chart. Current safeguards include private enrollment, floors, certification by HCFA, quality assurance plans, grievance and appeals statements systems, peer review organization reviews, HCFA on-site reviews, and penalties imposable by both HCFA and my own office. All but the first of these methods are similar to techniques used in traditional fee-for-service settings. Recently, attention has turned to newer approaches like client surveys, outcome measures, report cards, and private certification.

I don't think we should rely on any one of these methods. We should use them all. Each one has its imperfections. We are working with HCFA now to develop and refine these processes and to find ways to target scarce resources where they can be most effectively used.

HMOs and other forms of managed care are here to stay. We have much to gain from them, but we need to protect our beneficiaries and our financial investment.

Thank you for inviting me to share the results of our work with you, and I will be happy to answer any questions you may have.

[The prepared statement of Ms. Brown follows:]

Federal Oversight of Managed Care: Vulnerabilities and Safeguards

Testimony of
June Gibbs Brown, Inspector General
Department of Health and Human Services

Hearing before the
Senate Special Committee on Aging
William S. Cohen, Chairman

August 3, 1995

Office of Inspector General
Department of Health and Human Services

Testimony of
June Gibbs Brown
Inspector General, Department of Health and Human Services

Good morning. My name is June Gibbs Brown, and I am the Inspector General, U.S. Department of Health and Human Services. With me today is George Grob, Deputy Inspector General for Evaluation and Inspections. We are pleased to be here today to discuss issues relating to Medicare and Medicaid managed care programs.

The Federal Government, State Governments, large and small private businesses, and individuals are increasingly looking to managed care programs as a way to contain costs while providing greater access to care and improving quality of care. In fact, we can report on some of the beneficial aspects of managed care programs; but we have also found some problems. Vulnerabilities are in many respects different than those that exits in fee-for-service health plans. And while a number of safeguards are currently in place to guard against abuses, we need to learn how to make better use of them, and how to develop additional measures to protect beneficiaries and safeguard Federal and State financial investments.

INTRODUCTION

Managed care is a loosely defined term used to describe any system of health care payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan. Health maintenance organizations (HMOs), independent practice association (IPAs), preferred provider organizations (PPOs) are all types of managed care arrangements. About 50 million people are currently enrolled in some type of managed care plan.

In the Medicare program, most beneficiaries obtain medical care through a fee-for-service program. However, they do have the option to enroll in a HMO if one is available in their area. There are three types of managed care programs that operate within the Medicare program: risk HMOs, cost HMOs, and Health Care Prepayment Plans (HCPPs). These entities currently enroll over 3.5 million Medicare beneficiaries (9.5 percent). This represents an increase of 16 percent over the previous year.

Medicaid's managed care plans cover a wide variety of health delivery arrangements. These range from HMOs that receive a monthly prepaid capitation payment for providing all inpatient and outpatient medical services for each enrollee, to individual physicians or physician groups who receive a case management fee to manage all Medicaid services. In 1993, 42 States had Medicaid managed care programs serving over 4.8 million recipients. Last year, Medicaid had a 63 percent increase in the number of beneficiaries enrolled in managed care plans (to 7.8 million).

VULNERABILITIES IN MANAGED CARE PROGRAMS

The conventional wisdom about vulnerabilities in managed care arrangements is that they turn fee-for-service vulnerabilities on their head. It is widely believed that a fee-for-service arrangement encourages over-utilization, while managed care encourages under-utilization; fee-for-service promotes "cadillac" care, while managed care promotes bare bones care; fee-for-service provides incentives to make money, while managed care provides incentives to skimp on services.

While this is certainly true, it is also simplistic. As I will discuss later, our first encounters with the managed care market had as much to do with financial irregularities as with quality of care. Wherever there is money, there is an incentive to take it. It would be a serious mistake to focus exclusively on quality of care problems when so

many public dollars are at stake and when the opportunities to steal them are so numerous and, because this is a rapidly changing field, so novel.

In addition, there are risks to the very stability of the managed care organizations themselves. This can result from poor management, inadequate financial reserves, and outright fraud. Lack of stability could leave patients without care and leave Federal and State Governments at risk of, or at least under enormous pressure for, funding financial shortfalls.

To help put these various risks in perspective, and to serve as a guide for future investigations, audits, evaluations, and sanctions, we have developed a list of potential vulnerabilities in the managed care setting. It is found as Appendix A and summarized on chart #1.

OIG ASSESSMENT OF MANAGED CARE

We have encountered many manifestations of the vulnerabilities mentioned previously in our investigations, audits, and evaluations. I will discuss these below. But I want to emphasize first that not everything we found was bad. On the contrary, some of our more recent work, particularly surveys of beneficiaries, have demonstrated an overall satisfaction for services received in Medicare HMOs. These surveys revealed some problems, including some serious ones we were not previously aware of; but they also made it clear that many beneficiaries are quite happy with the way they are being treated in these new settings.

I firmly believe that we must exercise caution to ensure that we balance our assessments, highlighting what works as well as what doesn't. With this in mind, let me now summarize some of our more significant findings in this area.

Our work extends back to the mid 1980s, with an examination of one of the first and largest Medicare HMOs in Florida. We found significant enrollment and financial abuses. Further studies and investigations of other HMOs conducted by our office have revealed marketing abuses, profits that exceeded State Medicaid agency guidelines, questionable business practices, and false claims. We have also examined State oversight of Medicaid managed care plans. More recently, we have tried to determine what the beneficiaries themselves think of the services they have been receiving and what experiences they have had in enrolling in HMOs. I will now describe our work in more detail.

Enrollment and Financial Abuses

Nine years ago, we investigated allegations of impropriety at a Florida HMO. Many of the allegations came from Congress and were related to quality of care, delays in treatment, the financial viability of the plan, and delays by the plan to pay providers for services.

We examined the billing practices for routine pre-enrollment and screening services at four wholly-owned clinics of the HMO and identified $2.5 million in overpayments. We also examined HCFA's role in monitoring of the HMO's contract and found delays by HCFA in disenrolling deceased beneficiaries; a failure to conform with the 50/50 enrollment criteria; and a lack of sufficient guidelines on the financial stability of affiliated entities. Finally, we analyzed complaints, questionnaires, correspondence and survey forms submitted by Medicare HMO enrollees and referred to our investigators documents which appeared to relate to quality of care issues for a detailed analysis. Subsequent to our review, the plan was declared insolvent and the assets were sold. In addition, we pursued criminal and civil actions against several individuals.

Since then, we have also worked with HCFA on reviews of other South Florida HMOs. One review of an HMO's financial and enrollment practices led to HCFA's termination in 1988 of the plan's Medicare demonstration contract. Our review found issues that seem to be prevalent in a number of problem HMOs. For example, we found problems in marketing where beneficiaries were unaware of their enrollment in the HMO, problems with

payments due to providers, understatement of the plan's liabilities, inappropriate related party transactions (e.g., a personal loan to owners guaranteed by the HMO), and inadequate insolvency insurance. We also found that the plan's owners obtained a personal loan that was secured by the HMO's assets.

Marketing Abuses

In the fall of 1990, newspapers in South Florida ran articles alleging marketing abuses by HMOs. The articles indicated that Medicare beneficiaries were sometimes inappropriately enrolled and not adequately informed of the requirement that all medical care must be received from HMO-affiliated providers. We therefore undertook two reviews, one analyzing the marketing practices of six South Florida HMOs, and one analyzing enrollment patterns in the five HMOs that served the Miami area.

Overall, our review found positive results. We found that almost three-fourths of the beneficiaries in these plans initiated contact with the HMO, few of them felt pressured by sales staff, and most knew that they could only use providers affiliated with the HMO. We did, however, find some instances of inappropriate marketing practices as reported by the beneficiaries:

- Eight percent said that salespersons made unannounced visits to their homes asking them to enroll in an HMO.
- Nine percent said that they had not known that they were enrolling in an HMO when they signed the application.
- Ten percent were unaware that they could only use HMO providers.
- Seventeen percent were unaware that they could "back-out" if they changed their minds after signing the application.
- Some beneficiaries had been vulnerable to unethical sales practices (e.g., "churning," which occurs when a salesperson enrolls and disenrolls a beneficiary in order to gain a sales commission -- we found 26 people that had been enrolled a total of 424 times).

In our review of enrollment in the Miami area, we found that the proportion of Medicare beneficiaries choosing HMOs over Medicare fee-for-service was higher than nationally. We also found that Medicare enrollees changed plans more frequently than any other group in the nation but that when beneficiaries leave one HMO most choose another HMO over fee-for-service coverage. Because of this last finding, we did not conclude that beneficiaries were dissatisfied with the HMO arrangement as such. Nor were we able to determine if the frequent disenrollments were indicative of poor quality of care. However, we found that excessive turnover of beneficiaries among HMOs may jeopardize patient care and that inappropriate enrollments result in unnecessary costs to HCFA and the Social Security Administration.

Profits Exceeding Guidelines and Questionable Business Practices

We have reviewed two Medicaid managed care plans during the past few years. Our review of one plan covered the period April 1989 through December 1991. We determined that the reported pre-tax earnings were understated because payments to the plan's owners, directors, and related companies were omitted. The profit we recalculated exceeded guidelines established by the State's Department of Insurance for the managed care industry in the State. Had these guidelines been more closely followed, additional dollars could have been saved on the contracts during the 33-month period of our review.

In addition, our review noted substantial related party transactions between the plan and its owners/directors and affiliated companies. We determined that during the period of our review, the plan paid millions of dollars to these related parties. Based on the documentation provided by the plan, we were either unable to determine the

reasonableness of these transactions, or we determined that some of them resulted in additional administrative costs, thus artificially reducing the plan's reported pre-tax earnings. The types of related party transactions included management fees, guarantee fees for a line of credit, profit on a subcontract with an affiliate, and interest-free loans to the owners.

We also had concerns about the type and level of reinsurance that was purchased and noted that the State Medicaid agency routinely granted waivers from penalty provisions under the contract--a practice that defeats the purpose of the penalty which is to encourage contractor compliance with important contract provisions. Routine waivers amounted to $1.2 million that would have been paid as penalties.

We reviewed a second Medicaid managed care subcontract plan for the 5-year period from January 1988 through December 1992. We found:

- Only about 69.6 percent of the Medicaid capitation revenues received by the plan were used for medical services and family planning services. This is low compared to the 85 percent industry average as defined by a joint State Department of Insurance and HMO industry task force study.

- Profits on the subcontracts exceeded profit guidelines established by the State's Department of Insurance.

- The plan contributed about $20.7 million of these profits to its parent company.

We noted that despite the relatively low percentage of revenue spent on medical services, nothing came to our attention that would indicate that the quality of care provided was deficient. However, we did not specifically analyze these aspects of the plan.

Improper Payments

In the Medicare area, we have been recently working with HCFA to ensure that Medicare capitation payments to HMOs are correct. The HCFA authorizes fixed monthly payments to risk-based plans for each enrolled Medicare beneficiary. The payment rates are adjusted by a set of risk factors such as the beneficiary's age, gender, and Medicare entitlement status. An increased payment rate is made for certain high-cost categories of beneficiaries. We have found erroneous payments in each of these categories:

- Managed care plans receive an average of $3,000 per month for each beneficiary enrolled who has end stage renal disease (ESRD). We found $600,000 in improper payments to 2 plans for beneficiaries who were misclassified as having ESRD. The plans agreed with our findings. We are expanding our work to identify the national scope of the problem.

- Managed care plans receive an additional average of $200 per month for beneficiaries who are enrolled who are also eligible for Medicaid (dual eligibles). We found $70.5 million in inappropriate payments to HMOs for these dually eligible beneficiaries. These payments occurred because HCFA computer systems did not recognize those beneficiaries initially classified as dual eligibles but who had subsequently lost their Medicaid eligibility. HCFA has begun to collect the overpayments.

- Managed care plans receive an additional average of $360 per month for beneficiaries who are in an institution (a resident for 30 days or longer of a nursing home, sanatorium, rest home, convalescent home, long term care hospital or domiciliary home). We found $1.1 million in improper payments to 3 plans for beneficiaries who were not in an institution. The plans agreed with our findings. We are expanding our analysis to other plans.

State Oversight of Managed Care Plans

State Medicaid agencies conduct a variety of quality assurance activities to monitor to ensure that contracting HMOs provide appropriate and good, quality care to Medicaid beneficiaries. In a 1992 report, we found that State Medicaid agencies most frequently rely on structural standards which provide an assessment of the HMO's health care resources, or process standards which assess intermediate products of care such as utilization rate, choice of therapy and effectiveness of procedures. These standards included activities such as patient education programs, medical record review, credentialing and access to care requirements, and mandating that HMOs develop a written quality assurance plan and establish a patient complaint and grievance process.

Process standards such as clinical practice guidelines and management of physician conduct have not been as easily assimilated in Medicaid quality assurance programs. In addition, Medicaid agencies are less involved in activities related to outcome standards. In this area agencies rely on complaint and grievance standards more than patient satisfaction surveys and health outcome reviews to ensure quality.

Since the issuance of our report, much has changed in State managed care plans and State oversight. One of the primary efforts for oversight has been the development and testing of an outcome measurement system. We are now beginning work to assess current State efforts in providing oversight of managed care networks for Medicaid beneficiaries.

Beneficiaries' Perspectives of Medicare HMOs

We recently completed a survey of almost 3,000 Medicare beneficiaries who were enrolled in or had recently disenrolled from a risk based HMO. Generally, beneficiary responses were positive (the results are summarized on chart #2):

- Most beneficiaries indicated that risk HMOs provide adequate service access. For example, 95 percent of enrollees thought they had good access to primary, specialty, hospital, and emergency care.

- Most beneficiaries reported timely doctor appointments for primary and specialty care. For example, 94 percent of enrollees and 85 percent of disenrollees got an appointment within 1 to 2 days when they believed they were very sick. Over 75 percent waited 8 days or less for appointments with primary doctors and about two thirds waited the same time for specialists. Ninety three percent of enrollees waited an hour or less in the office to see primary doctors.

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

- Most beneficiaries believed that they were personally well-treated by their HMO.

- The great majority of enrollees believed they got the services they needed.

- The majority of disenrollees joined another HMO upon leaving the one they were in.

However, while most beneficiaries indicated that they were obtaining good health care in HMOs, we did find a few problem areas, especially as reported by disenrollees:

- Compliance with Federal enrollment standards for health screening and informing beneficiaries of their appeal rights appeared to be problematic. For example, 43 percent of beneficiaries, who could remember, said they were asked at application about their health problems. In fact, between 2 and 3 percent stated that they were asked to take an exam before joining the HMO, a clear violation of the law. Twenty-five percent reported that they did not know that they had the right to appeal their HMO's refusal to provide or pay for services.

- Disenrollees rated their health care lower than enrollees, 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.

- While the majority of disenrollees reported good access to the services they needed, 20-25 percent said they failed to receive primary care, referrals to specialists, and HMO coverage of emergency care which they believed they needed.

- 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.

- Busy telephone lines and misplaced medical records caused appointment difficulties for some beneficiaries. For example, 11 percent said they sometimes gave up on trying to make appointments because of busy phone lines.

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

- Disabled/ESRD disenrollees most often reported access problems in several crucial areas of their HMO care; two thirds wanted to leave.

- Choice of primary HMO doctors and high beneficiary expenses were the two most important reasons for leaving or wanting to leave the HMOs.

This is one of our more recent reports on managed care. Since it goes to the heart of what we are discussing today, I would like to submit a copy for the record.

SAFEGUARDS

Based on the work that we have done, we believe that managed care can work for many Medicare and Medicaid beneficiaries. However, we also see a need for improved safeguards over managed care programs to reduce the risks of insolvency and poor quality of care. In addition, we recognize that more research needs to be done on managed care arrangements and have, therefore, planned a significant amount of additional work in this area.

There are a variety of mechanisms currently in place to help ensure the quality of care provided by, financial and management stability of, and appropriateness of Federal payments for managed care systems. Current safeguards include private enrollment floors, certification by HCFA, quality assurance plans, grievance and appeal systems, Peer Review Organization reviews, HCFA on site reviews, and penalties imposable by both HCFA and my office. Recently, attention has turned to client surveys, outcome measures, report cards, and private certification. Safeguards in managed care are discussed in detail in Appendix B of my statement.

We believe that <u>all</u> of these are important. Program managers and others with oversight responsibilities need to learn how to use them better and how to target scare oversight resources. We also need to develop new methods to respond to the changing managed care environment.

Need for Greater Oversight

In terms of Medicare and Medicaid managed care plans, we believe that HCFA and State oversight and monitoring could be strengthened to:

- Ensure that beneficiaries are aware of their appeal rights as required by Federal standards.

- Monitor service access problems reported by disabled/ESRD beneficiaries. These problems need to be carefully examined, as they are a vulnerable group.

- Monitor Medicare risk HMOs for inappropriate screening of beneficiaries' health status at application.

- Mandate a minimum net worth for Medicaid managed care plans.

- Establish controls over reinsurance agreements.

- Establish a uniform capitation rate-setting methodology and a method to determine what excess profit is hand how it should be treated.

- Require an annual audit of managed care plans.

Continuing OIG Work

We recognize that much more work needs to be done to assure that managed care programs are working properly. This is in part because managed care systems continue to evolve as physicians, hospitals, and other providers form new types of organizations. These new organizations range from relatively loose associations of physicians, through physician-hospital joint ventures, up to fully integrated insurer-provider HMOs.

The Medicare and Medicaid managed care programs have also evolved and grown since their inception. Because we believe that this is such an important area, we have developed a strategic plan to address issues associated with managed care. We plan to undertake a number of reviews to address issues involving program integrity, quality and access to care, rate setting, accuracy of payments, and financial integrity. We will also investigate possible violations of the law and patient abuse.

- Program Integrity. We plan to examine program integrity issues to determine how well managed care programs are managed. We will review Federal and State oversight and standards, cost report reconciliation, customer surveys conducted by HMOs, computer systems security for the protection of confidential medical data, and whether beneficiaries understand their grievance and appeals rights.

- Quality of Care/Access to Care. We plan on addressing quality of care and access to care issues by reviewing performance indicators, reasons for disenrollment, and utilization of services by disenrollees.

- Rate Setting and Cost Effectiveness. We plan to examine the contracting methodology, controls on profits, and cost reporting to determine whether policy makers can accurately rely on existing data as a measure of relative cost effectiveness.

- Accuracy of Payments. We will evaluate the adequacy of management and internal controls for assuring that the amounts being paid to health care providers are correct and that patients are eligible for services.

- Financial Integrity. We will review various financial aspects of managed care programs to determine if they have fiscally sound operations.

CONCLUSION

It is evident that our system of financing and delivering health care is moving to the use of more, and more integrated, networks of providers and managed care systems. Third party payers are encouraging such integration because it holds out the promise of lowered costs and better risk management. Many providers are willing to give up some portion of their clinical autonomy in order to preserve their market share and obtain a stream of referrals or support from other providers in their community.

Given the growing interest and support for managed care programs, it is critical that these programs are well managed, financial and programmatic integrities are assured, tax dollars are protected from fraud and abuse, and quality of care as well as access to care is maintained. We realize how critically important these issues are: billions of Federal, State, and private dollars are currently being channelled into managed care programs and it is likely that an increasing amount of money will be spent on these programs.

I appreciate the opportunity to appear before you today and to share with you some of our concerns and work we have done pertaining to managed care. I look forward to sharing the results of our continuing efforts in this area. I would be happy to respond to any questions you might have.

Appendix A

POTENTIAL VULNERABILITIES IN RISK MANAGED CARE PLANS

QUALITY OF CARE VULNERABILITIES

Limiting enrollment to healthier patients

- Health screening at time of application
- Facilities at inconvenient and dangerous locations and service hours at inconvenient times
- Marketing campaigns (mail, house calls, advertisements)targeted on healthier patients
- Promoting disenrollment of sicker patients

Not providing needed care, or providing low quality care

- ESRD, disabled
- Barriers, administrative hassle, delaying, preventing approval of, or not paying for out of plan care
- Same as above, but especially for emergency care
- Delays and difficulties in arranging service appointments
- Poor telephone service
- Providing allied service care when physician care is needed
- Not providing preventative or follow-up care to EPSDT children
- Putting beneficiary in nursing facility when skilled nursing facility care is needed
- Dumping (moving unstabilized patients to another institution)

Refusing to pay for emergency care

Inappropriate incentives for physicians and other providers to reduce costs by reducing services

Violating 50% (Medicare) or 75% (Medicaid) private enrollment floors

Falsification of provider credentials

Barriers to exercise of appeal and grievance rights

FINANCING AND REIMBURSEMENT VULNERABILITIES

False bills

- Bogus enrollments
- Billing for unjustified enhanced reimbursement clients (ESRD, institutionalized, dually eligible)
- Billing working aged as non-working

Excessive or falsified adjusted community rate

- Padding expenses to justify rate
- Not enriching services or returning excess if costs are lower than rate
- Excessive profits
- Excessive payment to subsidiaries
- Inflated reports of patient traffic or treatment costs

- Excessive payments from mismanagement or subcontractor fraud

Overlap with fee for service reimbursement

- Delay in effective date of services after enrollment
- Premature discontinuance of service at time of disenrollment

Marketing practices

- Strong arm sales tactics, such as:
  -- encouraging churning
  -- selling to those who cannot understand
  -- high pressure sales
- Not fully explaining lock in, out of area requirements, appeal rights
- Misrepresenting coinsurance, fees, etc.
- Misrepresenting performance indicators, customer survey results, etc.
- Enrollment incentives, e.g., free gifts to beneficiaries
- Commissions for sales representatives based on enrollment
- Payments for referrals
- Using minimally trained sales personnel
- Using independent contractors as sales representatives, thus providing "deniability" for their actions

STABILITY VULNERABILITIES

Inadequate financial reserves

Poor management

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Appendix B

OVERSIGHT AND QUALITY ASSURANCE MECHANISMS

A variety of mechanisms are now available to help insure the quality of care provided by, financial and management stability of, and appropriateness of Federal payments for managed care systems. The most important are:

MEDICARE HMOs

The 50 Percent Rule. All HMOs in which Medicare beneficiaries enroll must have at least half of its members made up of non-Medicare and non-Medicaid beneficiaries. This is meant to provide an assurance that Medicare HMOs do not constitute a separate and perhaps "second class" system of care for the elderly and disabled.

Certification. HCFA must certify that HMOs meet certain conditions, such as financial and management soundness, and provide mechanisms to ensure quality of care, appropriate health care utilization control, access to services, and fair marketing practices.

Internal Quality Assurance Systems. This is one of the important requirements of certification mentioned above. HMO's must have formal systems in place to review and assure quality of care.

Beneficiary Grievances and Appeals Systems. This is another requirement for certification. The Medicare statute requires risk and cost-based HMOs to establish appeal and grievance processes to handle complaints by their Medicare beneficiary enrollees.

Two mutually exclusive avenues exist for Medicare patients who wish to express dissatisfaction with their HMO; a grievance procedure internal to the plan, and an appeal process, which begins within the plan and extends to outside administrative and judicial review.

Appeals are primarily complaints concerning payment for services or denial of services. Most other complaints are considered grievances.

Appeals may be made regarding:

- Reimbursement for emergency or urgently needed services;
- Any other health services furnished by a provider or supplier other than the HMO which the enrollee believes are covered under Medicare, and should have been furnished, arranged for, or reimbursed by the HMO.
- The HMO's refusal to provide services the enrollee believes should be furnished or arranged for by the HMO and that the enrollee has not received outside the HMO.

The appeal process might includes a review of the internal determination made by the plan, a reconsideration determination issued by HCFA, a hearing by an Administrative Law Judge, an appeals council review, and even judicial review in Federal court in some cases.

The grievance process relates to such things as determinations of services furnished or arranged for by the HMO for which the enrollee has no further obligation for payment, accessibility, dissatisfaction with the primary care physician, physician demeanor and behavior, adequacy of facilities, and involuntary disenrollment issues.

HCFA On site Monitoring. HCFA makes on site reviews of HMOs approximately once every two years.

Peer Review Organizations (PROs). Medicare Peer Review Organizations may make findings about inadequate or substandard care for HMOs just as it does in the fee-for-services arena.

HCFA Penalties. HCFA may impose a number of fines and penalties on HMOs who fail to comply Federal rules and regulations. In addition, HCFA can freeze enrollment of Medicare beneficiaries in an HMO while HMO works to correct deficiencies.

Office of Inspector General Authorities. My own office may impose substantial fines on HMOs or may suspend them from the Medicare and Medicaid programs for failing to provide necessary care affecting beneficiaries, charging premiums in excess of permitted amounts, expelling or refusing to re-enroll individuals under certain prescribed conditions, discouraging enrollment of individuals needing services in the future, providing false or misrepresenting medical plan information to the Secretary, failing to assure prompt payment for Medicare risk-sharing contracts or incentive plans, or hiring individuals who had been excluded from Federal health care programs under certain circumstances.

MEDICAID MANAGED CARE PLANS

The 75 Percent Rule. Like Medicare HMOs, Medicaid managed care plans must consist primarily of non-Medicare and non-Medicaid enrollees. However, the Medicaid standard is stricter--three fourths must be private enrollees.

Medicaid Waivers. As noted earlier, States may seek waivers to demonstrate innovative managed care programs. The waivers are granted by the Secretary only if certain conditions are met. These may vary from program to program, but all waiver approvals address important quality of care and financial matters.

State Laws and Regulations. Medicaid managed care programs are supervised by State Medicaid Agencies, and are subject to a variety of State rules and regulations.

PRIVATE SECTOR ACCREDITATION

The National Committee for Quality Assurance is a private sector organization which provides a quality accreditation service for HMOs. Many employers require their company HMO to be subject to such reviews.

SURVEYS AND OUTCOME MEASURES

Much attention is now being paid to using surveys of HMO enrollees and systems of outcome measures (e.g., health status indicators), along with associated "report cards," to ensure quality and soundness of managed care organizations. As discussed in my testimony, we have conducted a large scale survey of Medicare HMO beneficiaries. The HMOs themselves are also conducting and publishing the results of their own client surveys. Virtually all HMOs certified by Medicare do this, and a majority do so at least once a year. However, most of the surveys do not distinguish Medicare and non-Medicare enrollees. Furthermore, the survey instruments themselves lack uniformity, making it difficult to compare client satisfaction or experiences of different HMOs.

Work in the field of outcome measures is much more exploratory at this time.

INTERAGENCY COORDINATION

In addition, my office has been active in an interagency work group dealing specifically with issues of managed care and fraud. The work group is sponsored by the Department of Justice and members include the Department

of Defense, Federal Bureau of Investigation, Office of Personnel Management, Internal Revenue Service, HCFA, and State Medicaid Fraud Control Units. One of the recent activities of this work group was to sponsor a conference last May designed to examine and improve Federal and State governmental responses to the problems of fraud and abuse in managed care. The conference explored existing and potential fraud and abuse in managed care, and focused on identifying and sharing strategies, expertise, and coordination needed by those with law enforcement and administrative responsibilities over managed care.

Managed Care Vulnerabilities

Quality of Care

- Limiting Enrollment
- Withholding Care
- Low Quality Care
- Refusing to Pay
- False Credentials
- Improper Cost Reduction Incentives

Financing and Reimbursement

- False Bills
- Excessive Rates
- Fee-for Service Overlap
- Improper Marketing

Stability

- Inadequate reserves
- Weak Management

Managed Care Beneficiary Survey

Positive

- Good Access
- Prompt Appointments
- Good Adherence to Enrollment Standards
- Most Personally Well Treated

Negative

- Prescreening
- Busy Telephones
- Lost Records

Special Problem

- Disabled
- Kidney Patients

Safeguards

Current

- Private Enrollment Floors
- Certification
- Grievances and Appeals Systems
- Internal Quality Assurance Systems
- On-Site Monitoring
- Peer Review Organizations
- Corrective Action Plans
- Civil Monetary Penalties, Exclusions

Future

- Beneficiary Surveys
- Performance Indicators
- Report Cards

Private Sector Accreditation

The CHAIRMAN. Thank you very much, Ms. Brown.

We have a vote at 10:35 a.m., so we will try to complete our questioning during the first round at least for this panel.

Perhaps I could turn to you, Ms. Jaggar. HCFA is going to indicate later that your report is out-of-date, that it's flawed, that a number of initiatives have been instituted, that a new sense of energy has been injected by the Administration into its enforcement policies. As a matter of fact, they would point out that out of the 150 Medicare HMO risk contracts, there are about 7 currently under investigation and of the 7, really it is 6 because one of the HMOs is the same HMO doing business in a different area, and out of the 6, they have one case recently closed because the HMO was brought up to compliance, and 2 others had letters sent in the past 2 months. So basically, they are saying "what is the problem" and that your analysis is simply out-of-date. Would you respond to that?

Ms. JAGGAR. Yes, sir, I would be glad to.

We want to go on record as applauding the initiatives and the efforts that HCFA has undertaken. We, in our conversations with individuals at regional offices and in headquarters, have noted an increase in attention to the quality area and know that HCFA has quite a number of initiatives underway. Recently, for example, in a meeting in Colorado, they have started working more closely with private companies. They are participants now in a group called FAACT, the Foundation for Accountability, and there are a number of initiatives that are underway.

What we are concerned about, however is that there has been discussion of improvements and plans for improvement for many years. As the pile of paper you have in front of you attests, we have been here talking about quality issues and quality issues with HMOs for many years. We would like to see there be assurance that action will be taken.

With the increased growth of enrollment of Medicare beneficiaries in the HMOs, we believe it is more important than ever that the routine monitoring that HCFA undertakes be comprehensive and effective. In our study, we looked at three cases that were ones where there were significant, longstanding problems. In so doing, we picked the most egregious studies. Our theory is that if there are very severe problems that have gone unsolved for many years, it seems likely to us that there may also be many routine problems that also add up to be something serious that need attention.

Yes, there are actions underway but no, we don't believe the problem is solved. We would be delighted to be here in about a year or 2 years telling you the problem is solved, but at this point, we think there is still significant attention that needs to be given to improving quality.

The CHAIRMAN. Basically, you're paraphrasing a famous New England poet who said that we have promises to keep and many miles to go before we can sleep on this particular issue?

Ms. JAGGAR. But he was much more eloquent. Yes.

The CHAIRMAN. Well, he's from New England.

Let me turn also to the question of enforcement. One of the issues or criticisms has been a lack of adequate oversight to make

sure that the HMOs coming into the system are financially solvent, that they do provide quality care, that when they detect that those managed care programs are not measuring up to the quality, they have certain enforcement techniques or vehicles available to use and they fail to use them.

HCFA has indicated to my staff that during the past few years we've seen a tremendous growth, about 70 percent, in enrollment and they also believe that there has not been an HMO plan that has had such glaring violations that would require terminations or the imposition of severe monetary penalties.

I guess the question I have is, did you find any merit to this argument that they are measuring up to such a degree that it would be inequitable to either terminate an HMO plan or impose a serious penalty? Has there been a continuous lack of incentive on the part of HCFA to impose penalties or would that be something that is counterproductive?

Ms. JAGGAR. The cases that we studied did not involve financial insolvency situations themselves. The concern that we had relates to some of the issues that Ms. Brown mentioned in terms of the vulnerabilities of the program, and focus a lot on the possibility of underservice. They also focus on the ability of plans to develop and abide by capitation rates that keep the plan viable and able to provide the needed care and services to the beneficiaries.

We are not saying here today that there are instances where fiscal sanctions should have been imposed and were not. We didn't study that and I don't have additional information in that area.

Mr. STROPKO. What we did find that was fairly glaring was extraordinarily high levels of quality problems identified by PROs, quality problems in the neighborhood of 15 to 25 percent. A typical PRO, going through an HMO's records, will find 1.5 percent to 2 percent quality problems. They were confronted with a spike and we think they should have reacted a lot more quickly than the 4 years that it took for a reaction. We would not necessarily advocate terminating a contract because we're dealing with things that are fixable.

The one thing that keeps getting ignored as a sanction by HCFA that is not so onerous as a sanction but a very reliable tool for protecting beneficiary interests is terminating enrollment privileges for a period of time. You'll notice that most of the HMOs that have problems have high disenrollment rates. We suspect there is some connection between high disenrollment rates and the problems they have. Simply requiring that they no longer enroll people until they correct their problems, I think, would get their attention. Nothing else seems to have gotten their attention.

The CHAIRMAN. What about public notification? How do beneficiaries know whether they're getting into a good HMO or one that is financially shaky or one that doesn't provide the kind of quality care that has been represented to them? Is there any sort of public awareness or any mechanism whereby that information can be made available to the public or is that something that would be counterproductive?

Ms. JAGGAR. We believe that the public by and large now assumes, as they should be able to, that if an HMO is available to them as a Medicare beneficiary, the certification that HCFA has

done means that HMO is of good quality and financial stability and so on. They should be able to trust that.

When HCFA identifies a quality problem, we believe that the corrective plans and the studies—the identification of the problem itself—may not necessarily need to be immediately made public, but certainly if a point comes up that the situation is considered egregious, we believe the public should be made to know about this problem.

In addition, we very strongly recommend—and know that HCFA is considering—that there be kind of a report card setup so that the public has information specifically, for example, about the disenrollment rate, about the complaint rate, about the occurrence of certain other more quality-oriented, medically-oriented conditions in the HMO. Thus the public has a basis for deciding whether that is an HMO it wants to join.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

Do HMO the enrollees who are denied any type of coverage by an HMO know about their rights of appeal? It seems like I've seen a figure somewhere that about 25 percent of enrollees are not made aware of their rights. Who has an obligation to tell them about their righrts and is this statistic correct?

Mr. GROB. Our recent survey showed that about 25 percent of the beneficiaries that we surveyed were not aware of their appeal and grievance rights. In fact, one of the studies we're going to be working on now is an examination of how effective the grievance and appeal system is.

Senator PRYOR. Who has that responsibility? Is that HCFA or is that the HMO's responsibility? What is being done about it?

Mr. GROB. It would be primarily the responsibility of the HMOs to inform their beneficiaries they enroll about the rights they have. It would be HCFA's responsibility to make sure the HMOs do have the appeal and grievance procedures in place. When an HMO proposes to be a part of the Health Care Financing Administration's Medicare Program, there is a certification process they go through. One of the things HCFA must certify to is that they have such a grievance and appeals system. It would be the HMO that has to tell the beneficiaries about it. HCFA can also provide more information in its Medicare handbooks and in other ways. That would probably be useful. We've called that to HCFA's attention, and they've pretty much agreed it is something they need to pay more attention to.

Senator PRYOR. The Office of Inspector General has recently found that some of the Medicare HMOs were cherry- picking the Medicare beneficiaries. During the last 2 years, we've learned a lot about cherry-picking. Is this practice illegal today and is it occurring? Are the HMOs going out there choosing the most healthy of the Medicare population?

Mr. GROB. We know from the survey that we took that the people who are enrolled in the HMOs believe that they are very healthy. Their record of appointments with doctors and the kind of services they are receiving show that overall, they are a very healthy population. That would seem to indicate that the HMOs are successfully enrolling healthy individuals into the HMOs.

The CHAIRMAN. Are you talking about Medicare HMOs or private sector?

Mr. GROB. Medicare. The survey we took was to almost 3,000 people who either were currently members of HMOs or who had recently disenrolled from the HMOs. We found across the board that they thought they were healthy and their record of medical care pretty much indicates they were.

Whether that is because it is the healthier individual who would be attracted to the HMO concept or whether the HMOs in various ways are trying to ensure they get a healthy population is hard to tell. One finding that we found interesting was that 40 percent of the people that we interviewed said they remembered being asked about their health condition at the time they were being enrolled. About 2 to 3 percent actually said they were asked to take an exam before they were enrolled. That latter one certainly would definitely not be okay. The 40 percent may be overstated because after they enrolled, then the HMO can do a health assessment and there is some possibility the beneficiary was confusing the immediate time of enrollment versus shortly after. They make one a little bit nervous.

Senator PRYOR. Does HCFA have the enforcement obligation under the present statute?

Mr. GROB. It is illegal for an HMO to engage in activities like that. They are not allowed to do any health screening; and HCFA, in finding that an HMO does that kind of activity, can take any of the actions such as Ms. Jaggar earlier referred to. In addition, there would be a penalty or a fine that could be levied against an HMO that engages in that.

Senator PRYOR. Mr. Chairman, let me yield the balance of my time to one of our other colleagues because I know we've got to go in about 10 minutes to vote. I may have a few more questions in a moment but let me yield this time.

The CHAIRMAN. Thank you, Senator Pryor.

Senator Burns.

Senator BURNS. Continuing on that line of thinking of Senator Pryor on the enforcement end of it, HMOs are chartered primarily by the states, is that correct? In other words, they have to have certain standards and be chartered by the state. Do you work with the states in their certification so that if they are certified by the state, was it shown that would automatically be certified for Medicare?

Mr. GROB. There is a protection for Medicare beneficiaries in the sense that an HMO that a Medicare beneficiary is in must have more than half of its membership who are private enrollees, not Medicare or Medicaid enrollees. That provides a form of protection in the sense that you know it is a going proposition; so you have basically citizen participation in that.

Above and beyond the rules of the state, there is a certification process that HCFA does for each HMO that wants to participate in the Medicare Program. That includes an examination of their financial stability, their management processes, the existence of these grievance and appeals procedures, the fact they have to have an internal quality assurance program and things of that nature.

Senator BURNS. Since the introduction of HMOs, which in the business I think they are relatively new and some are still in the

experimental stage, have we perfected a way of certification or are we still struggling for rules and regulations with regard to regulating HMOs?

Mr. GROB. The rules of certification are very well established, I believe. This goes back to the early 1980s. I think the rules are clear, the standards are clear. Here, I would defer more to Mrs. Jaggar in terms of the study they did which examined the actual application of that certification process.

Ms. JAGGAR. The rules exist but HMOs themselves are continuing to evolve. Perhaps I will qualify that by saying that managed care itself is continuing to evolve. I think that is where some of the confusion comes about what are the standards that organizations must adhere to. HMOs, as we are referring to them here, are more highly defined entities than some other managed care type organizations.

Senator BURNS. Are we seeing an evolution of new services coming online? In other words, if the HMO idea doesn't really fit the needs or is not doing well, then are we seeing another evolution of an organization?

Mr. GROB. We're seeing an explosion of different kinds of managed care, and you can see this in Medicare where, in addition to the risk HMOs, there are what is called cost-based risk HMOs. There are HMOs that just do Part B. Where you really see it is in Medicaid where each state is allowed to undertake certain management care programs. They are experimenting with many different forms of managed care, use of gatekeepers and a whole variety of forms of managed care. So what you are discussing is actually happening.

Senator BURNS. Since I've been here, we've been debating health care and the Government's role in that health care. I have the distinct feeling no matter what we do, we're going to always be sort of behind the curve.

Mr. GROB. I think what we tried to illustrate on our last chart about the safeguards is exactly the point you're trying to make. Things are evolving very fast. What we are starting with the HMOs are the traditional methods of guaranteeing quality, the certification process, grievances and appeals. But as time is going on, we need to find other methods such as surveys like the ones we conducted. All the HMOs, by the way, are starting to conduct their own surveys of their clients as well, plus outcome measures, the report cards that were mentioned. I do agree with what you're saying that basically, it's like a basketball game, you have to be constantly on your toes trying to keep up with this ball.

Ms. JAGGAR. I don't believe that the Health Care Financing Administration needs to be behind the curve. They have been a leader in the health field for many, many years and I think it's very possible for them to continue to be or to regain that leadership role. I think although there is a great deal of change going on, there certainly is no purchaser of health care in the United States that is nearly as large, with nearly the resources or nearly the clout that the Health Care Financing Administration has. I think that is why we're here today, to say they should reclaim that leadership, especially in the quality area.

Senator BURNS. It would seem to me that with the tools we have in telecommunications and super computers, that we could identify trends more quickly now than at any other time in the history of any other organization trying to finance or provide a service in health care. I for one would like to streamline things much further that when we process at HCFA, maybe we ought to wire transfer funds. I think it all should be done bing-bang. It looks like with computers and telecommunications and instant reporting services, there is no excuse for being behind the curve. We should be able to identify trends much faster.

Mr. STROPKO. Actually, HCFA is somewhat ahead in the fee-for-service sector in terms of electronic transfers of funds. But in the HMO area, with the 15 years of experience it has, it has relatively little information on what goes on in HMOs. It has very little utilization data, very little encounter data, yet HMOs offer HCFA the opportunity to be sort of a laboratory to better understand how to manage care in the whole fee-for-service sector.

I think to assume that leadership role, they have to start being a little more aggressive in collecting some information so that they understand how the HMOs achieve the savings they can achieve. Today that opportunity has been wasted.

Senator BURNS. I would like to think if we, as policymakers, could establish those turns and trends to make what our Chairman has tried to do, take fraud and abuse, because we know we're going to have some financial crunches along the way and I think they go hand in hand with what we're trying to do here and what he has been on for quite a while, which is right to do.

Thank you, Mr. Chairman. I think we have to identify some areas and I look forward to the witnesses and working with these folks. I appreciate your report.

The CHAIRMAN. Thank you, Senator Burns.

Senator Kohl.

Senator KOHL. Ms. Brown, it's clear the private health care market is quickly evolving toward managed care. Now if we change Medicare and Medicaid to encourage greater involvement in managed care, the rate of market evolution is obviously going to skyrocket. I and others are fearful that these rapid health market changes will increase opportunities for unscrupulous providers to defraud the system.

My question is, does HHS and HCFA have the resources, not only to guarantee quality, but also to combat fraud?

Ms. BROWN. Of course it's a balancing act. We are short of resources, and we are utilizing all the areas where the health care programs are being defrauded. This is an emerging program, one of the newer ones. We've had very few referrals as far as fraud is concerned from the managed care side. To date, my office has exclusion authority which would prohibit an organization from having any government sector work. We have not excluded any of the HMOs. We haven't had the basis to do that. HCFA has been working and taking a much more aggressive stance than they had in the past. They are undertaking more investigations at their level which they would forward to us if fraud was indicated. They are doing on-site reviews now annually rather than biennially which they had

done in the past, and they are starting to look at outcome measures which is a rather new technique they are using.

Senator KOHL. HCFA is proposing annual on-site inspections of HMO facilities. Do you have the resources to do that?

Ms. BROWN. HCFA is doing that and yes, they have the resources to accomplish that.

Senator KOHL. Medicare HMOs are required to take all recipients who apply. How well have risk-based HMOs maintained quality of care for people with disabilities and beneficiaries that require extensive and potentially costly care?

Ms. BROWN. We were troubled by one aspect of our survey. Most people were very satisfied with their HMOs, but we found there was a substantial number of the population who had more serious health problems, end stage renal disease, for example, and that they were disenrolling or planning to disenroll from the HMO. We need to look into that further and see are they having difficulty getting service, are they dissatisfied with the service they get. We want to delve into that and find out why that population is leaving the HMOs.

Senator KOHL. As a follow-on to what Senator Pryor talked about which is the exclusion of some potentially high cost beneficiaries, when you have the special enrollment parties, doesn't that by design tend to exclude those people who are very frail, elderly or disabled from attending these enrollment parties? Isn't that a way in which you can exclude those you don't wish to enroll because of costs?

Ms. BROWN. We're very concerned about the marketing practices. That is certainly one that would be a rather natural methodology for excluding the more ill population. There are a lot of marketing practices that we're concerned about. Obviously the marketers get paid according to number they enroll. We had 26 people that enrolled 424 times; so obviously they were being taken advantage of in some way, or perhaps didn't really understand what was going on, but they kept enrolling them over and over. The marketer is probably getting a commission.

Senator KOHL. Ms. Jaggar, your GAO report indicates that HCFA has been reluctant to sanction HMOs for failing to maintain quality programs. Why is that? Could you tell us?

Ms. JAGGAR. Senator Kohl, HCFA's approach has, in general, been to work with the HMO and to develop what we would call or they call corrective action plans. The idea is to work with the HMO, identify what the problem is, allow the HMO to specify what should be done and go ahead and implement it. Of course that is what you want to have happen, a correction of the problem.

Our concern is that there is a certain point, a hard to define point in some instances but, nevertheless, a certain point you come to where you say, look, after 4 years we're tired of waiting, something more severe needs to be done. Let's put a halt to this.

Also, there can be instances early on when a problem is identified that is of such severe implication potentially to beneficiaries that you would put a sanction on the HMO, get its attention, and get a very rapid correction of the situation. That is what we advocate.

Senator KOHL. With respect to some of these plans that have been terminated or voluntarily withdrawn, has there been a problem with the Medicare beneficiaries who wind up being terminated also as a result of this withdrawal or termination?

Mr. STROPKO. That can be a problem. I don't think termination or withdrawal has been a particular widespread phenomenon, so I don't know to what extent we have experience with that. Obviously, it creates a disruption and there becomes an issue of finding secondary insurance.

Senator KOHL. Are you satisfied that if we have a tremendous increase in the next several years in managed care that we are prepared to handle that with respect to the responsibilities that you discharge? Are you scared about it?

Ms. JAGGAR. About our responsibilities?

Senator KOHL. Scared to the extent you think it may overwhelm our system and become chaotic?

Ms. JAGGAR. I think if there is a rapid growth, the enforcement, the review, the monitoring that goes on from all different points of view needs to be stepped up. When something is growing quite rapidly, as you know, there are often growing pains and a number of things that need to be given special attention.

I think given the things that can be learned from private sector initiatives—putting their experience together because there is such a large proportion of the private sector market that is now enrolled in HMOs or managed care-like organizations—that there are many models HCFA could take advantage of to help themselves meet the challenge. But also, we are now dealing with a very small growth—17 or 16 percent growth of 7 percent is still a real number, a big number, but it's not millions and millions of people every month. So if HCFA is very assiduous, learns and takes advantage of the resources that are there, we are hopeful they will be able to do a good job. Of course we will be glad to help them.

Mr. STROPKO. There is one thing that can't persist and that is I don't think you can take a regulatory approach that takes years. I think we have to take a look at time frames in terms of weeks and months. The industry is just moving too fast.

Ms. BROWN. It's a matter of shifting resources because these people are currently on other care programs, Medicare or Medicaid, and as that population shifts, there will be some resources used for oversight of that.

Also, in these managed care organizations that actually act as the gatekeeper, they do essentially what the HCFA contractors do which is take care of all of those people who are the individual providers. I think it will have to be watched very closely and both HCFA and we are gearing up to do more work in that area. I don't think it's something that is out of control.

Senator KOHL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Pryor indicated there might be a problem of cherry-picking in this particular field. My understanding is that HMOs are not allowed to prescreen prior medical history and exclude only hospice and end stage renal disease patients. So, if one were qualified before developing the renal disease, he or she would still be entitled

to enrollment but a person at that end stage is not entitled to be enrolled under the HMOs, correct?

Mr. GROB. That's right. The ones we found in our survey should have been people who were struck by that condition after they enrolled.

Ms. BROWN. I might add that, HMOs get $300 a month for those patients who have end stage renal disease; so there is additional money paid because of the intense treatment they need.

The CHAIRMAN. Are more resources going to be needed by HCFA in order to adequately monitor the increased coverage? Is this something we have to face up to saying you have to have a better job of monitoring, you have to have more people, more equipment, new information technology?

Mr. GROB. I think HCFA will have to answer that question when it comes. Ms. Brown made one good point which is, a good investment is to make sure the HMOs themselves have the systems to monitor the quality of care within their HMOs because the payoff is great. If they are doing that job, that would mean less federal resources.

Ms. BROWN. There is protection built in the fact they can only have 50 percent of their enrollees in Medicare. In fact, it has to be 75 percent private enrollees for Medicaid patients. That is a good control that they have to maintain a certain standard.

The CHAIRMAN. Did you make any kind of cross comparison in terms of greater satisfaction in the private sector for those companies who have their employees enrolled in a managed care program versus HMO beneficiaries?

Mr. GROB. Let me mention that our survey only looked at the Medicare enrollees of these HMOs. However, we have now obtained the surveys that the commercial HMOs are using. Some of them distinguish their Medicare from their non–Medicare enrollees, and we're in the process now of analyzing the surveys they are conducting to see if we can get a handle on that and also to find out how they are using the surveys to improve quality.

Ms. JAGGAR. There are several organizations doing studies, but they actually are excluding the Medicare population. I think the kind of additional research in that area, as Mr. Grob said, will be warranted.

The CHAIRMAN. We have to take into account also the fact that if you've got employers who have a younger working force, healthier working force, people who might not be calling upon the health care system as much as those who are Medicare retiree beneficiaries, you would obviously have a great discrepancy in the study itself.

I believe, Ms. Jaggar, you could answer this one. There seemed to be some coordination problems within HCFA itself. My understanding is there are two divisions in HCFA, one the Office of Managed Care which is charged with the oversight of Medicare HMOs, and the other the Health Standards and Quality Bureau which is a division that oversees the peer review organizations. There seems to be some disconnect between how that information is shared between one and the other.

My understanding is the information that HCFA receives from the PROs is not computerized, it's entirely manual and that you in-

dicated that HCFA doesn't link its contract compliance monitoring with PRO's monitoring and it doesn't draw on PRO staff expertise to help verify whether an HMO's quality assurance program is actually working.

Is there a serious problem in terms of the sharing of information within HCFA itself?

Ms. JAGGAR. In doing our work, we did encounter a number of instances where individuals in one or the other of the organizations—the Office of Managed Care or the Health Standards and Quality Bureau—were a little bit uncomfortable with the sharing of information between them, between the regional office, and between the PROs and/or with the HMO directly.

It looked to us like the relationship and coordination between those two parts of HCFA perhaps contributed to the length of time that it took for some of the actions to be taken against the significant problems that we identified in our study.

Yes, we would say from our experience at this point it does look like there is an area where improvement can be made.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Mr. Chairman, Senator Harry Reid is now with us and he has not had an opportunity to make a statement or ask a question, let me yield if I could then and then at the end I'll have just a brief comment.

STATEMENT OF SENATOR HARRY REID

Senator REID. I appreciate very much your yielding to me, but I came in late. I am the ranking member of a subcommittee and we just held a hearing and I didn't feel it was appropriate to barge in. I'm interested in the subject.

Senator PRYOR. Senator Reid, you are always appropriate to ask any question you want.

I just have a comment and will follow on with some written questions, Mr. Chairman. I want to thank the GAO and you, Ms. Jaggar, for three outstanding staff people who have helped us better understand these issues through this excellent report. These people are: Ed Stropko, Lourdes Cho, and Charles Walter. They are to be commended and we want to express our thanks to them.

Ms. JAGGAR. Thank you very much.

Senator PRYOR. And our public thanks to you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Pryor.

We're going to break now for the first vote of the morning. Hopefully we can complete the other panels.

Thank all of you for coming. I think we want to emphasize once again the purpose of the hearing is not in any way to discourage those who would like to enroll in HMOs. I think it's certainly one of the waves of the future. We want to make sure that those who are being enrolled and seeking enrollment can maintain the quality of care they are justifiably entitled to and that we have federal officials who are charged with the responsibility of ensuring that these programs measure up to the quality we expect since there are U.S. taxpayer dollars involved in compensating the HMOs for their service. We want to make sure they are doing the job they are contract-

ing for. Your testimony was very helpful in at least setting the ground rules for that.

Thank all of you very much.

We will stand in recess for about 15 minutes.

[Recess.]

The CHAIRMAN. The Committee will come to order.

Our next witness this morning is the Honorable Bruce Vladeck, Administrator, the Health Care Financing Administration, that has the responsibility to oversee our Medicare HMOs. Mr. Vladeck, why don't you proceed. If you can summarize, it would be appreciated. I'm told they want me on the floor by noon to offer an amendment. I'm not sure how I can get through by noon, but we will try.

STATEMENT OF HON. BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman.

I appreciate the opportunity to appear here this morning to talk about the Health Care Financing Administration's oversight of health maintenance organizations, providing services to Medicare beneficiaries.

I'm very cognizant of the longstanding role that this Committee and that you, personally, have played in trying to focus attention on what is necessary to improve the quality of care provided to Medicare beneficiaries.

The CHAIRMAN. Let me interrupt you and say I have been sitting here as long as Senator Pryor on the Aging Committee and the two of us have worked together very closely over those 17 years and prior to that, I was serving on the Aging Committee in the House when it began as the Aging Committee back in 1975. One of the problems is that you are in the unenviable seat and that we have had more turbulence in HCFA than in most other agencies. It's very hard to hold onto people in that office. You come in, start off, and say we're going to make some changes and they do but then the administrators move on. I don't know how many times we've tried to get a commitment, saying how long do you intend to stay here because we need good people like you to stay in that position because it's a very, very tough job with a lot of responsibility. It's very complicated and you need all the help you can get.

I'm one of the first to say to you up front that I think you've done some outstanding work and HCFA has made some improvements. That is why I took care this morning to point out that we think you have done good work there but there is a long history. Tell me how many directors have preceded you in the past 10 years—probably at least 7 or 8, maybe more. It's been very hard to hold good people in this position because of the difficulty and the talented people who occupy that position, and the attractions of serving for a while and then going into the private sector.

With that, you can proceed.

Mr. VLADECK. I appreciate those comments, Mr. Chairman. I will note for the record what I've told my staff which is that my son begins his junior year in high school in Montgomery County next month and I promised him, we will not relocate again as long as he is in high school.

The CHAIRMAN. What year is he?

Mr. VLADECK. A junior. Since he's 6 foot 8 inches and 248 pounds, I keep my promises to him.

I'm not going to give you a long defensive argument about the past because I think many of the concerns and criticisms that have been expressed of our monitoring of HMOs in the past are very much on point. We have taken them to heart.

I do think over the last year-and-a-half or so, we have begun to turn this around and what I would like to do very briefly is just highlight several of the things we are doing or are planning to do.

The first is, as you've heard reference to, we are substantially changing and strengthening our routine monitoring process and we are putting more resources to bear because indeed, as noted by the GAO, we have not traditionally had the sort of clinical expertise available on our staff to review some of the more technical medical or other clinical material. We are increasingly for the first time using on a contract basis physicians, nurses, and other health professionals to assist us in our review. We're also hiring physicians and nurses to work in these areas. We are going from a bi-annual review of compliance to an annual review. We are getting data from our Standards and Quality Bureau that is generated by the PROs to the folks who are responsible for oversight of the HMOs in our Office of Managed Care and our regional offices.

We have not as of yet invoked our authority to levy civil monetary penalties but we have cleaned up a terrible regulatory backlog that existed when I took office about 2½ years ago. We now have clarified our legal authority to levy so civil monetary penalties and we will do that when appropriate and necessary. We are retraining and reallocating staff to these functions.

I must say, however, that as has been discussed, these are very process-oriented ways of looking at the quality of services being provided by HMOs and we need to move forward with systems to give us the capacity to continuously monitor in a more systematic and automated way the actual patterns of service being delivered to our beneficiaries.

There are three points I will make very quickly. The first is for the first time in quite a while, we are working very much in collaboration with leading purchasers in the private sector who have very much the same concerns that we do and very much the same agendas about monitoring what they are getting when they buy managed care on behalf of their employees or retirees.

We've been meeting on a regular basis with groups of employers and other large purchasers to talk about common agendas, about data,. about standards. We've been working very closely with the National Commission on Quality Assurance and have put in place a plan in which there will be a major Medicare component in the next version of the so-called HEDIS system, the leading private sector report card that is now generally available for HMOs. We will be participating with them in the development of Version 3.0 of HEDIS which will have a major Medicare component in it and will give us some of those report card characteristics.

The second part of this effort, and it is something we are doing in close collaboration with the private sector, is data. Again, both GAO and the Inspector General noted appropriately that the kind of data we collect on HMO performance tends to be limited, tends

to be after the fact, and tends to be nonsystematic. We do need to move toward the world of standardized reporting and data from all HMOs to all purchasers. We have been consulting very extensively with both the HMO industry and the private sector in that regard. We hope by the end of this year to have some consensus about a basic HMO encounter dataset that could be adopted throughout the managed care industry and by the major private purchasers as well.

Third, the place where we lag the most seriously but where we also have major investments has to do with the way in which we communicate information to our beneficiaries, both about their choice of plans and the performance of plans in which they have been located.

When HCFA was created in 1977, it spun off to a large extent from the Social Security Administration and had always provided services Medicare and Medicaid beneficiaries had gotten through the Social Security district office structure. There was a decision made at the time, largely for budgetary reasons, not to create any mechanisms of direct communication between HCFA and its beneficiaries. We've been paying the price for that decision and playing catchup ever since.

We have a major investment in beneficiary communications and customer communications. Much of it is contained and we hope will survive in our fiscal 1996 budget. We are already, however, beginning the research and demonstration work with focus groups among beneficiaries and testing possible informational documents and so forth. In order for the program of the future to work, we need better informed beneficiaries making choices not only about their plans but about what kind of medical care they will receive and how they will receive it. They need to know more about what their rights, how to appeal and so forth. The world of communications and information technology, I don't have to tell anyone, is exploding. Historically, we have been significantly behind that curve. We are in the midst of a major effort to play catchup in all areas and we are focusing particularly on information and managed care.

I would tell you that I think we are a year to 18 months away from being able to routinely provide beneficiaries the kind of customer information they need in order to make informed choices about their health care. It clearly is the third piece of this puzzle of getting past the retrospective cops and robbers approach to quality through a continuous improvement model based on ongoing, uniform data, shared with the private sector and as well as within Government and then getting that information to beneficiaries in a way they can use it. Obviously, there are a lot of pieces to all of this and I'd be happy to talk about any of them that you'd like.

In the interest of everyone's time, let me conclude my opening remarks again with my thanks to the Committee for its longstanding interest in this area and all the help they have extended to us in the past few months in putting all of this together.

[The prepared statement of Mr. Vladeck follows:]

PREPARED STATEMENT OF BRUCE C. VLADECK

INTRODUCTION

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on the Health Care Financing Administration's (HCFA) oversight of health maintenance organizations (HMOs) providing services to Medicare beneficiaries. The Special Committee on Aging has over the years played an important role in focusing attention on the issue of quality of care in Medicare managed care plans. We appreciate Senator Cohen and Senator Pryor's continued interest in this area, and we look forward to working with this Committee on further improvements.

Over the past two years, Medicare managed care enrollment has increased dramatically. In the first 6 months of 1995 we have already seen a 9 percent increase in managed care enrollment, an acceleration over last year's annual rate of 16 percent growth. Enrollment is growing at a rate of 75,000 per month. Currently, 9.5 percent of all Medicare beneficiaries—over 3.5 million people—have chosen to enroll in managed care plans. Seventy-four percent of Medicare beneficiaries have access to a managed care plan, and 57 percent have a choice between two or more plans.

More than 250 managed care organizations currently contract with HCFA to serve Medicare beneficiaries. Interest in the Medicare managed care program continues to increase. Much of the recent growth in new contracts has been in regions that have not had a strong Medicare managed care presence in the past.

I want to describe for you how HCFA is honoring its commitment to ensuring that the growing number of beneficiaries served by managed care plans receive high quality care. First, HCFA has recently improved its monitoring and enforcement program for Medicare HMOs. Second, we have several initiatives underway to ensure quality, such as the development of performance measures and improvements in the appeals process. Finally, we are improving our efforts to inform beneficiaries about their managed care options.

MONITORING AND ENFORCEMENT

Over the past few years, we in HCFA have been involved in an unprecedented effort to review all of our activities in light of our mission and strategic plan. This review has led to a new focus within the agency on our beneficiaries as our primary customers. It has also led to a rethinking of our relationships with the providers, contractors and health care plans as our partners in serving the beneficiaries.

As the nation's largest purchaser of managed care, HCFA is committed to ensuring the quality of care for our beneficiaries. We believe that the best way to achieve this end is to work in partnership with the plans to achieve continuous quality improvement. But HCFA is not just like any private sector purchaser. We are purchasing care for Medicare beneficiaries and therefore, have to keep their interests at the forefront of our efforts. For this reason, HCFA and its managed care contractors must be held to a higher standard of accountability. Thus, on occasion, we have to call our partners to task for not holding up their end of the bargain. This Administration has demonstrated that in instances where plans fall out of compliance with standards, we have not hesitated to take swift action.

Beginning in 1994, HCFA initiated an aggressive enforcement process to remedy the root causes of quality and access problems. HCFA has initiated eight investigations in the last two years, three in 1994 and five in 1995. These investigations identified problems with utilization management systems; quality assurance; administration and management; availability, accessibility and continuity of health care services; high rates of disenrollment; and marketing and contract management. In all eight investigations, plans have developed acceptable corrective action plans to address the findings of the investigations. As a result of these investigations and the corrective action plans implemented, we have seen improvement in plan performance as indicated by our monitoring data and our site visits.

Not only have we moved aggressively when we have identified compliance problems, but this Administration has significantly improved and expanded our oversight activities in three ways. First, we have brought new resources to bear on oversight activity. Using our contracting authority, we have expanded our own review staff with private sector clinical and technical expertise when needed including physicians, registered nurses and statisticians. This had not been done before by previous Administrations.

Second, in 1993, and again in 1995, we made significant improvements to the protocol and procedures used in our monitoring process. These improvements included incorporating PRO review findings as an integral part of the quality assurance review; enhancing methods to evaluate situations in which HMOs delegate quality assurance activities to providers; and developing a score sheet which provides the re-

viewer with a more definitive methodology for evaluating and assessing quality assurance.

Finally, starting in January, on-site monitoring will take place on an annual, rather than biannual, basis. These improvements clearly indicate the high priority that this Administration places on our oversight responsibilities.

In preparing its recent report on our oversight activities, the GAO only fully considered enforcement cases as of June 1994. Therefore, its report does not fully reflect the new energy that this Administration has injected into enforcement activities, nor the results that we have been able to achieve. The GAO report also leaves the impression that our activities should be judged based on the number of civil monetary penalties or intermediate sanctions we impose. We emphatically disagree that this is the appropriate standard.

First, one could argue that in a world of publicly-traded health plans and intense private purchaser scrutiny, HCFA has a more powerful enforcement tool than simple penalties and sanctions. I would ask which is more likely to motivate a plan manager, a $15,000 or even $100,000 civil money penalty or the marketplace's reaction to the adverse publicity resulting from an investigation. We believe that angry and disgruntled purchasers and shareholders are major motivators for plan managers and that plans are "sanctioned" when they have to inform shareholders of negative findings from our investigation.

Second, we believe that the time and energy spent developing the documentation necessary for a civil money penalty or intermediate sanction is better spent working with the plan to correct the particular deficiency or quality problem. I would add, however, that HCFA has obtained voluntary enrollment freezes from plans in instances where we believed such a freeze would be in the interest of beneficiaries.

ADDITIONAL INITIATIVES TO ENSURE HMO ACCOUNTABILITY

While we have made improvements to our quality assurance reviews, we would agree with the GAO that we must further remodel our methods for ensuring quality. We are keenly interested in assuring that as the Medical managed care program grows and evolves, we have adequate measures in place to assure and improve the quality of care plans provide to our beneficiaries.

Like other purchasers, we are attempting to develop process and eventually outcome measures of quality. Designing these measures is a challenge, as we must broaden our focus from individual, physician-based care to performance measures for entire populations. Further, unlike fee-for-service medicine, where each medical encounter results in a claim, information about specific services provided by managed care organizations has historically been limited.

Public as well as private sector purchasers have only recently begun to require plans to collect the encounter data necessary to develop plan performance measures. Little consensus has emerged, however, on what measures to assess, what types of encounter data to collect, how to ensure encounter data and performance measures are reliable and comparable across plans and how to best present information on plan performance to consumers.

We are facing up to this challenge and working closely with the managed care industry and private sector purchasers to develop appropriate and meaningful procedures that can be relied on by HCFA, by our beneficiaries, and by the managed care plans. For example, HCFA, together with the Department of Defense and the Federal Employees Health Benefits Program, has joined private sector health purchasers, including GTE, AT&T and PepsiCo, in an unprecedented partnership to explore the formation of a new organization for quality improvement and managed care accountability. This new organization, the Foundation for Accountability (FAcct), will develop performance measures that will assist purchasers and consumers when choosing a health plan. This organization will also help to eliminate unnecessary duplication in individual quality improvement and HMO accountability efforts. The collective membership of this organization represents approximately 80 million covered individuals. HCFA is also convening a series of meetings on "Accountability, Information and outcomes" with public and private purchasers of health care services, consumer groups, providers, and managed care plans to discuss best practices for ensuring quality. Just last week; we had our first meeting with major private purchasers.

Because plan performance measures required by private sector purchasers may not always be relevant to the Medicare population, HCFA has undertaken several initiatives of its own to develop performance measures applicable to our beneficiaries. For example, HCFA plans to collaborate with the National Committee on Quality Assurance (NCQA), with the support of the Kaiser Family Foundation, to

modify the Health Plan Employers Data and Information Set (HEDIS) to incorporate measures more germane to the Medicare population.

In addition, in May 1995, we launched a pilot test of performance measures for the treatment of diabetes, developed by the Delmarva Foundation and Harvard University, to be used by Peer Review Organizations (PROs) in their external review of HMOs. The Delmarva contract was intended to help HCFA and the PROs shift from the current retrospective case review method of HMO oversight to one based on outcomes measurement and continuous quality improvement.

As described in the GAO report, the current process through which beneficiaries can appeal HMO coverage decisions is not as effective as it could be in protecting beneficiaries against potential underservice by plans. This is the case because the current process takes too long to resolve disputes over services that beneficiaries believe are urgently needed. As the report also indicates, we have taken steps to improve the appeals process. We are planning additional improvements such as a mechanism for providing expedited appeals. We are also determining how to best educate beneficiaries regarding their appeals rights and the appeal process.

BENEFICIARY EDUCATION

Before beneficiaries can make choices among managed care plans, they must first be aware that they have a choice between traditional Medicare and Medicare managed care plans. HCFA has several initiatives underway to ensure that beneficiaries are aware of their option to join a HMO. For example, HCFA works with Social Security Administration (SSA) District Office personnel are knowledgeable about managed care options available to our beneficiaries. HCFA also publishes several handbooks, brochures and directories which includes information about managed care options. We have even placed information on Medicare managed care on Compuserve and the Internet.

We would like to do even more to ensure that beneficiaries are aware of their option to enroll in Medicare HMOs. To this end, we are examining all HCFA publications to determine if managed care information needs to be included or if new, enhanced brochures are required. As part of this effort, we are collaborating with the Spry Foundation to interview beneficiaries on the usefulness of HCFA's managed care publications.

Finally, we are planning to modify the information included in the initial enrollment package to ensure that the beneficiaries are aware they have a choice enrollment package to ensure that the beneficiaries are aware they have a choice between traditional Medicare and Medicare managed care plans. The initial enrollment package is mailed to beneficiaries six months before they turn 65.

Providing beneficiaries with reliable, comparative information on managed care plans will be a much more difficult task and will require a significant investment on HCFA's part—one that HCFA is willing to make. As explained earlier, at this stage in the evolution of plan performance measures and their inclusion in consumer "report cards," there is no single best approach. Private sector purchasers, health plans and organizations such as NCQA have only recently begun developing information in a format that would be useful to consumers in evaluating the quality of care provided by health care plans.

We intend to continue to work with a broad range of private sector organizations, as well as pursuing our own developmental work, to move forward as quickly as possible. For example, as part of HCFA's competitive pricing demonstration, beneficiaries would receive objective, comparative information about the plans available to them in their market areas. Accordingly, we have solicited proposals for the development of an information, education and marketing strategy to inform beneficiaries about their health plan choices. We have received several proposals in response to this solicitation and are currently reviewing them. We expect to award the contract by late September.

Through the competitive pricing demonstration and its open enrollment process, HCFA will learn what types of comparative information on plans are useful to beneficiaries and how best to communicate that information. It is in this context that HCFA will determine how best to use information from its monitoring visits such as disenrollment rates, the number of beneficiary complaints and enforcement activities.

CONCLUSION

As managed care enrollment continues to expand, oversight of managed care plans will become an even more important part of HCFA's mission than it is today. We have made significant enhancements in this area but we recognize that we face continuing challenges.

We believe beneficiaries should have access to a wider range of managed care choices and hope to work with the Congress toward that end. As Congress considers restructuring the Medicare program, however, we believe this committee has a special role in ensuring that beneficiary protections are not diminished while options are expanded.

Thank you for the opportunity to testify on this important subject. I would be happy to answer any questions you have.

The CHAIRMAN. Thank you very much, Mr. Vladeck.

Senator Thompson, do you have an opening statement?

STATEMENT OF SENATOR FRED THOMPSON

Senator THOMPSON. Not as such, Mr. Chairman.

First of all, I appreciate your having these hearings. I'm here to learn. Obviously managed care and HMOs are going to become increasingly important as we try to solve our health care problem and our Medicare problem in this country. Some are concerned that we are moving from a system of how much care can we give a patient to a system of how little care can we give a patient. I think all of us are concerned as to how we're going to maintain the level of care on the one hand and save money on the other. I'm sure you have a solution for that this morning and I'm just here to listen to it.

The CHAIRMAN. Thank you very much.

As I indicated in my opening remarks, the Committee has had a long history of concern about this particular subject matter. In 1987, Senator John Heinz issued a minority staff report that concluded "HCFA monitoring of risk HMOs has been sporadic and reactive. To date, there has been little effort to collect critical data on access, quality in marketing on a systematic basis." Four years later, this Committee had hearings on Medicare HMOs and noted that "HCFA has not yet made a clear commitment to monitoring HMOs to ensure Medicare beneficiaries are adequately protected against abuses." So we've had a period of some 8 years that have transpired and we're still hearing the same essential song.

The question I guess we have is when are we going to really start having that kind of quality assurance analysis being undertaken and then adequately enforced? You mentioned we're 18 months away from a lot of things here.

Mr. VLADECK. There are various parts to that, Senator. I think some pieces are already in place, other pieces are coming down the line and some pieces may be further away. Let me perhaps walk through several of those.

We have indeed totally revised the way in which we do our routine compliance surveys or plans. Again, that tends to focus on after-the-fact kinds of issues, on process rather than outcome and it tends to be a sporadic rather than continuing intervention. We believe it has already made a considerable amount of difference.

The eight investigations that we have undertaken were in three cases completed over the last year significant problems were identified. On those that are far enough down the road, we think we have measurable improvements in the performance of the plans that have had that new level of more intense scrutiny. We are in much better shape to go back if they backslide from the improved performance they achieved.

We are integrating our medical monitoring system through the peer review organizations with our administrative oversight better. More importantly, we are in the field now testing an entirely new process by which the peer review organizations would monitor the quality of care being given by Medicare HMOs. In the past, they basically pulled a random series of patient records and looked at them in an inherently subjective process. We have been working through a program in which we will have standard, nationwide quality indicators and quality standards of care for identifiable conditions. We're beginning with diabetes which is a very common serious problem.

The CHAIRMAN. Are you going to use trained, clinical staff in conducting these?

Mr. VLADECK. Yes, we will.

The CHAIRMAN. You haven't to date?

Mr. VLADECK. More importantly, the professional staff that will be reviewing the data are trained clinicians. Furthermore, our reviews will not be just a random, "let's see what we can find" kind of notion. There will be a high degree of professional consensus about a set of basic guidelines for standards of care for that condition and a set of norms that we can apply nationally to see how the HMOs are measuring up against it.

There will be a Medicare–HEDIS, 3.0 report card in 1996 and that will begin to be available once it's tested. There will be agreement on a standard encounter dataset for a continuing monitoring of HMOs within the next 6 to 9 months and then it will be a question of how quickly the plans can develop the data systems to put that in place.

Those are the time lines we're talking about in these areas.

The CHAIRMAN. What is the time frame that you allow for beneficiary appeal under the HMO arrangement?

Mr. VLADECK. Under the current regulations, it is up to 6 months from the time of filing. That's not an acceptable norm and it should be acceptable only in rare, complicated, nonurgent instances, but we do need to revisit and change that policy where relatively urgent conditions are involved.

In our review of HMO appeals decisions or reconsiderations, we have gotten our Contract and Design Group to change its procedures so that they prioritize more urgent kinds of cases and give quicker answers on those.

The CHAIRMAN. It's a 6-month appeal from the initial decision of denial. Is there a time frame in terms of the reconsideration of the appeal?

Mr. VLADECK. The HMO must give the beneficiary notice of its initial decision within 60 days of the enrollee's request for payment.

The HMO either makes a fully favorable decision and issues a decision to the enrollee within 60 days, or forwards the case to HCFA within 60 days from the date of receipt of the reconsideration request.

If a plan upholds its initial decision in whole or in part, the appeal case is sent to Network Design Group (NDG), HCFA's independent reviewer, who then conducts a reconsideration. NDG also

abstracts data on the plan's timeliness in handling the reconsideration.

On average, a decision is rendered within 64 days after a case reaches NDG.

NDG makes a reconsideration determination, and if found to be liable the HMO has 60 days to provide for pay for the service.

If the NDG upholds the HMO's decision, the beneficiary can continue through the Medicare appeals process the same as if he or she were in the fee-for-service program.

The CHAIRMAN. My understanding was that you allow a maximum of 60 days to reconsider a beneficiary's appeal but the GAO has found there are several HMOs in California and Florida who have retained beneficiary appeals between 130 and 200 days. Are you familiar with that?

Mr. VLADECK. It is difficult to obtain more specific information about the HMOs in California and Florida without the names of the plans and the dates of violation. It is also unclear whether the 130–200 day period refers to the entire appeals process or to the HMO's reconsideration decision. However, a delay of 130 to 200 days in the beneficiary appeals process is clearly unacceptable. Plans are required to process the initial appeal within 60 days.

HCFA has taken a number of steps to improve the timeliness of the appeals process.

HCFA has worked with our independent contractor, Network Design Group (NDG), to establish an expedited review process for pre-service denials. NDG now screens all new arriving cases and directs all pre-service denials into a fast-track review process. Some urgent cases can be decided in 24 to 48 hours, with an average time of 11 days.

Between 1994 and 1995, marked improvement can be seen in Medicare HMO's compliance with the 60 day timeliness standard. For example, there was a 15.8 percent increase in the number of HMOs who met the 60 day standard. In addition, there was a 17 percent increase in the number of HMOs that submitted cases within 65 days. The number of cases taking over 100 days to process at the HMO level has also decreased in the past year.

The CHAIRMAN. That seems to be an intolerable level.

Mr. VLADECK. It is. It won't be permitted.

The CHAIRMAN. What about accreditation? Many of the large employers are now turning to the private sector to accredit these HMOs, for example the National Committee for Quality Assurance. Is that something HCFA is giving any consideration to in terms of whether or not you can delegate that kind of responsibility to the private sector?

Mr. VLADECK. As I mentioned earlier, we are working with NCQA on adaptation of their basic measurement device to Medicare. We just released last month a draft reporting system for Medicaid HMOs that was developed in conjunction with the National Commission on Quality Assurance. If there is widespread acceptance of those measures and standards, they might give us the basis for a Medicare-specific accreditation.

I must say, however, our recent experience with voluntary accreditation and with some of the difficulties experienced by the Joint Commission on Health Care Accreditation of Health Care Or-

ganizations with hospital accreditation make us hesitant about jumping too quickly into automatic acceptance of private accreditation.

We have worked on private accreditation in clinical laboratories and in-home care, and we do have generic rules for doing it. It's always a very complicated process, but to the extent there is convergence between our standards and those in the private sectors, we can do a lot to avoid duplication in terms of reporting, inspection and so forth between what the private agencies do and what we do.

The CHAIRMAN. HCFA's Office of Managed Care testified before the House last month that many HMOs don't have patient-physician encounter data on services provided by the HMOs. This data has been referred to as the building blocks of any future performance reporting system. If you don't have this kind of data, how can you be sure that you don't have the kind of problems they found in South Florida's HMOs happening across the country? How do you make that assessment?

Mr. VLADECK. The assessment we made historically has been on the basis of various, one-time surveys or studies. Either they are specific to plans or specific to HMOs in general. You're absolutely right that a long-term quality assurance strategy requires encounter data. I just might note that it is often the plans with the least good encounter data are the older group or staff model HMOs, with the better reputations and experience in the Medicare Program, and many Medicare enrollees. So we have been working with many of the most distinguished HMOs in the country to identify a way in which they can begin to get that data. It is the newer, more commercial for profit HMOs in general that have better data than the older, established, nonprofit HMOs.

The CHAIRMAN. Are you going to require that HMOs furnish that information in a format that you can actually use for monitoring?

Mr. VLADECK. We will. The question is the extent to which we can build a public-private consensus about appropriate data systems so that we don't find ourselves in the position of having a government regulatory case but rather a broad, public-private initiative in this regard. If we can't do it on that basis, we will have to look again at just moving ahead in a regulatory mode. At the moment, we're hopeful we will be able to get a voluntary public-private process to get those data standards.

The CHAIRMAN. Senator Pryor and I have been concerned for a number of years that Medicare beneficiaries have had problems in registering their complaints either about a service or a program or an action. Of course we've established Medicare hotlines. Do you intend to have any kind of hotline to register complaints for HMOs? Is this something you'd recommend or reject?

Mr. VLADECK. One of our fondest dreams, which we hope the appropriations process doesn't entirely squelch, is to go a step beyond that. We need in the Medicare Program to have a level of customer service that Americans expect in many private service businesses. By the end of this decade, we need a national 800 number for all Medicare beneficiaries on all Medicare-related inquiries which can then switch for special problems or special kinds of concerns and is built on the kind of data processing system for which the tech-

nology is readily available now so that we can routinely log and monitor complaints and do sophisticated statistical analysis of what is happening in trends and complaints and questions.

The CHAIRMAN. We have had several references made this morning about the level of health care fraud in our system. It's all pervasive, in virtually every aspect of our system. GAO indicated we're losing roughly $100 billion a year through fraudulent activity, about $47 billion a year coming out of the federal programs, about $27 billion coming out of Medicare and Medicaid itself. That translates into pretty big dollars on a daily basis. Most of the federal officials would say the front line of defense is not here in the FBI or the Inspector General's Office at HHS, it's with the beneficiaries themselves, that they are the ones that have to call attention to the fact that either they are not receiving services for which Medicare is being billed, or Medicare is being overbilled, or there are other irregularities that ought to be called to the attention of Federal law enforcement.

If we have this dramatic shift from the Medicare beneficiary fee-for-service into HMOs, don't we have to have a similar front line of defense out there for them?

Mr. VLADECK. Absolutely, Mr. Chairman. They need to have a phone number they can call confidentially to raise questions and to make complaints, and to make allegations when they have them. That is essential.

The CHAIRMAN. Is there anyplace that beneficiaries can go today and have a list of do's and don'ts in looking at HMOs? If you put those charts up, there are some pretty positive things that beneficiaries can look at. They can see elimination or reduction of paperwork, perhaps elimination and certainly reduction in copayments and deductibles, they can find coverage for prescription drugs, maybe eye care, dental care. There are a lot of very positive features about HMOs but they also ought to be aware of what the downside is.

Is there anything or anywhere they can turn to today to find a list, of the do's and the don'ts, so they are aware of the things they should look for in determining what to do when you are selecting an HMO?

Mr. VLADECK. There are three basic documents which we publish which currently address that in part. Our basic Medicare Beneficiary Handbook, the Guide to Health Insurance, that we publish relative to Medigap insurance, and a special guide book on choosing managed care. We are in the process of revising all of them in time for the 1996 versions to more adequately serve that purpose.

Publications are only a limited help in that regard and we are increasingly working with the health insurance counseling programs that we fund in each of the States. They provide beneficiaries with advice about insurance choices and health care so that their volunteers can function more effectively as sophisticated counselors to beneficiaries trying to make that choice. We will have to put a lot more effort into that.

The CHAIRMAN. Thank you very much.

Senator Pryor.

Senator PRYOR. I'm sorry I was on the floor and couldn't get over here in time to hear your statement and to get the first questions.

A number of proposals we're looking at right now would convert Medicare into a defined contribution system or voucher program. Under these proposals that we're looking at, beneficiaries would be given a voucher and that would be used to purchase private health care coverage, including managed care. You know all about this. What implications do you think these proposals have for say the vulnerable population such as the disabled and such as the elderly?

Mr. VLADECK. We would be very, very concerned about such an approach in general, particularly about its implications for the most vulnerable beneficiaries. Unfortunately, in the Medicare population as in most populations, there is a very strong, inverse correlation between health and income. That is a fancy way of saying the older you are, the sicker you're likely to be and the less income you're likely to have. While in theory one could define a super sophisticated voucher system that would somehow account for all of that, our experience in the Medigap market and even in the HMO market is it is very hard to prevent a smart insurer from engaging in marketing or other risk selection behaviors that discourage those enrollees who are likely to be most expensive from picking their plans.

It is very likely that under most plausible voucher scenarios, the most elderly and lowest income beneficiaries would be at significant risk for either entering or being forced into less desirable arrangements of one sort or another or in fact not being able to get health insurance at an out-of-pocket cost they could afford.

Senator PRYOR. Earlier I stated in our opening statement, this particular Committee has sort of focused in the past decade on quality care and quality assurance. How does HCFA's work right now in quality assurance compare to that of the private sector?

Mr. VLADECK. I'm glad you asked that because I think as discussed earlier, perhaps 15 or 20 years ago, HCFA was in the forefront of developing of health care quality assurance techniques and I think in the last decade, we fell behind. I think some of what we've been doing over the last couple of years has put us back in step with leadership in the private sector as well. In fact, we have been meeting in a number of forums with leading private sector buyers and other private sector organizations to talk about our common concerns and common agendas. I think we are very much on the same wave length and in many instances at the same evolutionary point in measuring quality and where we are going in this direction.

There is a very exciting set of changes going on in this world. We are only beginning to see the first fruits of some of these changes. We have a particular leap to take still in getting the data that everyone now agrees is necessary for continuing quality monitoring. There is a growing area of consensus among ourselves and leading folks in the private sector on the steps we have to take next to get the sort of quality assurance system we need in place.

Senator PRYOR. There is a term floating around here, that arouses curiosity. HCFA has been criticized I think for not using the tools that Congress has granted it to enforce Medicare HMO program standards, and one reason we're told for is that this HCFA considers HMOs to be in some areas their "partners." We've

been told that the Office of Managed Care considers participating HMOs to be their "business partners." What does this mean?

Mr. VLADECK. I think that is accurate in the sense that we have, in our efforts to apply quality improvement principles, focused on our partnership with all the providers of service with whom we do business. The analogy is quite appropriately the way in which automobile manufacturers, for example, have redefined their relationships with their major parts suppliers or the way in which other large manufacturing corporations have redefined their relationships with folks they do business with on a continuing basis.

It means that we do have a common interest, both us and the providers of service in seeing to it that our beneficiaries are satisfied and get very high quality service.

It doesn't in any way, in response to your question, relieve us of any of our obligations or our responsibilities to make sure that our partners are meeting certain basic legal, performance and operational standards and for conditioning continuation of the partnership on their doing so. To the extent that in the past people may not have adequately made that distinction, that is one of the things we've been working very hard educating folks about.

Senator PRYOR. Thank you, sir.

The CHAIRMAN. Thank you, Senator Pryor.

Senator Thompson.

Senator THOMPSON. Do you anticipate, based on all the health care reform talk, a massive influx into these HMOs?

Mr. VLADECK. Senator, it depends on what you mean by massive. Medicare HMO enrollment is currently growing at the rate of about 50,000 people a month. That's a pretty healthy clip. It's probably pretty close to the maximum at the moment that I think we and the HMOs can absorb without some of the dislocation you get in too rapid startup.

If we envision moving millions and millions of people over a period of a year or a year and a half from existing fee-for-service arrangements into managed care, I just don't think it would be either practical or prudent to do that. Could we move from a rate of 50,000 a month to 100,000 a month? If we planned it and put some of the resources in place to do that, we'd have to hold our breath and I'd be really nervous but if we had the kind of lead time and resources, we could do that. Could we move from 100,000 a month to 1 million a month without serious negative consequences, I wouldn't want to be a part of that kind of process.

Senator THOMPSON. I take it there is no real way you can predict, based on what kind of legislation might come out, what the rate of influx might be. Are you looking at various scenarios right now?

Mr. VLADECK. Let me say two things. One is we are very much committed to the notion that Medicare beneficiaries have the health care arrangements of their choice and therefore, if you really believe in customer choice, you never know for sure what the customer is going to choose.

The second thing we know is that the great growth in managed care in the private sector over the last 5 or 6 years has not been in traditional HMOs, it's been in so-called provider organizations, PPOs and in a point of service or open-ended HMOs. We do not

now have legislative authority in Medicare to contract with PPOs. We've talked to a number of members of both parties about changing the law and we would expect as part of any legislative process this year, the range of plans with which we contract would expand very dramatically. That would permit much faster growth in Medicare managed care than would be possible if we only stayed within traditional HMOs.

Senator THOMPSON. I take it that would have implications for your agency in terms of staff?

Mr. VLADECK. We recognize already that over the next few years a significant fraction of the resources that we have devoted to administering Medicare as a fee-for-service program will have to be reallocated, retrained, redeployed. Unfortunately, from the viewpoint of a manager, we don't expect the fee-for-service work to go away either, so we're going to have to essentially have dual sets of competences in many parts of our organization.

Senator THOMPSON. You expressed concern in response to Senator Pryor's question about a voucher system and potential cherry-picking. Do you see any other way to increase utilization of managed care, specifically HMOs other than that, that would not present that particular kind of problem?

Mr. VLADECK. Yes. We believe even under a purely voluntary choice model without the financial pressure of a voucher, we could very significantly increase Medicare, managed care utilization in two ways or as a result of two things. First, we have to offer a much broader range of managed care choices that again the closed HMOs——

Senator THOMPSON. Than you currently have?

Mr. VLADECK. Yes, and we would hope we could have legislation this year to do that and open up the PPOs and these new innovative delivery systems and a whole set of other arrangements.

The second thing is our focus groups and other survey research and the research of others suggests that some of what we're seeing among Medicare beneficiaries is a generational phenomenon and a market-specific phenomenon. In the Portland, Oregon, Seattle and Southern California markets where the private sector has had significant HMO activity for a long time, our beneficiaries are much more familiar with HMOs, much more attracted to them, more likely to enroll.

Similarly, someone who is now in their fifties or early sixties is much more likely to have been in managed care during their working life and to be familiar with it than someone who is currently in their seventies or eighties. Therefore, some of the growth in managed care will just occur as the population ages. Some of that will occur as the private sector penetration spreads. With some lag, the acceptability of managed care arrangements to Medicare beneficiaries will spread. So I think even in a purely voluntary model, without changes and financial incentives as a result of those two forces, we will see these changes in the next decade. We're now at about 10 percent and I would expect if nature takes its course, between 25 and 50 percent without any particular additional pushing or kicking.

Senator THOMPSON. What about as some proposals would do, giving the patient a part of the savings either as part of a voucher

system or I suppose even under the current system, you could do that? How significant do you think that might be?

Mr. VLADECK. Under current law, as I'm sure you know, if an HMO expects to be able to deliver the services to a Medicare beneficiary for significantly less than we pay them, they have to give that back to the beneficiary not in cash but in expanded benefits. We've sort of gone about the issue of whether to cash out that addition over time.

I would feel more comfortable with that proposal if we were a lot more sophisticated than we are now about limiting cherry-picking behavior or at the same time adjusting our payments to plans on the basis of the relative risk of patients. The current state of the art, the opportunity for the fast operator to use manipulation, such as cash incentive, to enroll lots of healthy patients would worry me not in terms of the effect on patients but in terms of our ability to save any money through a device of that kind.

Senator THOMPSON. I'm sure you know Tennessee is in the middle of an experiment for managed care for Medicaid recipients and it's received mixed reviews. Are there any lessons to be drawn from that experience or similar experiences in looking toward increased utilization for Medicare?

Mr. VLADECK. I'm reluctant to draw too many conclusions about Tenn care. In part we expect to have a 100 percent encounter date on the system from the outset; we've had real problems getting the data systems up and running. So we don't have as much information as we'd like or we should have which I think is a lesson in itself.

There were clearly adverse consequences from the speed with which Tenn care was implemented. There was not enough lead time, planning, or education for beneficiaries. Some of the effects in the first 6 months in particular could have been significantly reduced with more lead time and more planning and a more gradual phase-in.

There are two other lessons we have so far. One is that if you have adequate lead time, you can improve access to primary care services for low-income people through managed care mechanisms. I think that has demonstrably happened in parts of Tennessee and that's what Tenn care was all about.

The other lesson that I believe the new administration in Tennessee has taken very much to heart is that under a managed care plan, capitation payments and payments to providers shouldn't be set by fiat. There needs to be a continual negotiation between the payers and the plans. To the extent the plans are acting as agents of physicians and hospitals, you can squeeze down too tight and lose providers from the system or create problems by doing so.

There is more than a budgetary formula involved. There really needs to be a back and forth and a continuous negotiation.

Senator THOMPSON. You are familiar with that system, I can tell.

Mr. VLADECK. I think that is starting to happen there and I think that's helping a lot.

Senator THOMPSON. Thank you.

The CHAIRMAN. Thank you.

Mr. Vladeck, we're going to conclude with you because we've got two more panels. I just want to say one of the problems we've had

over the years with HCFA is a lot of promises have been made—I quoted Senator Heinz from 1987, the same sort of problems that existed in 1987, exists in 1994. Noteworthy as far we're concerned, the staff of the Health Standards and Quality Bureau which is a part of HCFA, told the GAO as recently as December 1994, "Now beyond Florida, we're not aware of a particular strategy of HCFA to look at HMOs in other regions of the country. So this is coming from within HCFA itself in terms of developing an overall, nationwide strategy of dealing with it. So we've got a long way to go before we keep those promises.

Mr. VLADECK. I've been in this job about 2 years now and I believe this is the first opportunity I've had to appear before the Committee. I would very much hope in about a year, you would ask me back and hold our feet to the fire relative to some of these promises.

The CHAIRMAN. What year will your son be at that time?

Mr. VLADECK. He'll be going into his senior year, I'll be around and I look forward to that discussion.

Senator PRYOR. This is a breakthrough. I've never heard HCFA come before the Congress and say please hold our feet to the fire.

The CHAIRMAN. Thank you very much, Mr. Vladeck.

We're next going to hear from Geraldine Dallek, the Executive Director of the Center for Health Care Rights in Los Angeles, a group that provides counseling, education, and legal services to elderly and disabled Medicare beneficiaries in LA County.

Before you begin, in view of the time constraints, I know that my colleagues are going to be leaving soon for other responsibilities, one of the things I'm missing are perhaps some case examples of the kinds of problems that have been exhibited in the HMOs. Perhaps in summarizing your testimony, you could start by giving some specific examples of the kind of problems you have found that HMO beneficiaries have encountered under the system, I'd appreciate it.

Ms. DALLEK. Okay. I'd be happy to.

STATEMENT OF GERALDINE DALLEK, EXECUTIVE DIRECTOR, CENTER FOR HEALTH CARE RIGHTS

Ms. DALLEK. My name is Geraldine Dallek and I'm the Executive Director of the Center for Health Care Rights in Los Angeles. We provide education, counseling, and legal services to approximately 15,000 Medicare beneficiaries annually, funded through our State HICAP Program as well as federal ICA money.

We are the authors of a study in January 1993 on "Medicare Risk Contract HMOs, Looking at Marketing Quality, Due Process Rights," and we are just about to conclude a big study looking at consumer protections in state HMO laws across the country.

HMOs serving the Medicare population can and do provide high quality care to many enrollees. Their growth is testament to that. Approximately 30 percent of Medicare beneficiaries in California are enrolled in HMOs. However, our cases and those of other Medicare advocacy groups throughout the country are reflective of very serious problems in risk contracting plans that really must be addressed, especially if we're talking about wholesaling millions of Medicare beneficiaries into these plans.

We have four areas of concerns. The first relates to marketing, enrollment, and disenrollment. We continue to see misinformed marketing as well as marketing fraud and abuse. There is just no question that this is a continuing problem. After years of experience, we're still getting some cases in southern California. HMOs have been marketing for a long time in our area and we still see problems, but we especially see problems in areas where the beneficiaries have little experience with HMOs, where they have just expanded, in areas of fierce competition for Medicare enrollees and with HMOs who are inexperienced in marketing to this population. We see poorly trained marketing agents, compensation systems that lead to fraud and abuse by marketing agents, lack of information—good, clear information to Medicare beneficiaries. Recent HCFA Region 9 Medicare disenrollment information provides evidence of this problem.

I think it's really terrific that HCFA has released this information. We got information on rapid disenrollment rates in Medicare HMOs, defined as disenrollment within 3 months of enrolling. Somebody enrolls, they find out that they don't like it or that they were misinformed, or they didn't want to be in the HMO in the first place and they disenroll.

In northern California where HMOs are expanding like wildfire, we saw a rapid disenrollment rate average of 55.2 percent of those that voluntarily enrolled in HMOs of voluntary disenrollments, half were within 3 months. That is on average. One plan, Aetna, which is a very large HMO, had a 78.3 percent rapid disenrollment rate. That is astounding and is clear evidence of significant marketing problems. Northern California is reporting the same kinds of stories we were hearing in southern California in the early 1990's. For example, we hear from Medicare beneficiaries that: "The marketing agent just told me I was signing to show that he's been here." Lo and behold, the person is enrolled in an HMO. There is high pressure on monolingual, Spanish-speaking or Asian-speaking Medicare beneficiaries.

In New York, a recent study by the Medicare Beneficiaries Defense Fund showed that of the 12 plans marketing, only 3 had actual materials they could send someone who was Spanish-speaking. A lot of them didn't even have ability to answer questions in Spanish on the telephone.

We're seeing the same kinds of problems we saw in southern California, in New York, northern California, Nevada, and Arizona where HMOs are expanding. It hasn't gone away.

The second problem relates to quality and access. Enrollees have inadequate choice of providers within HMOs and especially within HMO contracting medical groups. The issue sometimes is not the HMO, it's the medical group which contracts with many HMOs. These medical groups often do not have an adequate number of contracting with specialty providers or delay referral services, deny needed care. So when somebody says which HMO is best, the question is which medical group can provide the best services. We constantly get complaints about some medical groups that contract for Medicare beneficiaries and not about others. So we need to look not just at the HMOs but the groups they contract with.

We see delays in obtaining specialty referrals, denials by HMOs or contracting medical groups of high cost services and procedures and I also believe that they use coverage guidelines which are more restrictive than the Medicare coverage guidelines. Nobody is looking at this issue. Medicare pays for all Medicare-covered services.

For example, Medicare covers some home health aide services if the person is also getting skilled home health care. I can't get any data, but we have had HMO marketing people say, "we don't cover home health aide services." I'm willing to bet you the amount of home health aide services provided by HMOs is minuscule. HCFA is paying for that service; HCFA is paying for a certain number of skilled nursing home days but we constantly get HMOs or HMO doctors saying we only cover 2 weeks of skilled nursing care or we only cover 2 weeks of nursing rehabilitation care. Medicare does not have that in their guidelines, so we really need to look at what the internal guidelines of these HMOs are and are they meeting the HCFA guidelines.

We have a lot of problems with certain kinds of care like skilled nursing care, home health care, physical therapy—lots of denials which we believe are absolutely inappropriate. We also have some cases where people are not getting appropriate referrals. One of our recent cases was an elderly man who had vocal cord damage. Everybody absolutely agreed that an operation would give him back his voice. The HMO agreed to the operation and sent him to a surgeon within their medical group who had never performed it before. He was about to disenroll and pay out-of-pocket costs to be able to go to UCLA. Once he got to us, we called the HMO and asked "what's going on here," and within 2 or 3 days, we got approval for out-of-plan claims.

We have another case where somebody was going to have an amputation of a leg because he had diabetes. He went out of plan and discovered there was a wound care center at a large hospital that could save his leg. The particular medical group didn't have a contract with that hospital and was not going to refer him to this group. The same HMO had another group that did have a contract, agreed to provide the wound care, and we got the client in immediately which he couldn't have done without our help. He got the surgery and his leg was saved.

Problems concerning whether HMOs are contracting with appropriate subspecialists arise all the time. The attachment to my testimony has lots of these kinds of cases, both from our program and other HICAP programs in California, and from the New York advocacy program. We need to look at whether there is any systematic underservice going on. I believe there is.

We understand that medical decisions on what is and is not appropriate are often difficult and medicine is not a black and white proposition, but we need data to figure out if the anecdotal stories I can tell you about are the tip of a deep and very large iceberg. I am concerned that they may be.

Nobody comes to us if they are happy with their HMO. They only come with problems. A lot of Medicare patients are clearly getting very good care but we need to look at what's happening to the most vulnerable of those patients and whether they are getting good care.

You've asked lots of questions about the appeals system. It is a disaster. It takes forever to go through the system. In the first two stages of the appeal system, you go to the same group that already said no, who denied the care in the first place. If you have an emergency case, you cannot get help through the appeals system. If someone has been denied rehabilitation care, surgery, what have you, and it's an emergency, you cannot wait 6 months to get through the appeals system.

HMOs and their medical groups are not providing notice when care is denied and if they are providing notice, it is often inadequate. HMOs do a very poor job in my experience of monitoring their medical groups. They are passing down the financial risk, either all of the financial risk or a good part of the financial risk, to the medical groups and then they are not monitoring very well what these medical groups are doing. We have lots and lots of cases associated with the appeals process.

As you've heard already, there is just no good information out there for consumers. It's not available. If you go and adopt a voucher system tomorrow, you will have an incredible disaster on your hands. I promise you that. Even when we know about HMOs in southern California, we still see a lot of misinformed enrollment. I can't imagine what it's going to look like if there's lots and lots of choices and no information to help beneficiaries understand what those choices mean and what plan is best for them.

I know HCFA is working on this, but we cannot adopt something that would push everybody into managed care without first having the data system in place to monitor quality and to get information out to consumers in a user-friendly manner.

Thank you very much.

[The prepared statement of Ms. Dallek follows:]

FEDERAL OVERSIGHT OF MEDICARE HMOS: ASSURING BENEFICIARY PROTECTION

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INTRODUCTION

My name is Geraldine Dallek and I am the executive director of the Los Angeles-based Center for Health Care Rights (CHCR).[1] I appreciate this opportunity to testify on Medicare risk-contract HMOs.

In January 1993, CHCR published the results of a year-long study on marketing, quality of care and due process protections in Medicare risk-contract HMOs (Dallek, *et.al*, 1993). This testimony is based on the study's findings, on a soon to be completed study on consumer protections in state HMO laws across the county (Dallek, *et.al.*, 1995), as well as on CHCR's recent experiences helping Medicare enrollees in HMOs.

Medicare HMOs are a popular alternative to fee-for-service Medicare in California. Approximately 30 percent of all California Medicare beneficiaries are enrolled in risk-contract HMOs. They enroll because HMOs offer them increased benefits, especially prescription drugs, and significantly reduced out-of-pocket costs. HMO enrollees do not have to purchase a Medicare supplemental policy or alternatively pay the Medicare Part A and B deductibles and co-insurance.

HMOs serving the Medicare population can and do provide high quality care to many enrollees. The exponential growth of these plans is testament to the good care they provide. However, the experiences of CHCR's Health Insurance Counseling and Advocacy Program (HICAP) and other HICAP programs throughout California are reflective of very serious problems in the risk-contracting program that must be addressed.

The types of problems we see can be classified into four areas:

- Marketing/Enrollment/Disenrollment;
- Access and Quality;
- Due Process Protections; and

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[1]CHCR is an independent non-profit organization dedicated to ensuring that consumers obtain the medical care services to which they are entitled by law. Through funding from its state Health Insurance Counseling and Advocacy Program (HICAP) grant and Los Angeles County Area Agency on Aging and federal ICA grants, CHCR provides education, counseling and legal services to over 15,000 disabled and elderly Medicare beneficiaries in Los Angeles County. Approximately 40 percent of our work on behalf of Medicare beneficiaries relates to HMOs.

- Lack of Information on Access and Quality.

Appendix A provides a summary of a number of recent cases from Medicare advocacy organizations in California and New York which illustrate these problems.

If the recent activities of HCFA Region IX is any indication, I believe that HCFA is working to address some of the issues raised in this testimony. However, much more needs to be done to adequately protect Medicare HMO enrollees. California is a bell-weather state in the area of Medicare HMOs. As Medicare beneficiaries throughout the nation are encouraged to enroll in managed care plans, especially HMOs, I hope that we can learn from some of the problems seen in California to build a better system of care for America's elderly and disabled.

MARKETING/ENROLLMENT/DISENROLLMENT

Groups representing Medicare enrollees have documented a range of problems with HMO marketing and the enrollment/disenrollment process, including:

- Poorly trained marketing agents;
- Inappropriate financial incentives inherent in the commission-based compensation of marketing agents;
- Marketing fraud/abuse resulting from these first two problems;
- Lack of marketing materials in an enrollee's primary language; and
- HMO delays in disenrolling Medicare members.

Marketing/Enrollment

Several reports have found serious marketing abuse in the Medicare program. In a number of documented instances, HMO employees have lied to prospective Medicare enrollees about the benefits of HMO enrollment, pressured them to join, enrolled individuals who were unable to make an informed enrollment decision and obtained enrollment signatures under false pretenses. (GAO, 1993; Dallek *et. al.*, 1993).

Generally, these problems are especially prevalent in geographic areas where beneficiaries have little experience with Medicare HMOs, in areas of fierce competition for Medicare enrollees, and with HMOs inexperienced in marketing to this population.

Many HMOs pay their marketing agents a commission for each new Medicare enrollee. Without proper training and oversight, this compensation system is a recipe for disaster. For example, in the late 1980s and early 1990s, Los Angeles County Medicare beneficiaries were subjected to massive marketing fraud by one HMO. (Dallek, *et.al.*, 1993). Although HCFA was slow to react to this problem, once the agency took strong action, the HMO changed it agent compensation system and significantly increased agent training and oversight. Today, although marketing problems still exist in Los Angeles County, (see the case of Mrs. B. below), these are more the exception than the rule.

Unfortunately, this is not true in other counties of California, or in other parts of the country. For example, a Santa Cruz County HICAP volunteer recently attended a sales presentation by a large Medicare HMO and found that the representative significantly exaggerated the problems of Medicare fee-for-service. In particular, the sales representative stated that doctors could charge beneficiaries whatever they wished. The example given of fee-for-service Medicare charges was clearly incorrect and grossly inflated. The agent did not know about, or understand, Medicare's physician limiting charge or the 10 standardized Medicare supplemental insurance options available. Appendix A describes several recent cases in which HMO marketing agents misinformed beneficiaries or obtained enrollment under false pretenses.

The following recent cases are representative examples of inappropriate Medicare HMO marketing.

The Case of Mrs. B.

> Mrs. B., an elderly Los Angeles widow with a fifth grade education, received an unsolicited visit from an HMO marketing agent. The agent tried to pressure her into joining by telling her that Medicare would not be in existence much longer. When she told the agent that she was not interested, the representative persuaded her to sign an enrollment form by telling her that it would be used only to verify the agent's visit.

The Case of Mrs. J.

Mrs. J., an elderly Berkeley woman with two previous hip replacement surgeries who does not drive, enrolled in a risk-contract HMO. She believed that she had purchased a Medicare supplemental policy and continued to receive her care from a nearby physicians' group. Medicare subsequently denied her claims. The closest HMO primary care physician was ten miles from her home and inaccessible by public transportation. The local HICAP is appealing the claims denials and requesting retroactive disenrollment.

The elderly, the poor, and monolingual Medicare beneficiaries are especially vulnerable to inappropriate marketing. According to a July 1995 survey by the New York Medicare Beneficiaries Defense Fund, of the 12 HMOs marketing to Medicare beneficiaries in the state, only eight had customer service representatives who speak Spanish, one had to get an ATT interpreter, one used representatives from its Medicaid division and two had no Spanish speakers. *Only three of the 12 plans said they could send information in Spanish on their plans.*

Given these circumstances, it is difficult to understand how Spanish-speaking Medicare beneficiaries in New York can make an informed decision on whether to join an HMO.

Recent HCFA Region IX enrollment and disenrollment data for the first quarter of 1995 provides evidence that HMO's are improperly enrolling Medicare beneficiaries. HCFA analyzed the number of voluntary Medicare disenrollments by plan and the percentage of "rapid disenrollments," defined as disenrollments occurring within the first three months after enrollment (Appendix B).

Some HMOs, especially in Northern California, have extraordinarily high rapid disenrollment rates. For example, Health Net-North had a rapid disenrollment rate of 78.3%. The average rapid disenrollment rate in Northern California, which has recently experienced a dramatic increase in the number of HMOs competing for the lucrative Medicare market was 55.2% compared to 28.5% in Southern California.

Rapid disenrollment is a clear indication that new enrollees were misinformed about what enrollment means, were unable to make an informed decision about enrollment or were in some way inappropriately enrolled. One Northern California HICAP has recently seen a number of cases where an HMO marketing agent asked beneficiaries to sign an enrollment form, claiming that it was just a form to indicate that he/she had talked to the beneficiary (Appendix A).

Uninformed enrollment has very serious consequences. If beneficiaries continue to seek care in the fee-for-service system, they can face extremely high medical bills as neither Medicare nor the HMO will pay for the care received.

HCFA has a system to help these enrollees called retroactive disenrollment, which returns the beneficiary to fee-for-service Medicare effective the first day of HMO enrollment, thus voiding the enrollment altogether. But, our experience is that unless and until the beneficiary learns that they can retroactively disenroll, they become frantic about their unpaid bills, some of which may have gone to a collection agency.

Compared to the Medicare population in most other parts of the country, the California Medicare population is fairly knowledgeable about HMOs and how they operate. Yet we continue to see serious cases of uninformed enrollment. If Medicare HMOs expand rapidly in new areas unfamiliar with "lock-in," "gatekeepers," and other HMO requirements, and if the Medicare population is not adequately educated, I believe we will have a disaster on our hands.

Disenrollment

Compared to the population enrolled in HMOs through the workplace, Medicare beneficiaries have a much greater opportunity to change health care plans or return to the fee-for-service system. Currently, HMO enrollees can disenroll from an HMO either through a Social Security Office or their HMO. Disenrollment is effective the first day of the month following the month the disenrollment form was received. Thus, a beneficiary who disenrolls on July 26 should be back in the Medicare fee-for-service system on August 1.

This procedure presumes, however, that the HMO properly handles the disenrollment request. Recent HICAP cases (Appendix A) indicate that some HMOs may not be handling disenrollments in a timely fashion: disenrollment requests are lost or, according the HMO, never received.

The Case of Mrs. C.

According to Mrs. C., she attended a meeting to learn more about an HMO operating in Ventura County, California. She remembers signing an attendance sheet and nothing more. She says she received more letters inviting her to meetings, but she never went.

In April 1994, Mrs. C. had knee replacement surgery. After the surgery, she received a notice that Medicare denied all claims because she was enrolled in the HMO.

Mrs. C. immediately called the HMO and told them she had never intended to enroll and wanted to be disenrolled. She also requested that the HMO send her a copy of the enrollment form they said she signed. The HMO never responded to this request. With the help of HICAP, Mrs. C. was retroactively disenrolled. In its letter to HCFA requesting retroactive disenrollment, HICAP wrote that "Mrs. C was quite distraught over this turn of event and it appears to be adversely affecting her health."

Unfortunately, some enrollees feel they cannot disenroll because of the high deductibles and co-insurance in Medicare's fee-for-service system. Most HMO enrollees give up their supplemental coverage when they enroll in an HMO. Upon disenrollment, they may find that no insurance company will sell them a supplemental policy. This is a serious problem for beneficiaries who disenroll because they are ill and believe the HMO is not providing them adequate care.

Despite problems associated with disenrollment, the ability to obtain retroactive disenrollment in cases of improper marketing or ill-informed enrollment, and to obtain regular disenrollment the month following the request to disenroll are critical protections for Medicare HMO enrollees.

Recommendations

HCFA should:

- Require all Medicare HMO marketing agents to pass a HCFA required training program and written examination;
- Require HMOs to provide HCFA standardized, easy to read, information at all marketing presentations describing the rules of HMO enrollment, including "lock-in" and requirements for referrals to specialty care;
- Prohibit the payment of commissions to HMO marketing agents if a new enrollee disenrolls within three months of enrollment;
- Require HMOs to verify independently verify individual Medicare HMO enrollments within three days of each enrollment;
- Require Medicare HMOs to forward to the state all complaints received by the HMO concerning Medicare marketing and the results of the HMO's investigation of those complaints;
- Strongly enforce marketing rules through fines against the HMO for each confirmed case of marketing fraud;
- Require revocation of a marketing agent's license the third time a financial penalty is imposed for improper marketing;
- **Retain current disenrollment rights whereby disenrollment is effective the first day of the month following the month the disenrollment form is received and procedures for retroactive disenrollment;**
- Require Medicare HMOs to update their provider list (including specialty providers, nursing homes and home health agencies) monthly and to distribute this list to all prospective enrollees; and

- Require HMOs to develop marketing materials in the primary language of the enrollee.

ACCESS AND QUALITY

Risk-contract HMOs operate differently from fee-for-service (FFS) medicine. The structure of these two health delivery system create different financial incentives. In the Medicare FFS system, the incentive is to provide a high number of services, some of which may be unnecessary and harmful. The more care given and procedures done, the more money made.

The opposite financial incentives–to provide less care–operate in the HMO system. A system that puts providers at financial risk for expensive medical treatment inherently contains incentives to deny or delay needed care (GAO, 1989). We know little about the relationship of financial risk in HMOs (who is at risk, for how much, and for what services) and patient care outcome.

Medicare beneficiaries sign up not only with a specific HMO, but also with the HMO's contracting medical group. It is the medical group that often makes the decisions to provide or deny care.

The types of access and quality of care problems experienced by Medicare HMO enrollees who call CHCR and other California HICAPs for help fall into distinct patterns:

- Inadequate choice of providers within HMO contracting medical groups; and
- Delays in obtaining specialty referrals;
- Denials by HMOs and/or their contracting medical groups of high cost services and procedures, especially skilled nursing home care, rehabilitation services and home health care.

Access to Physician Services

Access depends on the capacity of HMO contracting provider groups to serve members who have enrolled in their group – too few providers, too many enrollees, or lack of geographically accessible primary and specialty providers will compromise access.

Generally, CHCR's clients have not faced major problems in finding a primary care physician. However, it has recently come to our attention that because some primary care physicians enroll more HMO patients they can handle, they hire other physicians to handle their case load. Thus, although an HMO enrollee may have signed up with Dr. X, he or she is consistently referred to Dr. Y. for care.

A second problem for enrollees occurs when their primary care physician leaves the group or the group no longer contracts with the HMO. Enrollees are not given adequate notice or help in choosing an alternative provider.

Third, HMO listings of contracting primary care physicians are sometimes out-of-date. Either the physician's practice is full or he or she no longer contracts with the HMO or the medical group. In these instances, Medicare beneficiaries who join a particular HMO because they hope to obtain care from a specific physician are out of luck.

A far more serious problem, however, relates to access to specialty providers and services. The primary care medical group may only contract with a limited number of specialists, none of whom have expertise in the beneficiary's problems.

For example, one major Medicare HMO in Southern California offers members a choice of provider groups in several geographic areas. The group serving the Northridge area of Los Angeles County includes two specialists each in endocrinology and in hematology/oncology and one each in neurology, surgery, obstetrics/gynecology, ophthalmology, cardiology, allergy/immunology, gastroenterology, urology, orthopedics and pulmonary diseases. Individuals who enroll in this group and need specialty care have a no or a very limited choice of providers from whom to seek services (Mitchell, 1995).

Some specialists may not have expertise in a particular medical condition. For example, if the only neurologist in the group is not familiar with MS, an enrollee with this condition may not get the care he/she requires.

Often, the medical group refuses to refer the patient to an out-of-plan provider, or even another medical group which contracts with the same HMO.

The following case from CHCR's HICAP files illustrates this problem. Other cases can be found in Appendix A.

The Case of Mr. R.

Mr. R. called CHCR's HICAP when his HMO refused to approve his request for out-of-plan surgery, and Mr. R. was awaiting an answer to his written appeal of the denial. At the time, Mr. R. was considering disenrolling from the HMO.

Mr. R.'s primary care physician had recommended thyroplastic surgery to regain the use of his voice due to a damaged vocal cord. Although the HMO group approved the surgery, it sent him to a surgeon who had never performed the type of surgery needed. The group informed Mr. R. that it had no other in-plan surgeon qualified to perform thyroplasty and refused to refer him outside the group.

After several days of telephone calls with Mr. R's primary care physician and the HMO's member services department, HICAP was able to obtain approval for Mr. R.'s out-of-plan surgery.

To reduce unnecessary care, HMOs and their subcontracting medical groups establish utilization review and referral systems. Primary care physician serve as "gatekeepers." These gatekeepers often must obtain authorization for referrals to specialty services. In addition, utilization review systems constantly monitor the length of time a patient receives a particular service (such as skilled rehabilitation, hospital or home health care).

An HMO's referral system may make it difficult for enrollees to obtain care from non-contracting providers, even when these services are not available in the HMO or subcontracting medical group. Moreover, HMO contracting physician groups and IPAs often will not provide enrollees with referrals to specialty physicians and hospitals which contract with the same HMO but are not members of the particular group or IPA.

The Case of Mr. R.

Mr. R. is a 72-year-old Los Angeles Medicare beneficiary who has diabetes and problems with circulation in his lower limbs due to vein blockage. This resulted in a partial amputation of his foot in November 1994. Because of continuing problems, his primary care physician recommended amputation of his foot and lower leg to just below the knee. He received a second opinion from another physician in the same medical group. No alternative to the amputation was mentioned by either physician.

Upon hearing that a less radical alternative to amputation might be possible, Mr. R. sought the opinion of an out-of-plan physician at the Wound Care Center of a large Los Angeles hospital. The doctor suggested that Mr. R. have vein bypass surgery (revascularization) immediately to save his leg. Although Mr. R.'s medical group did not contract with a hospital that could perform this surgery, another medical group contracting with Mr. R.'s HMO did have a contract. Mr. R. tried to transfer to this second group, but was told he could not transfer until the end of the month, an unacceptable delay given the emergency nature of his condition.

After contacting CHCR's HICAP program (which in turn contacted the California Department of Corporations asking for immediate intervention), the HMO transferred Mr. R. to the second medical group and he obtained the needed surgery within the week. He is currently doing well and remains able to walk.

"Physicians Who Care" charge that some HMOs or contracting medical groups purposely do not contract with specialists with expertise in certain conditions or procedures and then refuse to authorize out-of-plan care for patients who need this expertise. This was true in one well-publicized case in California. Following an HMO's refusal to refer a young girl for appropriate treatment for her Wilm's tumor, the California Department of Corporations fined an HMO $500,000 for failure to provide appropriate care and failure to demonstrate that its refusal was not affected by fiscal considerations. The physician whom the HMO had originally assigned to perform the surgery had previously neither operated on children nor on a Wilm's tumor. (Wagner, 1995, Johnson, 1994).

Access to Skilled Nursing Home, Rehabilitation and Home Health Services

Advocates who represent the interests of elderly and disabled Medicare HMO enrollees report a pattern of HMO denials for appropriate skilled nursing facility, rehabilitation or home health services, sometimes explaining to enrollees or family members that they may be able to obtain these services if they disenroll from the HMO and rejoin the fee-for-service system (Dallek *et. al.*, 1993; *Grijalva et al. v. Shalala*, 1993). Take the cases of Mr. W. and Mrs. J.

The Case of Mr. W.

Mr. W's son called CHCR's HICAP when his father was given a notice that he was no longer eligible for Medicare-covered skilled nursing home care and the physical therapy provided him following a stroke. Mr. W's HMO physician told Mr. W's son that the HMO "never provided more than two weeks of skilled nursing home coverage." It was not clear from the written notice given to Mr. W. whether the HMO's subcontracting medical group was retroactively denying coverage for the skilled care already received or informing Mr. W. that additional care would not be provided. Moreover, the notice did not specify why care would not be covered, simply stating that "this determination was based upon our understanding and interpretation of Medicare covered policies and guidelines." The notice failed to meet Medicare's most basic notice requirements.

Following-up for Mr. W., HICAP called the nursing home's physical therapist, who reported that Mr. W. was still "making progress" and had "not plateaued," a requirement for continued Medicare covered physical therapy. HICAP asked the HMO to investigate why its contracting medical group terminated what appeared to be medically necessary care. Within two days, the medical group called Mr. W's son informing him that physical therapy was being resumed and that the medical group would pay for the two weeks of skilled care already received. The medical group, which has contracted with several Medicare risk HMOs for a number of years, claims it inadvertently sent the wrong notice to Mr. W.

The Case of Mrs. J.

Mrs. J's son contacted the Contra Costa County HICAP regarding his 88-year-old mother's HMO's refusal to pay for skilled nursing care following a stroke. The HMO authorized payment for her first 20 days in the facility from 10/5/94 to 10/24/94. The plan sent the patient a letter stating it would no longer pay for her stay beginning 10/25/94 stating that "the care you are receiving...no longer meets Medicare guidelines or [the HMO's] guidelines for skilled nursing facility care." No specific reason for the termination of services was given in the notice, as is required by Medicare.

The nursing home staff informed the beneficiary's son that his mother's condition would continue to meet Medicare's SNF guidelines because she required daily skilled nursing and rehabilitation services. The son felt he had no choice but to disenroll his mother from the HMO effective November 1, 1994. As expected, Medicare approved payment for her continued SNF stay until her 100 days of benefits were exhausted.

Medicare requires risk-contracting HMOs' to provide all Medicare covered benefits. The capitated rate paid to Medicare risk-contract HMOs is calculated on the basis that all Medicare covered benefits will be provided. Nevertheless, CHCR and other HICAPs have encountered scores of cases where an HMO appears to have established its own more restrictive coverage guidelines.

Problems sometimes result from HMO staff ignorance concerning Medicare coverage guidelines.

The Case of Dr. L.

Dr. L. is an HMO physician who called HICAP because she was unable to obtain approval for physical therapy for one of her Medicare patients. The plan's utilization reviewer claimed that physical therapy was not a Medicare covered benefit and no amount of argument could convince her otherwise. Dr. L. asked HICAP for a copy of relevant Medicare regulations and guidelines regarding physical therapy and was finally able to get her patient the therapy she ordered.

Groups representing Medicare beneficiaries recognize that decisions on what is and is not appropriate or medically necessary care are often difficult. Medicine is not a black and white proposition. Often, after an investigation of enrollee complaints, CHCR finds that the HMO's or contracting medical group's denial of care is appropriate.

However, based on the types of client complaints received by CHCR and other groups representing Medicare HMO enrollees, I believe that risk arrangements result in some provider groups denying high-cost but appropriate medical services. This is especially true for expensive services such as physical therapy, home health care and skilled nursing facility care. One home health executive told CHCR that, given the number of HMO enrollees in one HMO contracting medical group, she expected to see 450 home health visits each month; instead, the group ordered an average of only 60 visits per month.

In a recent survey of Medicare HMO enrollees and disenrollees, most beneficiaries stated that they were treated well by their HMOs or primary doctors. However, disenrollees rated their quality of health lower than that of enrollees and reported a much greater decline in health status during their HMO enrollment (OIG, 1995).

HMOs which violate Medicare HMO rules seem to do so with impunity. To my knowledge, HCFA has never fined an HMO for failure to provide medically necessary care. Recently, Foundation Health Corporation did halt enrollment of new Medicare enrollees in California following a HCFA monitoring report which indicated serious problems with its quality assurance plan, its data collection system, and Medicare appeal's system. However, the action was taken voluntarily, not at HCFA's request (Philp, 1995, HCFA Region IX, 1995) .

HCFA should be more willing to use its sanction authority to make it clear to plans that there will pay a price for failure to provide appropriate care (GAO, 1992). "Money does talk."

Recommendations

HCFA should:

- Require HMOs (and/or) their subcontracting medical groups to have contracts with a full range of specialty providers who have expertise in the problems faced by disabled and elderly Medicare enrollees;

and

- Require HMOs to pay for out-of-plan providers (including "centers of excellence") with expertise not available in the HMO;
- Establish detailed standards and procedures for referrals to both contracting and non-contracting physicians and other providers, including maximum waiting times for a referral;
- Establish maximum times in which a referral decision must be made not to exceed ten working days except for potentially serious conditions or urgent situations, in which case referrals must be made within two working days;
- Review annually all Medicare risk-contract HMO's internal coverage guidelines to ensure that they are not more restrictive than Medicare coverage rules;
- Require Medicare supplemental insurance companies to allow Medicare enrollees who drop their insurance when they enroll in an HMO to repurchase the insurance if they do so within the first three months of enrollment;
- Require HMOs to offer Medicare enrollees a point-of-service plan;
- Compare information with other state regulatory agencies with HMO oversight responsibility; and
- Fine HMOs which fail to provide appropriate care or fail to monitor their contracting medical groups to ensure that they provide Medicare covered benefits.

THE HMO APPEAL'S PROCESS

Because Medicare beneficiaries are "locked-in" to their HMOs, their right to appeal a denial of care is crucial. Although Medicare's five step appeals process[2] appears to be

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[2]Organizational determination, HMO reconsideration, HCFA review (done by HCFA's contractor Network [illegible] Group), Administrative Law Judge, Appeals Council and quite extensive, it does not meet HMO enrollees' needs for the following reasons:

- Medicare beneficiaries are often not aware of their appeal rights (OIG, 1995);
- HMOs (or their contracting providers groups) often do not provide Medicare enrollees with a notice when care is denied; nor do they inform enrollees that they have a right to appeal that denial. When notice is provided, it is often inadequate;
- The appeal's process is too lengthy (the first two steps of the appeal's process take a minimum of 120 days) and provides no help in emergency situations where delays in care could result in significant harm;
- The first two steps of the appeal's process are internal reviews within the HMO--the organization which denied (or refused to pay for) the services in the first place; and
- HMOs often fail to meet Medicare appeal time lines.

When faced with poor quality care, or denial or delays in access to care, the Medicare HMO enrollee's only choices are either to work through the lengthy HMO appeals system or to disenroll.

Coverage of Out-Of-Plan Claims/Meeting Appeal Time Lines

Medicare risk-contract HMOs must, by law, provide their Medicare enrollees with all of the medical care that would be covered by Medicare in the traditional fee-for-service (FFS) system. This includes paying for out-of-plan care that enrollees receive in emergency situations or when enrollees are out of the HMO's geographic area and need care urgently. This requirement also includes paying for out-of-plan services for Medicare-covered care that the HMO failed or refused to provide.

Medicare HMO enrollees experience serious difficulties in obtaining coverage for out-of-plan emergency and out-of-area urgent services. Despite strong HCFA oversight in this area, CHCR continues to find that some plans do not process claims in a timely manner. For example, HCFA's July 1994 audit of one large California Medicare HMO found the plan extremely deficient in this area:

> "[The HMO's performance in this area declined dramatically from the last monitoring visit. The current review disclosed 14 of 23

Federal Court.

> clean claims were paid late. Only 9 claims or 39% were paid within 30 days. This standard was also cited during the last monitoring visit" (HCFA Region IX, 1994).

The problem of unpaid claims often lies with an HMO's subcontracting medical groups. For example, during the HMO's monitoring visit, HCFA was unable to evaluate claims processing timeliness for two of three contracting medical groups visited because the groups were unable to even produce unaffiliated provider claims.

The Case of Mr. K.

While traveling in Texas, Mr. K. became ill and was admitted to a Texas hospital for what was later diagnosed as congestive heart failure. The HMO gave approval for the emergency and hospital care received. While still in Texas following discharge, Mr. K. obtained two follow-up visits for the same condition. The HMO denied claims for these visits.

Mr. K. contacted CHCR's HICAP which submitted a reconsideration request with the HMO. Within the 60 days required by Medicare, the HMO responded to the claim, denying coverage. However, the HMO failed to notify HICAP, Mr. K's legal representative, as was required. Moreover, although the HMO was automatically required to send the denied claim to National Design Group (NDG, HCFA's contractor responsible for all HMO reconsiderations requiring HCFA review), it failed to do so for five months. Following reconsideration, NDG found in favor of Mr. K.

Recent HCFA Region IX data indicate that some California and Arizona Medicare HMOs still do not automatically send denied claims to NDG within the required 60 days (65 days including 5 days for mailing). Of the 21 plans, four did not meet this requirement. The average for one plan was 123 days (See Appendix B).

Inadequate Notice of Appeal Coverage Denials and Appeal Rights

Despite years of experience with Medicare, a number of HMOs in California and/or their subcontracting medical groups do not meet Medicare requirements for notifying enrollees when a service is denied or terminated. Even when a denial notice is given, it is often inadequate (see Appendix A)..

Some Medicare HMOs in New York are even failing to provide notices when claims are denied reports the Medicare Beneficiaries Defense Fund:

The Case of Mrs. F.

Mrs. F. a 92 year-old California Medicare beneficiary and a member of a Medicare HMO, entered a nursing home following hospitalization for congestive heart failure. At the SNF, she received physical therapy five days a week and a skilled nurse monitored her unstable medical condition. For these reasons, Mrs. F. clearly met Medicare SNF coverage guidelines. However, Mrs. F.'s HMO denied the coverage, claiming the services did not fit Medicare's definition of "skilled services."

The HMO did not give Mrs. F. a written denial explaining her appeal rights. Following an appeal by MBDF, the HMO was required to cover the majority of Mrs. F.'s nursing facility stay. However, because the appeals process was so lengthy, the SNF illegally transferred Mrs. F. out of the SNF to a county infirmary.

Like Mrs. F., many Medicare HMO enrollees are unaware of their appeal rights. The recent Office of Inspector General's survey of HMO enrollees and disenrollees found that two-thirds of disenrollees criticized the lack of information on appeal rights and the effectiveness of HMO care and access to services. (OIG, 1995).

Lack of Provisions for Expedited Review in the Appeals Process

Perhaps the greatest problem with the appeal system is that it does not generally include a mechanism for expedited, independent review outside the HMO in situations where delays in care could result in serious harm. The only exception is for hospital discharge cases where the HMO enrollee can appeal to the Peer Review Organization (PRO) for review if he or she feels the discharge is premature.

The Case of Mrs. S.

Mrs. S. is a 73-year-old Medicare beneficiary in Los Angeles suffering from chronic pulmonary disease. In December 1993, while visiting her daughter in San Diego, Mrs. S. required emergency hospitalization at a non-HMO hospital that placed her on a ventilator to help her breathe. Her non-HMO attending physician recommended placing her in an acute rehabilitation hospital for aggressive respiratory therapy so that, in time, she could be weaned from the ventilator and return home.

Despite the attending physician's opinion that her condition would prove fatal if she were placed in long-term care facility that could not provide the therapeutic services she required, the HMO refused to approve the transfer and offered, instead to move her to a less costly nursing facility that did not offer such services.

CHCR's HICAP spent two frustrating days trying to

convince the HMO that Mrs. S. needed to be weaned from the ventilator, but the HMO refused to transfer her to the acute rehabilitation facility. Only after CHCR advised the HMO's officers that its attorney would appear in court the following morning to obtain a temporary restraining order did the HMO approve Mrs. S.'s transfer to the appropriate facility.

Although CHCR was able to help Mrs. S. obtain appropriate care, without the program's assistance, she might well have been transferred to a nursing home, where she would have remained while her appeal slowly made its way through the system.

CHCR will soon release a study of consumer protections in state HMO laws across the country. In this survey, we have found four states which have recently enacted legislation to require expedited review in some types of HMO cases. Other states provide for direct appeal to the state agency which is responsible for HMO operations in the state (Dallek, *et.al.*, 1995).

The ability of Medicare beneficiaries to get help if urgently needed care is denied should not be dependent on whether they are lucky enough to live in an area served by a HICAP or other Medicare advocacy group.

HMO physicians too need greater appeal protections. Some HMOs have issued "gag" orders on their physicians prohibiting them from making any negative comments about the HMO (Sacramento Bee, 1995). Moreover, physicians can be "deselected" from the HMO or medical group without any due process protections.

Recommendations

HCFA should:

- **Establish its own expedited review process independent of the HMO for cases in which the denial of care could result in significant harm. In these situations, the HCFA mandated review should be conducted with 48-72 hours.**

- Issue intermediate sanctions, including monetary sanctions, on HMOs and contracting medical groups when they fail to provide beneficiaries with legally required due process;

- Limit the time an HMO may take to review an enrollee appeal internally and allow the enrollee to appeal to HCFA (NDG) directly if the complaint is not resolved within a reasonable period of time; and

- Make HMOs financially responsible for all claims if the HMO fails to provide an enrollee with a written denial that includes information on how to appeal

LACK OF DATA ON QUALITY AND ACCESS

Advocates for Medicare enrollees understand that it is difficult to argue from anecdotal stories. Often, however, it is all we have. We don't know if the cases cited here are isolated instances of a health care system which consistently provides appropriate care to Medicare enrollees or whether they are the tip of a very large and very deep iceberg.

To make these judgements we need more data. CHCR 's Medicare HMO study (Dallek, *et.al.*, 1993) included an analysis of HMO hospital utilization data obtained from California's PRO. This analysis found a significant difference in hospitalization rates for specific DRGs -- including a six-fold difference in the rates of heart bypass surgery -- among the three largest Medicare risk-contract HMOs in California. Because of questions about the accuracy of the hospital HMO utilization data, CHCR did not reveal the names of the HMOs. Instead, it recommended that HCFA strengthen its enforcement of hospital reporting requirements so we could again analyze the data. To date, this has not be done.

I know that HCFA has been making significant efforts to institute a Medicare HMO data collection and analysis system to help us determine how well HMOs do in providing care to the Medicare population. HCFA regions IX's recent release of enrollment and other information is another indication of the agency's commitment to providing Medicare beneficiaries with the information they need to make informed decisions about their health care. CHCR applauds these efforts. Of greater import, Medicare beneficiaries applaud these effort.

In addition to the collection process and outcome data, HCFA needs to improve its complaint reporting system. Currently, HCFA receives few calls concerning HMOs from Medicare beneficiaries, primarily because Medicare HMO enrollees do not know that they can call HCFA or the PRO with a complaint (Appendix B).

The most common question asked by Medicare beneficiaries who want to join an HMO is "which one is best?" Right now we don't have an answer for them. Often the issue is not which HMO is best, but which contracting medical group will provide the best care. Unfortunately, we have found that HMOs provide inadequate oversight of the actions of the contracting medical groups.

As we all know, "managed competition" will only work if health care consumers have information about quality as well as cost. Yet Congress is considering financing schemes that will force millions of elderly and disabled beneficiaries into managed care plans without the information they need to decide what type of health care is best for them.

Recommendations

HCFA should:

- Require HMOs to report utilization data, including data on nursing home days, home health visits and rehabilitation services;
- Require HMOs to provide information on their referral process including the number of referrals denied and the reasons for these denials;
- Require HMOs to report the number of organizational determinations and HMO reconsiderations which were wholly or partially in favor of enrollees;
- Provide greater information to enrollees concerning their rights to complain to HCFA and the PROs;
- Establish a more systematic system of collecting and analyzing complaints to HCFA; and
- Continue reporting enrollment/disenrollment and other data to community groups and continue working on a system to obtain process and outcome data for all Medicare HMOs.

CONCLUSION

The beneficiaries described in this testimony and in Appendix A received help from Medicare advocates. However, for each person helped through California's HICAP and the other programs serving Medicare beneficiaries, there are hundreds more HMO enrollees with similar problems who also need assistance.

This is why we need systemic solutions to the problems described.

Providing care to healthy Medicare beneficiaries is easy. However, Medicare HMOs should be judged on how well they care for the sick, the disabled and the chronically ill.

No one in this age of extremely high health care costs will argue that HMOs should be required to provide "futile" care. However, we cannot accept the proposition that medical care to improve quality of life must be abandoned.

HMOs claim that they are much more heavily regulated than fee-for-service medicine. They are right. However, I think we all recognize that states and the federal government did a lousy job of protecting health care consumers from poor quality providers in the fee-for-service system, including from the provision of too much care.

Because we did a lousy job of protecting consumers in fee-for-service medicine is not an argument that we should do an equally lousy job of protecting consumers enrolled in HMOs. Moreover, fee-for-service patients could seek care elsewhere if they believed they were not well served by the provider. This is not the case for HMO enrollees.

Many in Congress are proposing a sea change in the way that Medicare beneficiaries receive their health care. I urge that you think carefully before making these changes. There is no "magic" solution or "quick fix" to Medicare's ills. Questions have been raised by a number of research groups on whether enrolling Medicare beneficiaries in HMOs even saves money.

Medicare is a success story, albeit an expensive one. It promised to provide the elderly and disabled, no matter how rich or how poor, no matter how healthy or how sick, with equal health care, and it has kept that promise. Some of the proposals being considered today will result in a separate and unequal Medicare system for low-income Medicare beneficiaries and will deny the promise of Medicare to generations to come.

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APPENDIX A

CASES FROM THE FILES OF THE CENTER FOR HEALTH CARE RIGHTS, OTHER HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAMS (HICAPS) IN CALIFORNIA AND THE NEW YORK MEDICARE BENEFICIARIES DEFENSE FUND

MARKETING/ENROLLMENT/ DISENROLLMENT

Case # 1

A San Diego beneficiary with recurring skin cancer enrolled in an HMO *after assurances from the HMO sales representative that he could continue to see a dermatologist for this condition.* After the appearance of another lesion he requested referral to a dermatologist. The primary care physician examined the lesion but did not believe a referral was needed. The beneficiary became alarmed and returned to his former dermatologist who promptly surgically removed the lesion. He appealed and coverage was denied because the care was not urgent and had not been authorized by the plan.

Case # 2

An elderly woman attended a meeting to learn a little more about HER local HMO. She remembers signing an attendance sheet and nothing more. She says she received more letters inviting her to meetings, but never went. Sometime in February, she and her regular (non-HMO) doctor arranged for knee replacement surgery on April 4, 1994. After her surgery, Medicare denied all payment because she had enrolled in the HMO. She immediately called the HMO and told them she had never intended to enroll and wanted to be disenrolled. She also requested that they send her evidence of her enrollment request. This was not done.

The woman is quite elderly and at times confused. She has absolutely no recollection of ever enrolling in the HMO, never used any HMO providers, and continued to pay her Medicare supplemental insurance premiums. She does not know when her enrollment became effective and is quite distraught over this turn of events, which appeared to be adversely affecting her health. Her request for retroactive disenrollment was approved.

Case # 3

According to Mrs. S. she attended a meeting to learn about an HMO and later had a saleswoman that she had met at that meeting come to her home. After being assured that she would continue to receive the psychological help that she needed, she signed an enrollment form.
As soon as the saleswoman left, Mrs. S. had second thoughts and called the saleswoman's office, asking her not to process the application until she could talk to her. Mrs. S. left the same message the following day and, getting no response to either message, sent a letter with the same request.

Later, the saleswoman called and informed Mrs. S. that her enrollment would be effective April 1, 1994. Again, Mrs. S. reiterated that she did not want to be enrolled. When a bill came for Mrs. S.'s premium, she mailed it back with a note stating that she had canceled her enrollment. Mrs. S. then received a phone call from Foundation explaining that she was enrolled as of March 1, and that she could no longer use her regular Medicare. She was very upset by this news and again made arrangements to disenroll. Her disenrollment was effective April 1, 1994.
The local HICAP submitted a request for Retroactive Disenrollment on her behalf to cover the costs of her out-of-plan care.

Case # 4

According to Mrs. R., she signed an enrollment form on October 25, 1994 with an effective date of enrollment on January 1, 1995. Mrs. R. changed her mind about enrolling in the plan and on November 15, 1994, sent a letter requesting immediate disenrollment. In March, 1995 believing that she was not enrolled in the plan, Mrs. R.'s physician referred her to a neurosurgeon for tests. Medicare denied her claim because she was enrolled in an HMO. Mrs. R. then contacted the HMO and was given a disenrollment request form and told her disenrollment would be effective May 1, 1995. She later received a telephone call informing her that her disenrollment date would actually be June 1, 1995. With the help of HICAP, Mrs. R. obtained retroactive disenrollment.

Case # 5

Mr. & Mrs. B. attempted to disenroll from their local HMO effective December 1, 1994. However, there was apparently a problem with the disenrollment and it was not actually effective until February. Because Mr. & Mrs. B. believed that the disenrollment was effective, they went to out-of -plan providers. According to the B.'s they were told that the mistake was the responsibility of the HMO and therefore the HMO would be responsible for the payment of the out-of-plan claims. However, the B's continued to be billed for these claims. The local HICAP was working to clear up the problem.

Case # 6

Mrs. A. went to the her HMO's office on July 1, 1994, requesting that she be disenrolled. She was told that the disenrollment would be effective on August 1, 1994. At the time she was given a copy of the REQUEST FOR DISENROLLMENT form from the HMO.

On July 10 and July 14 her HMO sent her letters advising her that she had been granted authorization to see several specialists. She saw those specialists in July 1994, believing she was still enrolled in the HMO. She was later notified by the specialists that the HMO had denied payment because she had been disenrolled effective July 1, 1994. With the help of her local HICAP,. the HMO paid the referral claims.

Case # 7

Mrs. B., an elderly widow with a fifth grade education, received an unsolicited visit from an HMO marketing agent. The agent tried to pressure her into joining by telling her that Medicare would not be in existence much longer. When she told the agent that she was not interested, the representative persuaded her to sign an enrollment form by telling her that it would be used only to verify the agent's visit.

disenroll when she moved to another state because she believed that her HMO was a Medigap policy. MBDF appealed her case to the regional HCFA office which granted Mrs. H. retroactive disenrollment from her HMO. Medicare then reprocessed and paid for the St. Louis physician's services.

Case # 8

Mr. P. and his wife live in New York have both Medicare and a supplemental policy. While visiting relatives in Florida, Mr. P. was visited at his relative's house by an HMO representative. Impressed by the low cost of the policy and swayed by the representative's sales tactics, Mr. P. signed papers that day. He and his wife were promptly enrolled in the Florida HMO. He did not drop his supplemental policy, nor did he understand that they were now members of a risk-contract HMO which required that they stay in Florida. Thinking that he simply had a new Medicare supplement, Mr. and Mrs. P. saw doctors outside of the HMO network for two months before Medicare began to send denials stating that they were enrolled in an HMO.

Case # 9

Mr. F., a native Spanish-speaker, was enrolled in a New York risk-contract Medicare HMO but received no literature in Spanish from the HMO explaining the rules of his contract. When the HMO failed to provide adequate care for Mr. F.'s severe knee pain, Mr. F. went to an out-of-plan doctor for knee replacement surgery. He did not realize he would be responsible for out-of-plan claims. His HMO denied coverage, saying the procedure was elective and he did not obtain prior authorization from the HMO. Mr. F., because of the language barrier, never understood the way his HMO worked until after he was hit with huge hospital and doctor's bills. The Medicare Beneficiaries Defense Fund (MBDF) appealed the HMO's denial of coverage and requested retroactive disenrollment for Mr. F. The appeal was decided against Mr. F., and MBDF is still waiting to hear whether or not retroactive disenrollment can be applied in Mr. F.'s case.

Case # 10

An elderly Berkeley woman with two previous hip replacement surgeries who does not drive was enrolled in an HMO. She believed that she had purchased a Medicare supplemental policy and continued to receive her care from a local physicians' group. Medicare denied her claims because of the HMO enrollment. The closest HMO primary care physician to this woman was ten miles away and inaccessible by public transportation. The local HICAP is appealing and requesting retroactive disenrollment.

Case # 11

A 76 year-old Riverside man's HMO doctor advised him that he needed surgery that the HMO was unlikely to approve. When he received a flyer from another HMO in the mail he responded and the HMO sent someone out to sign him up. Shortly thereafter his doctor called saying that the first HMO had approved his surgery after all. This beneficiary called the second HMO immediately and formally disenrolled. He then had the scheduled surgery. Later his claims were denied by the first HMO because of his enrollment in the second HMO. HICAP contacted HCFA and his enrollment in the first HMO was reinstated.

Case # 12

Nine Oakland Medicare-Medicaid beneficiaries were enrolled in an HMO. They subsequently disenrolled because their doctors were not contracting HMO providers. In all nine cases the marketing agents failed to explain the lock-in provision and the requirement to use network providers.

ACCESS AND QUALITY

Case # 13

A beneficiary's son contacted HICAP regarding his 88 year old mother's HMO's refusal to pay for skilled nursing care following a stroke. The HMO authorized payment for her first 20 days in the facility from 10/5/94 to 10/24/94. The Plan sent the patient a letter stating it would no longer pay for her stay beginning 10/25/94 stating, "the care you are receiving...no longer meets Medicare guidelines or [plan] guidelines for skilled nursing facility care." No specific reason, as is required, was given for the denial. The nursing home staff informed the beneficiary's son that his mother's condition would continue to meet Medicare's SNF coverage guidelines because she required daily skilled nursing and rehabilitation services. The son felt he had no choice but to disenroll his mother from the HMO effective November 1, 1994. As expected, Medicare approved payment for the beneficiary's stay in the SNF and continued payment for her stay until her 100 days of benefits were exhausted.

Case # 14

An 80-year-old woman, was refused services in a Medicare HMO that she had previously received as a covered Medicare benefit in the fee-for-service sector. She was required by her retirement health plan to switch from an HMO's cost plan to its risk plan. While a member of the cost HMO, the beneficiary used her Medicare benefits outside the system to obtain foot surgery. Following the surgery she received Medicare benefits for fairly extensive physical therapy and four weeks of home health care including a nurse and home health aide. When she had similar surgery as a HMO risk member, she was refused physical therapy and was told the HMO would not pay for such therapy until she is ready to walk. She has been in a wheel chair for the past six months and reports her muscles are losing strength while she waits to qualify for therapy. She received only limited home health care which consisted of a few visits from a nurse. She was refused a home health aide and told, "you have a competent adult at home and don't need anymore help." This "competent" adult is her 85-year-old husband with very poor vision who could not assist her.

The HMO refused to provide Medicare covered benefits and to provide a valid notice of non-coverage. This elderly beneficiary was unaware of her right to appeal, unaware of any grievance process available through the HMO, and unable to pursue these rights on her own.

Case # 15

A terminal cancer patient in Northern California with a Grade III decubitus ulcer was denied coverage by Kaiser in a skilled nursing facility. The family contacted HICAP. Kaiser retroactively covered the stay and continued benefits for the remaining month of his life.

The HMO refused to provide Medicare covered services until the intervention of a third party, and failed to adequately review the medical records before denying coverage.

Case # 16

A San Diego beneficiary went to her HMO's urgent care center and was told that there were many people waiting and only one doctor on duty. The beneficiary was instructed by staff to go to the local emergency room. The HMO subsequently denied the claim for emergency room care because the care was not authorized. An appeal is pending.

Case # 17

Mr. and Mrs. H. faced a difficult problem. Mr. H. was a diabetic and had severe ulcers on his feet. He was a member of Medicare risk-contract HMO, and his primary care physician had prescribed a treatment regimen that was proving ineffective.

In January 1994, at Mrs. H's urging, Mr. H.'s primary physician requested the HMO's approval for Mr. H. to go out-of-plan to a local wound center that specialized in diabetic wound treatment. The HMO denied the request, stating that an HMO contracted participating physician could be found to treat Mr. H.'s condition. Concerned that Mr. H.'s wounds were showing no signs of improving, Mrs. H. decided to seek non-HMO treatment for her husband, even though she would have to pay for the services out-of-pocket.

The following month, Mrs. H. Contacted the Center for Health Care Rights' HICAP to see if there were anything that could be done to help with the wound center costs. They discovered that the wound center contracted with a Medicare risk-contract HMO other than the one to which she and her husband belonged. She quickly disenrolled Mr. H. from the first HMO and enrolled him in the second. Mrs. H. then asked CHCR to appeal the first HMO's initial denial of authorization for Mr. H. to go out-of-plan for diabetic treatment.

The HMO denied the appeal and the case was automatically referred to Network Design Group (NDG), a consulting firm that reviews Medicare HMO appeals for HCFA. NDG overturned the HMO's denial because Mr. H. had, in fact, needed more specialized care than he had been receiving at the HMO. After reviewing the medical records of Dr. L., Mr. H.'s HMO primary physician, NDG found that: "Dr. L.'s office notes...do not indicate that specialized care through a plan provider was discussed."

With CHCR's assistance, Mr. H.'s original HMO will pay for the more than $5,000 worth of services he received at the wound center. Best of all, due to the wound center's treatment, Mr. H.'s wounds have healed significantly and he is able to walk again.

Case # 18

Mr. R. called CHCR's HICAP when his HMO refused to approve his request for out-of-plan surgery and Mr. R. was awaiting an answer to his written appeal of the denial. Mr. R.'s primary care physician had recommended thyroplastic surgery to regain the use of his voice due to a damaged cord. Although the HMO group approved the surgery, it sent him to a surgeon who had never performed the type of surgery needed. The group informed Mr. R. that it had no other in-plan surgeon qualified to perform thyroplasty.

After several days of phone calls with Mr. R.'s primary care physician and the HMO's member services department, CHCR was able to obtain approval for Mr. R.'s out-of-plan surgery.

Case # 19

Mr. W.'s son called CHCR's HICAP when his father was given a notice that he was no longer eligible for Medicare-covered skilled nursing home care and the physical therapy provided him following a stroke. Mr. W.'s HMO physician told Mr. W.'s son that the HMO never provided more than two weeks of skilled nursing home coverage. It was not clear from the written notice given Mr. W. Whether the HMO's subcontracting medical group was retroactively denying coverage for the skilled care already received or informing Mr. W. that additional care would not be provided. Moreover, the notice did not specify why care would not be covered, simply stating that "this determination was based upon our understanding and interpretation of Medicare coverage policies and guidelines."

Following up for Mr. W., HICAP called the nursing home's physical therapist, who reported that Mr. W. Was still "making progress" and had "not plateaued," a requirement for continued Medicare covered physical therap. HICAP asked the HMO to investigate why its contracting medical group terminated what appeared to be medically necessary care. Within two days, the medical group called Mr. W.'s son informing him that physical therapy was being resumed and that the medical group would pay for the three weeks of skilled care already received. The medical group, which has contracted with several Medicare risk HMOs for a number of years, claims it inadvertently sent the wrong notice to Mr. W.

Case # 20

Dr. L. is an HMO physician who called HICAP because she was unable to obtain approval for physical therapy for one of her patients. The plan's utilization reviewer claimed that physical therapy was not a Medicare covered benefit and no amount of argument could convince her otherwise. Dr. L asked HICAP for a copy of relevant Medicare regulations and guidelines regarding physical therapy. With this material, Dr. L. was finally able to get her patient the therapy she ordered.

Case # 21

Mrs. C. Was enrolled in an HMO in the New York City area. When she noticed that she had a skin lesion that was potentially cancerous, she went to see her primary care physician and asked for a referral to see one of the HMO's dermatologists. The primary care physician told Mrs. C. that she would arrange for the referral. Mrs. C. had to wait almost two weeks for an appointment with the dermatologist, only to find out once there that her primary care physician had not arranged for a referral after all, and so the dermatologist would not see her. Five weeks later, after several phone calls and two trips to the primary physician's office, Mrs. C. had still not been able to see the dermatologist. MBDF staff advised her to file a complain with the NYS Department of Insurance, and with the HMO. Mrs. C. filed both complaints and, frustrated by the long waits, disenrolled from the HMO. She is now in another HMO and receiving the necessary care.

Case # 22

Mrs. F., a 92 year-old Medicare patient and a member of a Medicare HMO, entered the hospital this spring for congenital heart failure and a number of other medical problems. She was discharged directly to a skilled nursing facility where she received physical and occupational therapy five days a week. Her unstable medical condition was also monitored by a skilled nurse. For these reasons, Mrs. F. clearly met federal Medicare guidelines for coverage of a skilled nursing facility stay. However, Mrs. F.'s HMO denied Mrs. F.'s coverage because it claimed that the services she received in the nursing facility did not fit Medicare's definition of "skilled services" and were therefore not covered.

Records show that Mrs. F. never received a written denial from the HMO explaining her appeal rights. MBDF staff appealed the HMO's denial on Mrs. F.'s behalf. After several months of negotiations with the HMO, HCFA, and staff at the nursing facility, MBDF received notification that the HMO would be required to cover the majority of Mrs. F.'s nursing home stay. Because the appeals process was so lengthy, however, the skilled nursing facility illegally transferred Mrs. F. out of the nursing home to a county infirmary.

Case # 23

Mrs. L. Is an insulin-dependent diabetic who has multiple sclerosis, arthritis, and is blind in one eye. She is a member of a Medicare HMO in New York City area. Mrs. L. began a home health care program after returning home from the hospital where she had been an inpatient for congestive heart failure. She received physical therapy and home health aide services three times a week through a Medicare certified home health agency contracted by her HMO.

At the end of a month, Mrs. L.'s primary care physician denied approval for continuation of Mrs. L.'s home health care program. Mrs. L.'s physical therapist wrote a letter to the physician stating that while Mrs. L. had shown improvement during the course of therapy, she continued to need physical therapy so that her maximum functional capabilities could be realized. Mrs. L. never received a written denial from her HMO, nor was she informed of her appeal rights. It became clear from MBDF staff's conversations with HMO representatives that they did not understand that a pre-service denial must be issued in writing. MBDF appealed on behalf of Mrs. L., and after several months the HMO agreed to continue Mrs. L. on a physical therapy program.

Case # 24

Mrs. W. had both Medicare and Medicaid benefits when she decided to join a Medicare HMO in order to have easier access to physicians. Shortly after joining, she suffered a stroke and entered the hospital. Upon discharge from the hospital, her HMO struggled to find her a bed in one of its contracting skilled nursing facilities. Eventually the HMO places Mrs. W. in a SNF inconvenient to her family, in an area of the city which afforded very little parking, making it difficult for her family to visit her. The family promptly disenrolled her from her HMO.

Case # 25

Mr. A. Lives outside of his Medicare HMO's service area. He had been a member of the HMO as an employee for years, and was allowed to stay in the HMO's Medicare division after retiring, even though he had moved outside the service area. Mr. A. may need dialysis shortly and his HMO is threatening not to cover the dialysis unless it is performed in one of the HMO's facilities. This means Mr. A. will have to travel hundreds of miles every week in order to receive coverage for his care. Mr. A. cannot afford to disenroll from his HMO, so he is moving in order to ensure that his dialysis will be covered without having to travel far from home.

Case # 26

Mr. P., a Medicare HMO enrollee, has a serious heart condition which his HMO did not feel they could treat. His HMO referred him to an out-of-network cardiologist for ongoing treatment. The cardiologist billed Mr. P. for more than a thousand dollars. When his wife called the HMO to inquire how much they would reimburse him, she was told that they would approve the same amount that fee-for-service Medicare would approve, which was substantially less than what the physician had billed. The cardiologist, however, held Mr. P. liable for the full billed amount, which Mr. P has since paid in full. Mr. P does not wish to pursue the matter with either the physician or with his HMO because he is still receiving treatment and is afraid that the cardiologist will refuse to continue to treat him.

APPEAL'S SYSTEM

Case # 27

An HMO in Alemeda County, California provided no coverage for the skilled nursing facility care a Medicare enrollee needed. Nor did it provide a written notice of non-coverage as required by Medicare law. An NDG reconsideration determination found that the HMO had failed to give adequate notice of non-coverage for skilled nursing care and required the HMO to pay the family for the denied care. Until the family came to HICAP, they did not know they could appeal the decision of non-coverage nor did they have an idea of how to do so.

Case # 28

An NDG reconsideration determination found that an HMO in northern California incorrectly denied skilled nursing care benefits for an Alameda beneficiary with a Grade II decubitus ulcer on her coccyx that required daily dressing changes. Medical records also revealed that this patient had lower leg edema requiring close monitoring, and that she was receiving intramuscular injections of Morphine which requires close, skilled observation.

The daughter believed her mother's condition was so serious that Medicare could not possibly deny coverage for skilled care. She had no information on any appeals or grievance process, nor any idea of how to challenge the HMO. She paid the nursing home for the denied care. Four months after the care was denied, the HMO paid the enrollee's family for the cost of her nursing home care.

Case # 29

An HMO in Sacramento denied skilled nursing home coverage to an 80 year old woman after covering 20 days of care. The HMO's notice failed to include the reason that care was no longer covered by Medicare. Nursing home staff informed the family that the required care met the Medicare guidelines for continued skilled care. The family disenrolled the woman from the HMO and Medicare continued to cover the stay for the remainder of the 100 days benefit.

The HMO cut off benefits for Medicare covered services, and failed to provide a valid notice of non-coverage. The fact that the remaining 80 days qualified for coverage under fee-for-service Medicare is evidence that a skilled care need existed. The family was unaware of any HMO appeal rights available to them until they came to HICAP. An appeal has recently been filed.

Case # 30

A San Diego beneficiary fell, breaking her finger and injuring her back. She was taken by ambulance to an non-member hospital and treated. The claim was denied by the HMO and her bill sent to collection.

The claim was appealed by HICAP and immediately reversed after medical records were supplied to the HMO. The HMO failed to adequately review the circumstances of this claim and denied coverage without obtaining the medical information necessary to make such a determination. This beneficiary was unable to pursue and appeal on her own and suffered financial hardship and emotional distress when her bills were sent to collection.

Case # 31

Ms. S. is a 73-year-old Los Angeles Medicare beneficiary suffering from chronic pulmonary disease (a lung disorder).

In December of 1993, while visiting her daughter in San Diego, Ms. S. Required emergency hospitalization at a non-HMO hospital that placed her on a ventilator to help her breathe. Her non-HMO attending physician recommended placing her in an acute rehabilitation hospital for aggressive respiratory therapy so that, in time, she could be weaned from the ventilator and return home.

Despite the attending physician's opinion that her condition would prove fatal if she were placed in long-term care facility that could not provide the therapeutic services she required, the HMO refused to approve the transfer and offered, instead to more her to a less costly nursing facility that did not offer such services.

Mrs. S.'s family contacted CHCR's HICAP and staff spent two frustrating days convincing the HMO that Ms. S. needed to be weaned from the ventilator. However, although the HMO finally acknowledged the need to wean Ms. S. from the ventilator, it still would not authorize transferring her to an acute rehabilitation facility. Only after CHCR advised the HMO's officers that it would appear in court the following morning to obtain a temporary restraining order, did the HMO approve Ms. S's transfer to the appropriate facility.

Case # 32

While traveling in Texas, Mr. K. became ill and was admitted to a Texas hospital for what was later diagnosed as congestive heart failure. The HMO gave approval for the emergency and hospital care received. While still in Texas following discharge, Mr. K. obtained two follow-up visits for the same condition. The HMO denied claims for these visits. HICAP, Mr. K's legal representative, submitted a reconsideration request. Within the 60 days required by Medicare, the HMO responded to the claim, denying coverage. However, the HMO failed to notify HICAP of its decision. Moreover, although the HMO was required to automatically send the denied claim to NDG, it failed to do so for five months. Following reconsideration, NDG found in favor of MR. K.

Case # 33

Mr. P., a member of a risk-contract HMO in New York, was visiting his daughter in Florida when, on Christmas Eve, he began experiencing severe difficulty breathing. He was rushed to the hospital and, as instructed on the HMO card, a family member immediately called from the hospital to notify the HMO that Mr. P. was having emergency treatment out of the HMO's service area. After Mr. P. returned to New York, his HMO informed him that none of the treatment would be covered because the HMO had not been notified within 48 hours of the emergency. The HMO claimed to have no record of anyone calling.

MBDF informed Mr. P. that Medicare HMOs cannot deny benefits solely because the HMO was not notified of the out-of-plan treatment. Therefore, even if no one had called to report Mr. P.'s emergency, the HMO is not allowed to deny coverage for that reason. MBDF is working to obtain full coverage for Mr. P's out-of-area care.

— APPENDIX B —

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Refer to: ORA-MCO-JC

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CHCR

Region IX
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JUL 7 1995

REGIONAL OFFICE HMO/CMP LETTER 95-06

SUBJECT: Region IX HMO Data - FYI

There has been increased interest for data pertaining to Medicare contracting HMOs. In response to that interest, we will be distributing, on a quarterly basis, data in three separate areas: disenrollment; reconsideration; and beneficiary inquiries.

Attached are reports in each of these areas for the first quarter of 1995: HCFA Region IX Disenrollment Reports; Report of HMO/CMP Reconsideration Activity; and HCFA Region IX Risk HMO Beneficiary Inquiry Tracking System (BITS) Review. The BITS is an internal inquiry tracking system used by the Regional Office.

I hope you find these reports useful. If you have any questions regarding these reports, please contact Julia Cohen at (415) 744-3625 or your HCFA Regional Office liaison.

Sincerely,

Elizabeth H. Foley, Director
Managed Care Operations

Attachments

HCFA REGION IX - DISENROLLMENT REPORT - 1ST QUARTER 1995
(RAPID DISENROLLMENT RATES)

EXPLANATION: Rapid disenrollments are those disenrollments taking place in the first three months after enrollment. The percent of rapid disenrollments for a plan should be compared to the market area average.

		ALL DIS-ENROLLMENTS*	ALL RAPID DISENROLLMENTS	% RAPID
ARIZONA				
H0303	FHP	2228	284	12.7%
H0307	HUMANA - PHOENIX	830	248	29.9%
H0350	MARICOPA	63	37	58.7%
H0351	INTERGROUP	694	311	44.8%
H0352	PARTNERS ARIZONA	240	74	30.8%
H0354	CIGNA	578	197	34.1%
	ARIZONA MARKET AREA	4633	1151	35.2% AVG
NORTHERN CALIFORNIA				
H0547	AETNA HEALTH PLAN	631	136	21.6%
H0569	PACIFICARE OF CA	1760	1034	58.8%
H0562	HEALTH NET - NORTH	1496	1171	78.3%
H0566	HEALTH PLAN OF THE REDWOODS	165	50	30.3%
H0568	NATIONAL MEDICAL ENTERPRISES	164	35	21.3%
H0570	HEALTH NET - CENTRAL VALLEY	226	134	59.6%
H0577	PRUCARE	85	72	84.7%
H0583/84	KAISER	1894	999	52.7%
H0586	FOUNDATION HEALTH - SAC	286	158	55.2%
	NO. CALIFORNIA MARKET AREA	6706	3789	51.4% AVG
SOUTHERN CALIFORNIA				
H0523	AETNA HEALTH PLAN	1653	283	17.1%
H0524/26	KAISER	2064	267	12.6%
H0543	PACIFICARE	7369	1073	14.6%
H0546	INTERVALLEY	425	51	12.0%
H0554	CAREAMERICA	1261	466	37.0%
H0557	FOUNDATION HEALTH	1041	428	41.1%
H0558	MAXICARE	84	39	46.4%

HCFA REGION IX - DISENROLLMENT REPORT - 1ST QUARTER 1995
(RAPID DISENROLLMENT RATES)

EXPLANATION: Rapid disenrollments are those disenrollments taking place in the first three months after enrollment. The percent of rapid disenrollments for a plan should be compared to the market area average.

		ALL DIS-ENROLLMENTS*	ALL RAPID DISENROLLMENTS	% RAPID
H0563	HEALTH NET-VAN NUYS	756	292	38.6%
H0564	CALIFORNIACARE	2	0	0.0%
H0570	PRUCARE	104	60	57.7%
H0581	CIGNA	96	53	55.2%
H9010	UNITED HEALTH PLAN	912	221	24.2%
H9030	FHP	6811	1158	17.0%
H9104	SCAN (RISK DEMO)	473	122	25.8%
	SO. CALIFORNIA MARKET AREA	23051	4503	28.5% AVG
NEVADA				
H2931	HEALTH PLAN OF NEVADA	639	274	42.9%
H2949	FHP	539	126	23.4%
	NEVADA MARKET AREA	1178	400	33.1% AVG

* DOES NOT INCLUDE INVOLUNTARY DISENROLLMENTS (IE. DUE TO DEATH OR LOSS OF PART B ENTITLEMENT).

HCFA REGION IX - DISENROLLMENT REPORT - 1ST QUARTER 1995
(MEMBERSHIP TO DISENROLLMENT RATE COMPARISON)

EXPLANATION: The percent of disenrollments in the area should be compared to the percent of membership in the area.

		MEMBERSHIP (AVG)	% OF MEMBERSHIP IN AREA	% OF DISENROLLMENTS IN AREA
H0564	CALIFORNIACARE	79	0.0%	0.0%
H0576	PRUCARE	1,121	0.1%	0.6%
H0581	CIGNA	6,978	0.9%	0.4%
H9016	UNITED HEALTH PLAN	12,280	1.6%	4.0%
H9030	FHP	203,793	26.5%	29.5%
H9104	SCAN (RISK DEMO)	7,383	1.0%	2.1%
		768,971		
NEVADA				
H2931	HEALTH PLAN OF NEVADA	20,080	55.0%	54.2%
H2949	FHP	16,458	45.0%	45.8%
		36,537		

HCFA REGION IX - DISENROLLMENT REPORT - 1ST QUARTER 1995
(MONTHLY DISENROLLMENT PERCENTAGE)

EXPLANATION: The average monthly disenrollment percentage should be compared to the market area average.

		MEMBERSHIP (AVG)	ALL DIS-ENROLLMENTS*	AVG MONTHLY DISENROLLMENT PERCENTAGE
ARIZONA				
H0303	FHP	83,897	2228	0.9%
H0307	HUMANA - PHOENIX	15,169	830	1.8%
H0350	MARICOPA	1,001	63	2.1%
H0351	INTERGROUP	23,182	694	1.0%
H0352	PARTNERS ARIZONA	11,849	240	0.7%
H0354	CIGNA	23,191	578	0.8%
	ARIZONA MARKET AREA	158,299	4633	1.2% AVG
NORTHERN CALIFORNIA				
H0547	AETNA HEALTH PLAN	22,683	631	0.9%
H0559	PACIFICARE OF CA	48,927	1760	1.2%
H0562	HEALTH NET - NORTH	42,080	1496	1.2%
H0566	HEALTH PLAN OF THE REDWOODS	6,486	165	0.8%
H0568	NATIONAL MEDICAL ENTERPRISES	8,262	164	0.7%
H0570	HEALTH NET - CENTRAL VALLEY	4,500	225	1.7%
H0577	PRUCARE	986	85	2.9%
H0583/84	KAISER	81,453	1894	0.8%
H0586	FOUNDATION HEALTH - SAC	7,745	286	1.2%
	NO. CALIFORNIA MARKET AREA	223,127	6706	1.3% AVG
SOUTHERN CALIFORNIA				
H0523	AETNA HEALTH PLAN	49,787	1653	1.1%
H0524/26	KAISER	144,605	2064	0.5%
H0543	PACIFICARE	263,175	7369	0.9%
H0545	INTERVALLEY	14,212	426	1.0%
H0554	CAREAMERICA	26,663	1261	1.6%
H0557	FOUNDATION HEALTH	7,185	1041	4.8%
H0558	MAXICARE	1,258	84	2.2%

HCFA REGION IX - DISENROLLMENT REPORT - 1ST QUARTER 1995
(MONTHLY DISENROLLMENT PERCENTAGE)

EXPLANATION: The average monthly disenrollment percentage should be compared to the market area average.

		MEMBERSHIP (AVG)	ALL DIS-ENROLLMENTS*	AVG MONTHLY DISENROLLMENT PERCENTAGE
H0663	HEALTH NET-VAN NUYS	30,473	756	0.8%
H0564	CALIFORNIACARE	79	2	0.8%
H0578	PRUCARE	1,121	104	3.1%
H0581	CIGNA	6,978	96	0.5%
H9016	UNITED HEALTH PLAN	12,280	912	2.6%
H9030	FHP	203,793	6811	1.1%
H9104	SCAN (RISK DEMO)	7,363	473	2.1%
	SO. CALIFORNIA MARKET AREA	768,971	23051	1.6% AVG
NEVADA				
H2931	HEALTH PLAN OF NEVADA	20,080	639	1.1%
H2949	FHP	16,458	539	1.1%
	NEVADA MARKET AREA	36,537	1178	1.1% AVG

* DOES NOT INCLUDE INVOLUNTARY DISENROLLMENTS (IE. DUE TO DEATH OR LOSS OF PART B ENTITLEMENT).

Medicare HMO/CMP Reconsideration Timeliness Report:
Report of Region 9 HMO Timeliness in Sending Cases to NDG
Cases Received During First Quarter, 1995

14:49 Thursday, April 20, 1995

PLAN	N Cases	N Missing	Min	Max	Mean Days Bene Req-Receipt NDG	N Cases W/in 60 Days	N Cases	N Missing	Min	Max	Mean Days HMO Decision -Receipt NDG
H0303 FHP - AZ	36	0	19	85	43.306	30	36	0	5	55	15.7222
H0307 HUMANA AZ	31	0	9	89	55.419	27	31	0	2	9	4.2903
H0351 INTERGROUP	13	0	41	214	81.769	6	13	0	3	94	32.0000
H0352 Partners AZ	1	0	54	54	54.000	1	1	0	1	1	1.0000
H0354 CIGNA AZ	15	1	36	123	78.067	4	11	5	3	49	16.3636
H0523 AETNA/S CA	59	2	7	139	59.322	43	16	45	2	98	53.7500
H0524 KAISER/LA	26	0	30	285	72.846	15	26	0	6	149	28.7308
H0543 PACIFICARE	81	1	8	58	31.457	81	80	2	3	17	7.6000
H0545 INTER VAL	9	0	6	108	43.667	7	6	3	7	84	24.5000
H0547 AETNA/W CA	11	1	19	72	47.455	9	11	1	2	82	24.7273
H0554 CAREAMERCA	25	0	3	62	46.160	23	21	4	4	66	16.4286
H0559 PACIFICARE	2	0	28	40	34.000	2	2	0	6	10	8.0000
H0562 HEALTH NET	2	0	57	61	59.000	1	2	0	3	36	19.5000
H0563 HEALTH NET	5	0	22	69	54.800	3	5	0	1	53	17.8000
H0566 HP REDWOODS	6	0	46	60	55.167	6	6	0	13	34	22.0000
H0583 KAISER/OK	1	0	53	53	53.000	1	1	0	10	10	10.0000
H2931 HP NEVADA	13	0	33	98	49.923	11	13	0	12	42	23.1538
H2949 FHP - NV	6	0	43	72	58.333	4	4	2	2	42	25.2500
H9016 UNITED HP	1	0	123	123	123.000	0	1	0	19	19	19.0000
H9030 FHP - CA	53	4	12	112	37.264	51	46	11	3	57	11.0217
H9104 SCAN HP	1	0	59	59	59.000	1	1	0	14	14	14.0000

The key column in this report is "Mean Days Bene Req-Receipt NDG." This column reflects the average amount of time it took for cases to arrive at NDG measured from the date the appeal was received at the plan. HCFA regulations require that plans process all cases within 60 days of receipt. Allowing 5 days for mailing, no case should be received by NDG beyond 65 days.

HCFA REGION IX RISK HMO BITS REVIEW FOR 1ST QTR

15-May-95

PIC#	PLAN	BITS INQ	CODE 12'S*	CODE 31'S*	CODE 37'S*	TOTAL MBRS (AVG)	INQ/PER 1000 MBRS	31'S/PER 1000 MBRS	37'S/PER 1000 MBRS
ARIZONA									
H0303	FHP, INC.-ARIZONA	201	1	5	0	83897	2.40	0.06	0.00
H0307	HUMANA	20	0	0	0	15169	1.32	0.00	0.00
H0350	MARICOPA	8	0	1	0	1001	7.99	1.00	0.00
H0351	INTERGROUP	79	0	0	0	23192	3.41	0.00	0.00
H0352	PARTNERS - ARIZONA	41	1	0	0	11849	3.46	0.00	0.00
H0354	CIGNA	46	0	2	1	23191	1.98	0.09	0.04
TOTAL - ARIZONA MARKET AREA		395	2	8	1	158299	2.50	0.05	0.01
NORTHERN CALIFORNIA									
H0547	AETNA NORTH	24	0	5	3	22683	1.06	0.22	0.13
H0559	PACIFICARE	76	0	11	15	48927	1.55	0.22	0.31
H0562	HEALTH NET	49	0	3	3	42080	1.16	0.07	0.07
H0566	HPR	2	0	1	0	6486	0.31	0.15	0.00
H0568	NME	6	0	2	2	8262	0.73	0.24	0.24
H0569	TAKE CARE	19	0	0	0	4118	4.61	0.00	0.00
H0570	HEALTH NET-VAN NUYS	10	0	0	0	4505	2.22	0.00	0.00
H0577	PRUCARE	2	0	0	2	986	2.03	0.00	2.03
H0579	TAKE CARE-SAC	1	0	0	0	752	1.33	0.00	0.00
H0583/84	KAISER NORTH	110	1	52	38	81453	1.35	0.64	0.47
H0586	FOUNDATION - SAC	20	0	3	7	7745	2.58	0.39	0.90
H0595	LIFEGUARD	3	0	3	0	160	18.75	18.75	0.00
TOTAL - NO. CALIFORNIA MARKET AREA		322	1	80	70	228157	1.41	0.35	0.31
SOUTHERN CALIFORNIA									
H0523	AETNA HEALTH PLANS	61	0	1	7	49787	1.23	0.02	0.14
H0524/26	KAISER - LA/BAKERSFIELD	133	0	11	23	144605	0.92	0.08	0.16
H0543	PACIFICARE OF CA, LA	206	1	28	11	263175	0.78	0.11	0.04
H0545	INTERVALLEY	10	1	0	1	14212	0.70	0.00	0.07
H0554	CAREAMERICA	24	0	4	3	26663	0.90	0.15	0.11

* CODE 12 - Inappropriate Care Received; CODE 31 - Inappropriate Enrollment; CODE 37 - Failure to Disenroll

HCFA REGION IX RISK HMO BITS REVIEW FOR 1ST QTR

15-May-95

PIC#	PLAN	BITS INQ	CODE 12'S*	CODE 31'S*	CODE 37'S*	TOTAL MBRS (AVG)	INQ/PER 1000 MBRS	31'S/PER 1000 MBRS	37'S/PER 1000 MBRS
H0557	FOUNDATION HEALTH	41	0	2	19	7185	5.71	0.28	2.64
H0558	MAXICARE	1	0	0	0	1258	0.79	0.00	0.00
H0563	HEALTH NET-VAN NUYS	35	1	1	3	30473	1.15	0.03	0.10
H0564	CALIFORNIACARE	3	0	0	3	82	36.59	0.00	36.59
H0576	PRUCARE	3	0	1	1	1121	2.68	0.89	0.89
H0581	CIGNA	4	0	0	4	6978	0.57	0.00	0.57
H9018	UNITED HEALTH PLAN	8	0	2	2	12280	0.65	0.16	0.16
H9030	FHP, INC.-CALIFORNIA	153	3	12	0	203793	0.75	0.06	0.00
H9104	SCAN (RISK DEMO)	10	0	4	1	7363	1.36	0.54	0.14
TOTAL - SO. CALIFORNIA MARKET AREA		692	6	66	78	768975	0.90	0.09	0.10
HAWAII									
H1203	HMSA	6	0	1	0	29210	0.21	0.03	0.00
H1230	KAISER -HONOLULU	1	0	0	1	12975	0.08	0.00	0.08
TOTAL - HAWAII MARKET AREA		7	0	1	1	42185	0.17	0.02	0.02
NEVADA									
H2931	HPN-LAS VEGAS	60	0	0	0	20080	2.99	0.00	0.00
H2949	FHP	55	1	1	0	16458	3.34	0.06	0.00
TOTAL - NEVADA MARKET AREA		115	1	1	0	36538	3.15	0.03	0.00
RISK PLAN TOTALS FOR REGION IX									
ARIZONA MARKET AREA		395	2	8	1	158299	2.50	0.05	0.01
NORTHERN CALIFORNIA MARKET AREA		322	1	80	70	228167	1.41	0.35	0.31
SOUTHERN CALIFORNIA MARKET AREA		692	6	66	78	768975	0.90	0.09	0.10
HAWAII MARKET AREA		7	0	1	1	42185	0.17	0.02	0.02
NEVADA MARKET AREA		115	1	1	0	36538	3.15	0.03	0.00
ALL MARKET AREAS		1531	10	156	150	1234164	1.24	0.13	0.12

* CODE 12 - Inappropriate Care Received; CODE 31 - Inappropriate Enrollment; CODE 37 - Failure to Disenroll

The CHAIRMAN. Thank you very much, Ms. Dallek.

Basically, are you finding a situation where you have these so-called, boiler room operations, where people move in and start hustling the HMO plans by telling beneficiaries that Medicare is going to be nonavailable to you, you'd better get into this HMO right away, it provides the following things?

Ms. DALLEK. In southern California, where we've had a lot of experience with Medicare HMO, we don't see that kind of blatant marketing problem. I have heard it's going on in northern California and other places, Ventura County. You do have some cherry-picking in the sense that if I were a Medicare beneficiary and I wanted a free breakfast every morning, I could go to an HMO presentation around LA County. They also hold square dances.

I did go to a number of Medicare HMO presentations in southern California and did find misrepresentation but it wasn't blatant. I didn't notice anybody at those presentations who were in a wheelchair. However, I've never had a complaint come into my office that I'm aware of where the client said the HMO won't enroll me. The issue is once they are in an HMO and you are disabled, are you going to get referrals.

If you have MS, are you going to get a referral to a neurologist who is familiar with MS, especially if there is only one neurologist signed up with the medical group and he may not have this particular expertise? If the beneficiary is not getting the kind of subspecialty expertise that he or she needs, they are going to disenroll. The OIG study showed that people who felt they were sicker were disenrolling at much higher rates.

The CHAIRMAN. Have you done any of the inquiries yourself or conducted any concerning that high rate of disenrollment ranging from 55 percent to 78 percent in one case? Did you ask why did you get in and why are you getting out?

Ms. DALLEK. There are several issues. One, there was improper enrollment, there was either fraud or abuse, or beneficiaries were misinformed, or they just don't understand. We still have clients who will say I thought I was purchasing a Medicare supplemental policy, and I'm not sure whether it's the marketing agent's fault. Sometimes it could be the client's misunderstanding. We've had clients who were blind who were enrolled, who had Alzheimer's who enrolled. That goes on but not as much in southern California. Again, I think it's a very significant problem in areas where HMOs are expanding. We need to be very proactive in those areas.

The CHAIRMAN. A number of the private plans have what they call point of service options that a participant can elect, if you pay an extra cost, to go outside that network of providers. Is that something we should consider?

Ms. DALLEK. That is one of my recommendations and I feel strongly that it will be a help, but not for the low-income seniors who don't have disposable income. If you talk about getting rid of beneficiary's right to disenroll when they are unhappy and their right to retroactive disenrollment, this is a problem. Right now if we see an enrollment that was improper or the beneficiary didn't understand the terms of HMO enrollment, we can get something called retroactive disenrollment from HCFA meaning that the beneficiary can go back into fee for service as if they'd never been in

the HMO. What happens, if they are inappropriately enrolled, they go to their old providers, they continue to get fee for service, and they may have hospital and doctor bills of thousands of dollars which nobody will pay for. Sometimes by the time they come to us, those bills have been sent to collection and the beneficiary is being sent threatening letters and so forth. It's quite frightening for them.

Right now, we can get retroactive disenrollment or we can get disenrollment the following month but I know you're talking about doing away with retroactive disenrollment and also doing away with disenrollment the following month a person applies for disenrollment. I think that would be very problematic.

Point of service plans will be a help but not for the lowest income folks.

The CHAIRMAN. During this appeals process, if you go to your HMO and say you'd like the following procedure, but it's not covered or you don't have a qualified specialist and you want to go outside, they deny that, you then seek treatment outside the plan, you appeal the decision of denial and it can take 6 months or longer and during that time you've got the people who provided the service pressing you for payment?

Ms. DALLEK. Right. What happens if you're a low-income person who doesn't have the money to go out of plan to begin with? Those people just don't have any options. If someone calls us, we can call the HMO. We have the hotlines of all the HMOs, we know who to call, we know who to contact, we know how to get the case investigated. And we send cc letters to the Department of Corporations, and HCFA. If it's a good case, and half the time we talk to client's and their family and after investigation we determine they the HMO decision was appropriate, but if we think there is a good case, we can generally help that client. Oftentimes they come to us well after the crisis and then it's an issue of getting payment for out of plan claims which can take forever.

The CHAIRMAN. Thank you very much.

Senator Pryor.

Senator PRYOR. There's a debate as to whether or not we should have an annual disenrollment period or a monthly disenrollment period. We have monthly now. Is this accurate?

Ms. DALLEK. Yes.

Senator PRYOR. Which do you prefer?

Ms. DALLEK. The monthly. If you have this kind of marketing fraud or misinformed enrollment because Medicare beneficiaries just don't understand HMOs and what it means to join, they're going to be stuck in there for a year. I think changing the rules will be a disaster. I understand that is an option people in the working population do not have, but this is a very vulnerable population and some of them are not able to maneuver within HMOs and can't get the care they need within this system.

Senator PRYOR. Thank you.

The CHAIRMAN. Senator Thompson.

Senator THOMPSON. Have you done any examining of why people go into the HMOs, what do they see there? I'm not talking about the ones who quickly become dissatisfied for whatever reason. What is your research on that?

Ms. DALLEK. It's all anecdotal, I don't have the money to do a big survey of Medicare beneficiaries. What we see is a 20-percent increase in Medicare HMO enrollments in California, a very large increase. They are going in primarily for two reasons—the extra benefits that our HMOs in southern California offer, especially prescription drugs—some of our clients have prescription drug costs of $1,000 to $2,000 a year—and the money it saves. They no longer have to buy a supplemental policy and they don't have to pay any cost-sharing—the cost-sharing is minimal. Again, that's in southern California. Some HMOs do charge higher premiums in other parts of the country. Beneficiaries are enrolling because it saves them a fair amount of money.

We go out and make presentations to the community and there are always people who say, I'm in HMO X and they have given me wonderful care and many of them have gotten terrific care. They've had their bypass, had no problem, everything was paid for, no paperwork and it's been terrific. But again, I don't know what percentage are having problems. There is a percentage that are having problems. I think maybe it's associated with the particular contracting medical groups and not the HMO as a whole, but I don't know that for sure.

Senator THOMPSON. That's a new thing for them to have to deal with.

That gets to your comments about the voucher system. You said you thought a large influx into that right now would be disastrous. Could you elaborate on that a bit as to why? Is it the same problem of lack of information or people with lack of education or people being susceptible to the pitch man and that sort of thing?

Ms. DALLEK. It is all of those above. When we first started in southern California doing this work, we were seeing Medicare beneficiaries who would come to us with 10 different Medicare supplemental plans they had bought, all duplicative, so confused and so susceptible. We don't see that anymore. Congress, in its wisdom, has streamlined and put in strict regulations on the selling of Medigap policies. This has made a world of difference. They standardized the policies and now all someone has to do is look at which plan do I want and compare costs. It really has made a difference.

Right now, there is no information out there on Medicare HMOs, none. The marketing is a problem, especially when you pay these marketing agents a commission for every warm body they sign up. We need to get the marketing cleared up. There are ways to do this (this is not rocket science), I have a number of suggestions in the testimony.

Right now, there are some medical groups that can't provide any encounter data at all to the HMO. Require the HMO to provide encounter data next week so we can determine whether the HMO is sending out any home health aides, the level of nursing home care provided, and how much service they are paying for, would not be realistic. We can't get that data because it's not there. A workable data collection system takes a while to build up. If you next year said everybody goes into these plans and there is no data, you can't have managed competition. We need information on cost and quality and there is no quality data right now.

Senator THOMPSON. Thank you.

The CHAIRMAN. Thank you.

Ms. Dallek, you've given us at least 33 cases of issues that we should be looking at and I hope my colleagues will take an opportunity to read those cases. They range all the way from a man who was covered in New York City who while visiting his daughter in Florida suddenly had chest pains, went for emergency treatment, had a relative notify the HMO back in New York, he was treated in Florida and by the time he got back to New York, the HMO denied coverage saying they hadn't received notice from anyone. That was ruled to be a nonreason for denial, that even if no one had in fact notified within 48 hours, he still would have been covered.

There are other cases in which someone may be on an HMO plan and have kidney problems and need dialysis, and be retired and move out of the area. If he moves out of the area, he may not be able to remain covered by the HMO because they will say you must get treatment here. So we have one case you pointed out where that individual will have to move back into the area in order to save himself several hundred miles of travel.

There are a multitude of problems associated with the coverage. I think we've really got to get a lot of information out there so people understand fully what they are getting into, what they will get out of it. In most cases, the benefits will seem to outweigh the downside but they should be aware of the downside as well. Your testimony was very helpful in pointing that out.

Ms. DALLEK. Let me say I'm not opposed to Medicare HMOs. I think they can and do provide good care, but we need to fix certain things.

The CHAIRMAN. Thank you very much, Ms. Dallek.

Our final panel of witnesses today is going to provide us some insight into the private sector's experience with HMOs. We're going to hear from Dr. Jesse Jampol, the Medical Director of Health Insurance Plan of Greater New York, representing Group Health Association of America, the association that represents HMOs; we also have Helen Imbernino, Assistant Vice President, National Committee for Quality Assurance which accredits HMOs and finally, Suzanne Mercure, Manager, Benefits Administration for Southern California Edison who will give us some insight into how HMOs for employees are monitored by the plan sponsors.

Dr. Jampol.

STATEMENT OF JESSE JAMPOL, M.D., MEDICAL DIRECTOR, HEALTH INSURANCE PLAN OF GREATER NEW YORK, REPRESENTING THE GROUP HEALTH ASSOCIATION OF AMERICA

Dr. JAMPOL. I'm Dr. Jesse Jampol and am currently a medical consultant to Health Insurance Plan of Greater New York. I'm a retired medical director. The Health Insurance Plan is a not for profit, prepaid group practice model health maintenance organization operating in New York and has affiliated HMOs in New Jersey and Florida.

I was a practicing physician in the HIP system for over 32 years and for the last 6 years until about 8 months ago, I was medical director for the entire plan. In my capacity as medical director, one

of my responsibilities was oversight of the HIP quality assurance programs.

I'm testifying today on behalf of the Group Health Association of America which is the leading national association for HMOs. GHA and its member organizations are pleased with the Committee's focusing on quality issues. My testimony will focus on four issues as they relate to Medicare populations: HMO quality assurance activities, current quality standards for HMOs including oversight by regulators, documenting HMO quality and consumer satisfaction and recommendations for future oversight of health care by HCFA and organized delivery systems.

There's been a profound change in the basic approach taken by HMOs to quality in the last few years. The organizational structure of HMOs has allowed us to move from using a chart review to identify outlying cases to a data-driven, systematic approach to identifying opportunities for improving care and services. HMOs are making these changes so that systems can be developed which improve the quality of care and service for all populations of patients, not just the patients of outlier physicians. It would be much more difficult if not impossible to do this in a fee for service setting.

The four general aspects of continuous quality improvement are the collection of data on utilization, patient satisfaction, physician practice patterns and performance, the development of an intervention strategy based on data assessment, patient needs, scientific evidence and clinical experience, the implementation of the strategy which frequently involves system changes or modification of physician practice patterns and then the measurement of outcomes, evaluating the results to determine what works and what needs further improvement.

To achieve these goals, the health plan will have a quality assurance/quality improvement committee which generally consists of the plan's medical director, some participating plan physicians and various staff members. The role of the committee is to oversee the quality improvement activities, including providing credentialling, development of screening and preventative health guidelines, plan studies, case reviews and oversight functions.

Recent studies have shown these quality improvement efforts have been quite successful. In May 1994 in the Journal of the American Medical Association, there was an analysis of 16 studies comparing quality of care in HMOs with care provided to similar populations in other settings. The study concluded that HMO quality is better than or equal to fee for service results in 14 of the 17 measures. People receiving care from HMOs consistently receive more preventative care such as breast, pelvic, rectal and general physical examinations as well as more health promotion counseling.

Overall satisfaction in HMOs has been quite good. A recent survey of 19,000 senior citizens by the National Research Corporation found that those enrolled in HMOs had a higher satisfaction than those involved in traditional fee for service Medicare at every level of health status.

Better indication of satisfaction or disenrollment rates, the most recent figures I know of are from 1994 and show that 84 percent remain with their HMO and only 4 percent return to local fee for

service care. The remainder either switch to another HMO or move out of the area or had some other reason for leaving.

The Federal HMO Act and regulations require HMOs as a condition of federal qualification to have internal quality insurance programs that stress health outcomes, provide review by physicians and other professionals of the process followed in the provision of health services, use systematic data collection of performance and patient results, including written procedures for taking appropriate remedial actions when problems occur.

Medicare's regulations for participating HMOs and competitive medical plans incorporate the Federal HMO Act requiring the internal quality assurance programs. They are in addition to the quality requirements for HMOs in 42 states, and many States have additional regulations related to the licensure of providers, measures of enrollee satisfaction, medical records and so forth.

HMOs have encouraged the setting up of private accrediting organizations which set standards for HMOs and assess when the plans meet these standards. Three major groups providing assessment of this are NCQA, the Joint Commission on Accreditation of Health Care Organizations, JCHO, and the Accreditation Association for Ambulatory Health Care, AAAHC.

NCQA has been most widely used and has gained the respect of major employers across the country. It is considered the gold standard for HMOs. It's not something that sets a basic industry average for operations; it sets what it hopes to be the best possible standards and reviews a plan's performance in a number of areas. It reviews their quality assurance system, utilization management, member rights and responsibilities, preventative health services and medical records.

GHA has recommended that Medicare must be updated to reflect the dramatic changes that have occurred in the private sector during the three decades since the program began. We believe Medicare can best be strengthened by giving Medicare beneficiaries the same kind of choices that are already available to millions of working Americans, including federal employees and Members of Congress. For this to be successful, Medicare must be reoriented to a model in which Medicare beneficiaries have the opportunity to choose from a broad array of options that compete on the basis of quality, service and cost and held to comparable standards.

The CHAIRMAN. If you could summarize, if at all possible. Otherwise, I'm afraid you're going to lose two-thirds of your audience.

Dr. JAMPOL. I've added to the record a fuller account of this but GHA is recommending strong standards that the Health Care Financing Administration take to improve administrative procedures but that we believe they have a very big role to play in maintaining a set of quality standards that will be present throughout the country.

Thank you.

[The prepared statement of Dr. Jampol follows:]

PREPARED STATEMENT OF JESSE JAMPOL, M.D.

Mr. Chairman, Members of the Committee, my name is Jesse Jampol, M.D. I am a Medical Consultant and retired Medical Director with the Health Insurance Plan of Greater New York. I am testifying on behalf of the Group Health Association of America (GHAA), the leading national association for health maintenance organiza-

tions (HMOs). GHAA's 385 member HMOs serve 80 percent of the 50 million Americans who receive health care from HMOs.

GHAA and its member organizations are pleased that the Committee is focusing on quality issues and federal regulatory oversight under Medicare in your hearing today. We come before you as health plans that provide care for about one-fifth of the nation's population—and that offer the nation's most systematic approach to health care quality improvement.

My testimony will focus on four issues, especially as they relate to the Medicare population:

1. Describe HMO quality assurance activities.
2. Briefly review current quality standards for HMOs, including the oversight by regulators (state and federal) and private review companies.
3. Provide the results documenting HMO quality and consumer satisfaction.
4. Discuss GHAA recommendations for future oversight by the Health Care Financing Administration (HCFA) of organized delivery systems under the Medicare program.

HMO Quality Assurance Systems

The last few years have seen a profound change in the basic approach taken by HMOs to quality assurance (QA). The early efforts in QA were directed at outlier identification, and used chart review as the principle means of case findings. The theory was that there were problems that needed to be addressed.

Influenced by the professors of CQI and TQM, HMOs are beginning to turn their attention to more data driven, systematic approaches to identifying opportunities for improving care and service. The theory in this model is that systems of care can be developed which improve the quality of care and service for populations of patients, not just the patients of the "outlier" physician. It is in approach that uses information, physician education and evaluation of "best practices" to improve care and service.

While the evolving internal quality systems differ among HMOs, there are four general aspects of continuous quality improvement:

Collecting data on utilization, patient satisfaction, physician practice patterns, and performances, that allow for a clear definition and articulation of areas in need of improvement.

Developing an intervention strategy, based on the data assessment, patient needs, scientific evidence, and clinical experience.

Implementing the strategy—frequency involving system changes or modification of physician practice patterns.

Measuring outcomes and evaluating results to determine what works.

This should be viewed as a continuing, and, in a sense, "circular" process, with measurement and assessment leading to efforts to improve care, and further measurement leading to further interventions.

In this way, the philosophy of QA is changing. The structure of the QA program at individual HMOs however has certain common elements. These include a QA/QI Committee. This typically consists of the plan medical director, participating plan physicians and various staff members. The role of the Committee is to oversee the various plan CQI activities including:

Provider Credentialing.—Physicians, etc.

Development of Screening and Preventive Health Guidelines.—These may be guidelines for pediatric immunizations or flu shots in the senior population.

Plan Studies.—Studies are used by the plan to test various hypothesis, see what effects specific action plans will have on the quality of care or service, or to establish baseline information that may be critical in evaluating future activities.

Case Reviews.—Individual case review is still a necessary activity in specific circumstances. The committee provides a mechanism whereby cases may be reviewed, evaluated, categorized and followed up. This can involve a specific corrective action plan or the tracking and trending of cases over time.

Oversight functions.—The Committee is often responsible for overseeing the QA activities of providers with whom the plan contracts. In this way, an integration of QA activities can be achieved across the whole spectrum of care being provided. These providers may be: Medical groups, IPAs, mental health providers, vision providers, pharmacy providers, dental providers.

While HMO quality improvement programs are carried out plan-wide and are designed to benefit all members—Medicare, Medicaid, and commercial—HMOs can use their quality systems to focus on specific initiatives or interventions that can improve a particular aspect of health care delivery for a defined subset of members. Preventive care initiatives are one example of the wide range of quality improve-

ment activities commonly undertaken by HMOs. Some "best practices" related to programs for Medicare beneficiaries provide good examples:

A flu prevention program developed by a plan to improve its flu immunization rate although two-thirds of sampled members had indicated that they received a flu shot in the preceding year in contrast to 22 percent of the elderly residents in the core county served by the plan. The program included notifying members when and where flu shots would be available without an appointment; arranging for nurses to administer flu shots to consenting homebound members; enlisting the support of participating physicians by providing medical data on the benefits of immunization; and distributing pamphlets from the American Lung Association with a letter from the plan's Medical Director citing the safety and effectiveness of the shot.

A stroke prevention program in collaboration with the National Stroke Association (NSA) that involves a survey of plan members to identify those with increased risk of stroke, then offers medical and lifestyle compliance counseling. A variety of interventions are used, including: Telephone counseling by NSA-trained stroke prevention educators; case management intervention by the HMO with selected high risk members; and educational materials focused on risk identification and reduction. To date, the program has surveyed 8,700 Medicare members. Two thousand have been counseled regarding medical compliance or lifestyle-related stroke risks.

A fitness program designed to increase seniors' wellness and physical activity, while potentially decreasing the incidence of health problems. The first phase of the program involves individual health assessments, including heart rate and blood pressure checks and a health questionnaire covering family history, eating habits, and current exercise level. Participants select an exercise class according to their level of physical conditioning, in which they can enhance their strength, endurance, and flexibility.

Plans will vary in their targeted areas based on demographics, utilization or QA data, and other factors.

HMO QUALITY SYSTEMS

Stated simply, HMOs are organized systems for financing and delivering health care. They provide a vehicle for systematic quality improvement that is not as readily available in more episodic financing arrangements such as fee-for-service (FFS) plans, because HMOs combine a number of interrelated features that foster a comprehensive approach to quality. These include: Selection of a defined, fully credentialed network of providers who can work together on care and quality issues; provision of comprehensive services across the spectrum of inpatient and outpatient settings, allowing a full range of quality interventions; and clinical and fiscal accountability for the health care of a defined population—allowing population-based data collection, analysis, intervention, and monitoring—and fixing accountability for performance.

HMOs have made quality improvement systems a key component of their approach to care across all of the populations that they serve. Their quality approach has traditionally included a focus on the three classic dimensions of quality assurance: Structure, which includes ensuring appropriate professional qualifications, adequate records, proper organizational arrangements; process, which encompasses the steps involved in provider/patient interactions; and outcomes, which involves determining whether medical interventions achieve desirable patient results.

While HMOs continue to maintain such approaches, they have in more recent years led the way in moving toward continuous quality improvement in health care, as noted above.

THE RESULTS

Discussion of different quality models and systems is irrelevant in the absence of results. The success of HMOs in improving quality of care has been documented again and again, as studies show care provided in HMOs to be as good or better than care provided in fee-for-service (FFS) plans.

A comprehensive review of the literature published from 1980–1994 appeared in the May 18, 1994 Journal of the American Medical Association. It analyzed 16 studies comparing quality of care of HMOs with care provided to similar populations in other settings. The study concluded that HMO quality is better than or equal to the FFS results on 14 of 17 measures. People cared for in HMOs consistently receive more preventive care—such as breast, pelvic, rectal and general physical examinations—as well as more health promotion counseling.

Some specific examples of studies on quality of care in HMOs are outlined below.

Elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the FFS system, according to a HCFA study that compared

Medicare records for 12 different types of cancer. Breast, cervical and colon cancers, along with melanomas, were diagnosed significantly earlier in HMOs than FFS. The largest difference was for cervical cancers: almost 60 percent of HMO members were diagnosed at the earliest stage, compared with 39 percent of FFS patients (American Journal of Public Health, October 1994).

HMO appendicitis patients were 20 percent less likely to suffer a ruptured appendix than appendicitis patients in a FFS setting, according to a study of hospital records in California (New England Journal of Medicine, August 18, 1994).

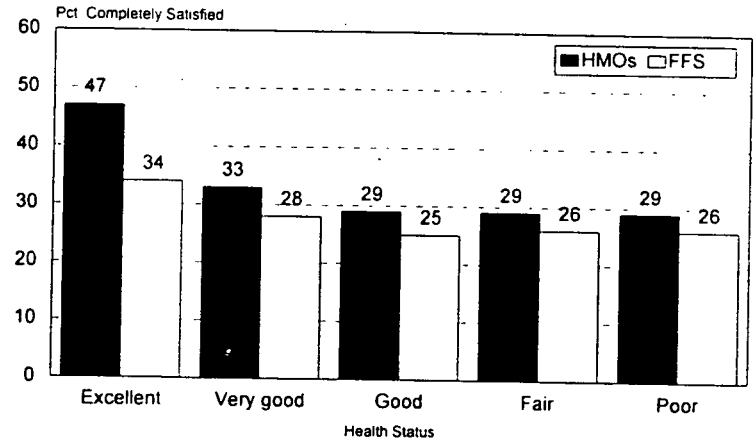
Women in HMOs were more likely to obtain mammograms, Pap smears and clinical breast exams than women in FFS settings. For example, 62 percent of women HMO members age 50–64 had a mammogram within the past year, compared to 50 percent of women in FFS (CDC/NCHS Advance Data No. 254, August 3, 1994).

Another recent review reported by Joan Meisel, PhD, MBA at Stanford University entitled "Quality of Care in HMOs: A Review of the Literature" reaches the same conclusions—that HMOs do not compromise the quality of care and are rated superior to fee-for-service in many important ways.

Finally, HMO members—elderly and non-elderly—are more satisfied overall with their health plan than FFS enrollees. For example, as shown in figure 1, a survey of 19,000 elderly Americans by the National Research Corporation found those enrolled in HMOs had higher satisfaction levels than traditional FFS Medicare enrollees for every level of health status.

Figure 1

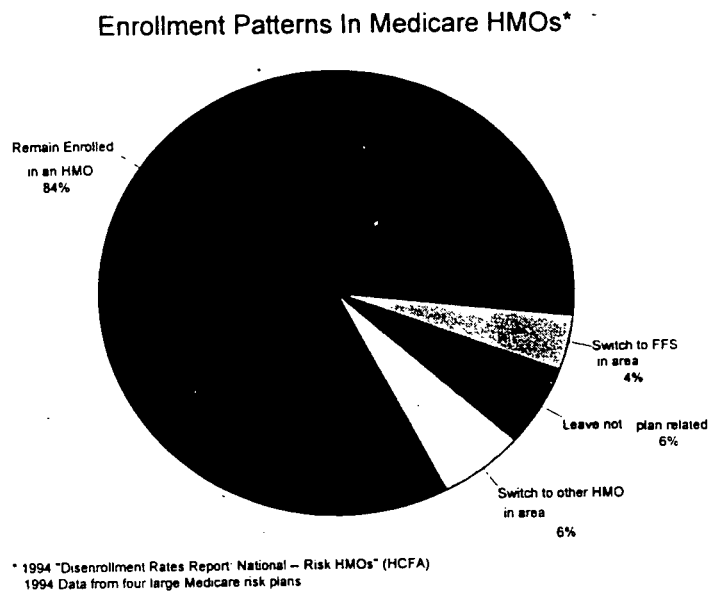
Overall Satisfaction with Coverage, Based on Health Status
HMO vs. FFS Medicare Coverage



Source National Research Corporation Healthcare Market Guide, 1994
Sample size 14,695

Perhaps a more important indication of satisfaction than enrollment rates is disenrollment rates. People can join a plan, but little is gained if they disenroll in a short period of time due to dissatisfaction. A recent study of Medicare HMO enrollees in 1994, whose results are summarized in figure 2, showed that: 84 percent remained with their HMO; 6 percent switched to another HMO in their area; 6 percent left for reasons unrelated to the plan (e.g., they move out of the area); 4 percent returned to local fee-for-service care.

Figure 2



QUALITY STANDARDS FOR HMOS

Federal and state governments and private accreditation organizations working with large employers have established a wide array of quality standards, and GHAA has long supported strong quality standards for health plans.

Federal HMO Act: The federal HMO act and regulations require HMOs, as a condition of federal qualification (53 percent of HMOs are federally qualified), to have internal quality assurance programs that: Stress health outcomes; provide review by physicians and other professionals of the processes followed in the provision of health services; use systematic data collection of performance and patient results, interpret these data for practitioners, and institute needed change; include written procedures for taking appropriate remedial action, in the case of inappropriate or substandard services, or when services that ought to have been furnished have not been provided.

Medicare HMO/CMP requirements: Medicare's regulations for participating HMOs and competitive medical plans (CMPs) incorporate the federal HMO act requirements for internal quality assurance programs. HCFA conducts site visits to monitor ongoing compliance with these requirements. In the past these site visits have occurred every two years, but beginning in 1996 site visits will be conducted annually under the Medicare risk contracting programs.

In addition, HMOs and CMPs participating in Medicare must maintain an agreement with a utilization and quality control peer review organization (PRO) for external review of care. The PRO review process is moving from a focus on individual cases toward assessment of trends and patterns of care and outcomes much the same as described above. PROs review a sample of the enrollees of an HMO/CMP, looking at care furnished over a twelve-month period. Action plans are developed by the HMO/CMP in cooperation with the PRO to address any problems encountered, and the PRO then conducts a targeted review to determine that the problem is corrected.

GHAA has been working with HCFA in its efforts to improve the PRO review process and to focus it on performance measurement that is consistent with the evolution of quality review in the private sector. A pilot project (the "Delmarva" project) has identified and refined a set of specific clinical indicators, including certain "core" measures (time to the first visit for new enrollees, mammograms, frequency of visits/ services; and flu shots) as well as some specific measures related to diabetes. This year, a selected group of HMOs and PROs will begin to work together to test these measures for an 18-month period. The project will involve a total of twenty-three HMOs in 5 states. The goal is to develop information that will help improve PRO oversight and that will be useful to HMOs in improving the quality of care.

State requirements: The states also set quality requirements for HMOs. According to the 1993 report on states with HMO licensure laws prepared by Aspen Systems for HCFA, 42 states have adopted some type of quality standards. This includes a variety of regulatory schemes by which States seek to assure consumers high quality health care. Among these are internal and external review requirements, as well as requirements related to licensure of providers, measures of enrollee satisfaction, medical records, and other matters.

The National Association of Insurance Commissioners (NAIC) has adopted a model HMO Act for use by states seeking to regulate HMOs, and 28 of the state HMO acts are based on NAIC model. The model act requires HMOs to file a description of their quality assurance program, and requires that quality assurance plans include a number of specific elements. In addition many states conduct on-site reviews to carry out their oversight responsibilities.

Private accreditation: Private accrediting organizations also set standards for HMOs and assess whether the plans meet those standards. The three major groups are the National Committee for Quality Assurance, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

The NCQA is the most widely used and has gained the respect of major employers across the country. It is considered the "gold standard" for HMOs—not an industry average or basic standard for operation. The NCQA sets specific standards and reviews plan performance in a number of areas: The quality assurance system—including its effectiveness in improving quality and service; credentialing process for providers; utilization management; member rights and responsibilities; preventive health services; and medical records.

The NCQA has also worked with employers and health plans to develop a standardized set of comparative information for health plans to report. The Health Plan Employer Data and Information Set (HEDIS) is comprised of 60 performance measures designed to give employers and consumers objective information on health plan performance. HEDIS is the first step in the development of a standardized set of performance measures for HMOs.

A comparable effort is underway to develop "report cards" on HMOs that will be useful to consumers in making informed choices. As such efforts become more sophisticated, it will be important for consumers to have data on the fee-for-service sector that permits an additional dimension of comparison.

FUTURE STANDARDS FOR HMOS AND OTHER OPTIONS UNDER THE MEDICARE PROGRAM

GHAA has testified recently on the future of the Medicare program and has recommended that Medicare must be updated to reflect the dramatic changes that have occurred in the private sector during the three decades since the program began. GHAA believes that Medicare can best be strengthened by giving Medicare beneficiaries the same kinds of choices that are already available to millions of working Americans, including federal employees and members of Congress. For this effort to be successful, Medicare—the Health Care Financing Administration (HCFA)—must be reoriented toward a model in which Medicare beneficiaries have the opportunity to choose from among a broad array of options that compete on the basis of quality, service, and cost and are held to comparable standards.

As HCFA makes this change, GHAA believes that it will be important to build on the present regulatory framework for HMOs/CMPs for two key reasons. First, we believe that the current standards provide the best foundation for assessing the full spectrum of options that may participate in the Medicare program in the future; and second HCFA's implementation of the present standards provides valuable experience for the oversight of organized systems of care in the future.

In order for HCFA to meet the challenges that lie ahead, resources that have been focused on individual claims payment will need to be refocused on integrated systems that deliver services, as well as finance their delivery. HCFA's oversight will need to ensure that all options, including the traditional fee-for-service Medicare

program, meet comparable standards in such areas as quality, access, and grievance procedures, and that all options are fiscally sound. This effort is critical to the future success of the Medicare program, because the implementation of such standards will ensure that beneficiaries can have the same confidence in the soundness of any option they select.

In addition to advocating strong standards, GHAA also recommends several improvements to simplify and streamline administration of the current program for HMOs/CMPs that would carry over into a program of expanded choices for Medicare beneficiaries. Specifically:

Administrative procedures and processing of applications: In the short-term, HCFA should take immediate steps to improve administrative procedures and processing time: reduce the time it takes to process and approve two types of applications from HMOs—initial applications to serve Medicare beneficiaries, and applications from approved plans to expand their service area and be able to serve additional Medicare beneficiaries; simplify administrative procedures for submission and processing of applications (i.e., permit information associated with the application to be submitted on computer disk); and streamline oversight of multi-state organizations, for example by eliminating duplicative filing requirements and facilitating communications among regions.

Policy guidance/regional variations: HCFA should take steps to identify and narrow the variation in interpretation of policy by regional offices and promote consistency in decision making in such areas as review and approval of contracts, products, and marketing materials; this should include the development and issuance of guidelines for regional offices.

Information/awareness: The Health Care Financing Administration (HCFA) should work with entities that participate in the Medicare program, including HMOs and in future, other arrangements, to develop information that HCFA could disseminate to beneficiaries about the enrollment options available to them, including educational information about the basic characteristics of those choices. This information should be sent to all prospective beneficiaries in the six-month period prior to their becoming eligible for Medicare, and periodically thereafter.

Deemed status: To enhance and streamline Medicare's quality assurance program, organized offerings that are accredited under standards at least as stringent as those established by the Medicare program by private sector organizations such as NCQA, JCAHO, and AAAHC, should be deemed to comply with applicable Medicare quality standards.

HCFA has entered into serious discussions with GHAA on most of these issues, and has embarked upon several promising activities. While the current regulatory program can be improved and the Agency faces significant challenges for the future, we believe that there is a great deal to be gained by building upon the framework and expertise for the oversight of HMOs/CMPs that exists under the Medicare program today.

CONCLUSION

Mr. Chairman, HMOs provide high quality care to 50 million members today—and are working to continue to improve the care that we provide in the future. The GHAA would be pleased to work with the committee as you examine the issues of quality standards and accountability and federal oversight of organized systems of care under the Medicare program. I would be happy to answer any questions that you may have.

The CHAIRMAN. Thank you, Doctor.

Ms. Imbernino.

STATEMENT OF HELEN IMBERNINO, ASSISTANT VICE PRESIDENT, NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Ms. IMBERNINO. Good afternoon.

I'm Helen Imbernino and I'm Assistant Vice President at the National Committee for Quality Assurance. I'd like to commend this Committee for convening this hearing about the oversight of care provided to Medicare beneficiaries.

NCQA is an independent, nonprofit organization that oversees two complementary approaches to health plan evaluation—that of accreditation and performance measurement. In the accreditation

program, we examine the infrastructure of the health plan along six categories of standards which have already been defined for you. Our board of directors is a balanced representation of large purchasers, health plan representatives, a consumer representative, a State legislator, a union representative, a representative from the AMA, and independent quality experts.

By the end of this year, we will have accredited nearly half of the health maintenance organizations in this country. That figure includes 80 health plans that account for two-thirds of the Medicare beneficiaries that are enrolled in risk contracts.

Approximately one-third of the health plans reviewed in our accreditation program have achieved full accreditation; 13 percent have been denied. The results of our accreditation process are available to the public at no charge. We recently experienced a weekend volume of 1,300 calls after a news media article about accreditation and the availability of information about health plans.

After July 1, we will be providing more detailed summaries about the accreditation information attained by health plans in accreditation summary reports which will also be available to the public.

The CHAIRMAN. Were those nationwide calls?

Ms. IMBERNINO. Correct. And the vast majority were from individual consumers as opposed to other healthcare organizations.

The primary reason that so many health plans have undergone such a rigorous process is purchasers' interest in ensuring quality for their employees; many large purchasers, including GTE, Xerox, and many states have mandated NCQA accreditation for health plans with which they contract.

In addition to accreditation, we've developed a set of performance measurements called HEDIS, the Health Plan Employer Data Information Set. The HEDIS measurements measure health plan performance in five areas—quality, access and patient satisfaction, membership and utilization, finance and health plan management activities. We are in the process of developing a HEDIS 3.0 that will include measures that address all of the populations that health plans take care of, including specific measures for the Medicare population which we are developing in cooperation with HCFA and for the Medicaid population.

We have recently convened a large performance assessment committee that will be responsible for developing a consensus among a broad constituency about what the important measures of performance in a health plan are. We are committed to incorporating into the development of HEDIS 3.0 measures that represent the entire population and particularly address the special needs of unique populations.

The two methods that NCQA has used to evaluate health plans, that of accreditation and performance measurement, are both based on the premise that the health plan is accountable and responsible for the care they provide. Many of the options now under consideration by Congress and the Administration would encourage a wider variety of managed care organizations such as PPOs to enter the Medicare market. We are concerned that the HMOs that have already come forward and participated in accreditation and release of performance information may be held to a higher set of standards than less "acceptable" health plan model types. We be-

lieve that all health plans, regardless of their financing or delivery structure, should be held accountable for the quality of care and service they provide; that a central goal of the Medicare reform should be to reward the plans that have come forward and made themselves accountable; and, that we should not ease regulations for the other models of health care that may come forward.

We will have accredited over half of the Nation's HMOs, we will have accredited plans that account for 66 percent of Medicare beneficiaries in TEFRA contracts. We don't believe accreditation should be a condition of participation for the Medicare program but we do believe that cooperation between HCFA, private accreditation programs and state activities are necessary to eliminate some of the redundancies present in oversight of HMOs in our markets today.

Thank you.

[The prepared statement of Ms. Imbernino follows:]

PREPARED STATEMENT OF HELEN IMBERNINO

Good morning Chairman Cohen, and members of the Special Committee. I am Helen Imbernino, Assistant Vice President with the National Committee for Quality Assurance (NCQA). As Congress and the Administration look to increase the use of managed care in the Medicare program, I commend the Committee for convening this hearing on the oversight of health plans providing coverage to Medicare beneficiaries.

NCQA is an independent, non-profit organization which oversees two complementary approaches to health plan evaluation: accreditation and performance measurement. NCQA accreditation examines a health plan's infrastructure, while clinical and service performance is measured through NCQA's Health Plan Employer Data and Information Set (HEDIS 2.0 and 2.5). NCQA is governed by a broad based Board of Directors which includes large purchasers, health plan representatives, a consumer representative, a state legislator, a union representative, an AMA representative, and independent quality experts.

By the end of this year, we will have accredited nearly half of the nation's health maintenance organizations (HMOs) against a set of rigorous and evolving standards. This figure includes eighty health plans enrolling two thirds of the Medicare beneficiaries in TEFRA risk contracts. The NCQA Standards are divided into six sections:

Quality Improvement: What improvements in care and service can the Plan demonstrate? Does the plan fully examine the quality of care given to its members? How well does the plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time?

Provider Credentials: Does the Plan meet specific NCQA requirements for investigating the training and experience of all physicians in its network? Does the Plan keep track of all physicians' performance and use that information for their periodic evaluations? Does the Plan look for any history of malpractice or fraud? Has the Plan performed a quality assessment for health delivery organizations such as hospitals, home health agencies, nursing homes, and free-standing surgical centers?

Members' Rights and Responsibilities: How clearly does the Plan inform members about how to access services, how to choose a physician or change physicians, and how to make a complaint? How responsive is the Plan to members' satisfaction ratings and complaints? Does the appeals process for grievances include a second review with different individuals?

Utilization Management: Does the Plan use a reasonable and consistent process when deciding what health care services are appropriate for individuals needs? Are appropriateness criteria clearly documented and available to participating physicians? When the Plan denies payment for services, does it respond to member and physician appeals? Are physician consultants from the appropriate specialty areas of medicine and surgery utilized as needed?

Preventive Health Services: Does the Plan encourage members to have preventive tests and immunizations? Does the Plan ensure that its physicians are encouraging and delivering preventive services?

Medical Records: How consistently do medical records kept by the plan's physicians meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients' abnormal test findings?

Approximately one third of health plans reviewed against our standards have received Full Accreditation and thirteen percent have been denied. The results of our accreditation process are available free of charge to any individual who phones or writes our offices, and summary reports for every plan reviewed after July 1st will be made available so that purchasers and consumers will have even more information with which to evaluate health plans.

The primary reason that so many health plans have undergone such a rigorous process is the purchaser's interest in ensuring that their employees are only enrolled in a quality organization. Large employers such as Xerox, GTE, IBM, Allied Signal, the States of New York, Tennessee, and many others have all required that the health plans with whom they contract seek NCQA accreditation.

In addition to accreditation, NCQA has developed a standardized system for measuring health plan performance, the Health Plan Employer Data and Information Set (HEDIS). HEDIS 2.5 is a set of sixty standardized measures of health plan performance in five areas. More than two thirds of the nation's HMOs are now using HEDIS to generate performance information. HEDIS covers five areas of a health plan's performance: Quality, Access and Patient Satisfaction, Membership and Utilization, Finance, and Health Plan Management and Activities.

While HEDIS 2.5 was initially designed for commercial purchasers, we are committed to a performance measurement tool which addresses the needs of all populations served by a health plan, regardless of the payor relationship. With funding from the Packard Foundation and in conjunction with HCFA and the State Medicaid Directors Association, NCQA just released a draft set of Medicaid HEDIS measures for review and comment. In addition, we are in the final stages of discussions with HCFA and the Kaiser Family Foundation for the development of Medicare HEDIS measures to be incorporated into HEDIS 3.0.

The framework for the development of HEDIS 3.0 will come from NCQA's Committee on Performance Measurement. The Committee on Performance Measurement is a broad based group of experts charged with overseeing the development of the next generation of health plan performance measures (HEDIS 3.0). In addition to corporate purchasers, health plans, providers, labor, AARP, CalPers, and a state Medicaid Director, we are pleased to have the director of HCFA's Health Standards and Quality Bureau as a Member of the Committee.

The two methods NCQA uses to evaluate health plans, accredition and performance measurement, are both based on the premise that a health plan is responsible and accountable for the quality of care and service that its members receive. Many of the options now under consideration by Congress and the Administration would encourage a wider variety of managed care organizations, such as PPOs, to enter the Medicare market.

We are concerned that HMOs which have made accreditation and performance information publicly available, could be held to a higher set of standards than less "accountable" health plan model types. All health plans, regardless of their financing and delivery structure, should be held accountable for the quality of care and service, and required to provide data on their performance. A central goal of Medicare reform should be to reward health plans for making themselves more accountable to the federal government and beneficiaries. Easing the standards for less accountable health plans would have the opposite effect.

As I mentioned earlier, NCQA will have accredited over half the nation's HMOs by the end of this year; a figure which includes health plans responsible for 66 percent of the seniors enrolled in TEFRA Medicare Risk Contracts. While NCQA Accreditation should not be a condition of participation in the Medicare program, health plans which have achieved accreditation should not be subjected to redundant HCFA certification processes.

Such a consolidation would minimize the administrative burden on health plans, while at the same time providing HCFA with a body of expert knowledge and experience. Federal oversight resources could then be re-allocated to higher priority areas such as new health plan model types, new entrants into the Medicare market, or existing plans experiencing large gains in Medicare enrollment. A model for the public/private partnership already exists in six states (PA, FL, OK, KS, RI, VT) where NCQA works closely with health plan regulators. Just as these states have coordinated their regulation of health plans with NCQA accreditation to eliminate duplication and increase efficiency, so too should the federal government.

NCQA recognizes that reducing the rate of growth in the Medicare program is a critical component of deficit reduction efforts, and we believe there is real potential to reduce costs and improve quality through the use of managed care. However, I urge the Committee to build on the work of this hearing and ensure that efforts to reduce costs do not compromise quality in the process.

Thank you again for the opportunity to testify.

The CHAIRMAN. Thank you.
Ms. Mercure.

STATEMENT OF SUZANNE MERCURE, MANAGER, BENEFITS ADMINISTRATION, SOUTHERN CALIFORNIA EDISON

Ms. MERCURE. Senator Cohen, I'm from a small town in New England, so I welcome New England jokes. I moved west, maybe a little too far, we'll see, and Senator Pryor, I met one of your constituents on the plane. She was very unhappy that you were leaving the Senate, but she also thought that there should be some HMOs added in your State.

Senator PRYOR. I may be looking for one pretty soon.

Ms. MERCURE. She's actually the CEO of a company that employs 200 people, so it was an interesting conversation—Southern California Edison having 17,000 employees and what the issues are for a smaller employer.

Senator PRYOR. Thank you very much.

Ms. MERCURE. And she voted for you.

Senator PRYOR. Good. Maybe I ought to reconsider.

Ms. MERCURE. Maybe you should. She had a lot of nice things to say.

Since we've heard a lot today, I really wanted to spend a couple of minutes talking about three major points. First is, Southern California Edison used to do everything ourselves. We had our own homegrown PPO, we managed it; we paid all the claims; and in January of this year, we got out of that business; and we purchase from the marketplace now. Cost was clearly the issue that lit the screen; quality was the issue we wanted to pursue. We thought the initiatives in the private sector to promote quality were ones we should build on. So my message here is that we really did a complete overhaul.

Most employers who have really committed themselves to managed care have completely overhauled and have a strategic, long-term plan. I know that is something difficult for Congress to do. For employers, there's been a long-term strategy in place for how to move the population into the managed care programs that has been consistent because there has been continuity for the commitment so that overhaul has been able to work.

In my testimony, there are details on the whole process. We have very few people who actually went into Medicare risk programs because the myths about managed care are still out there. There is a huge education process that is needed, so part of the commitment—and you've heard that from others today—is a long-term process to get people to change. A lot of older people have a relationship with a physician, and their first question is: "Can I still see my same doctor?" So we have to be very cognizant of that.

I think companies like Edison and some of the other ones others have mentioned do a lot of work on the education process. I was very pleased to see that there is a commitment by HCFA to do a lot of education and support. We have a staff that really is the monitoring staff—they answer the calls, they walk people through the process, and they deal with those individuals who are confused. We've even had home visits to people, so for our retiree population, a lot of support like that is needed.

The second thing I'd like to talk about is—just very briefly—we very actively, along with a lot of other employers, try to monitor performance. NCQA accreditation is one of the things we look for. Despite the marketplace in California, I was quite surprised when I moved there that a lot of plans are not accredited and they are just seeking accreditation. All of our plans either have been accredited or are at least seeking accreditation.

We also use the HEDIS dataset. We are very actively involved in promoting that; we're involved in the 3.0 next level of activities and I've even personally been asked to be on the committee to look at Medicare measures for HEDIS. We support that because we think there should be uniform measures for all parties. We're dealing with all segments of the population; not everyone who is employed is someone who is not vulnerable. We also have disabled people, so we are very interested in promoting uniformity for all payers.

We're also involved in customer satisfaction. We are actually in the process of doing two customer satisfaction surveys—one for our Medicare population separately and the other for our actives.

The fourth area we are involved in is performance goals. I'm sorry if I had the longest testimony because you got a copy of these but you might be interested. Other companies have similar sets. The plans aren't all pleased that we want these and we want to talk to them because of duplication. For us it frames a dialogue and a process where we can actually look to improve quality jointly in collaboration with the plan. There may be some things Edison can do to improve the communication and the education process and also, we monitor the customer complaints we get so we can go to the plan. We look at the plan's processes, and we've learned a lot from that.

The primary care physician turnover rate, red flag, (a data piece in HEDIS), is a question we ask on performance standards. If it's above a threshold, you think there might be a problem with continuity of care; if it's too low, maybe the plan isn't monitoring the physicians and what their performance is. So there are a lot of tie-ins for all of the measures.

The other area we're working on is communication. We are going to be using this consumer magazine, Health Pages, because we think we should be promoting better consumer information. Health Pages is going to be taking some of our HEDIS information and customer satisfaction data, and this will be available for all our employees and retirees this fall for open enrollment. It will help to explain a lot of the issues that are very confusing in this process. That is one of the ways we're trying to reach people.

The final comment I'd like to make is once again about promoting standardization and comparability. We need to work on the data issues and the information issues. A lot of the measures that are in HEDIS, and I was there when the first conversations took place to develop that starting in 1989, are process measures. That is the best we can do at the moment. That doesn't mean they are bad measures. We need to improve the measures, but we need to improve them for all segments of the population, whether it's Medicare, Medicaid or the insured population that we cover.

I want to thank you very much for the opportunity to comment, and I will take any questions that you have.

[The prepared statement of Ms. Mercure follows:]

PREPARED STATEMENT OF SUZANNE C. MERCURE

Mr. Chairman, and members of the committee: My name is Suzanne C. Mercure. I am Manager of Benefits Administration for health and disability programs for Southern California Edison (SCE). I appreciate the opportunity to testify today regarding the Federal Oversight of Medicare HMOs: Assuring Beneficiary Protection. Southern California Edison is the nation's second largest electric utility serving four million customers in Central and Southern California. SCE provides health care coverage for more than 55,000 employees, retirees, and their family members. Currently we offer both our employees and retirees a choice of four HMOs and two Point-of-Service (POS) plus an additional two Medicare Risk HMOs for retirees. We have diverse population in terms of both health care needs and geographic access due to the widely dispersed locations of our company.

Today I would like to discuss SCE's role as a purchaser of these health care plans and to share some of our experiences that could be applicable to the Federal oversight of Medicare HMOs.

SCE, like most large companies, believes that the provision of comprehensive health benefits is necessary to insure a healthy and productive work force. Our commitment is to assure employees receive high-quality, cost-effective health care services in the most appropriate setting. Comprehensive covered health benefits are essential to allow the medical community to provide the most appropriate services versus at times paying for the most expensive services. Health benefits should focus on preventive services, early diagnosis and treatment.

SCE'S HEALTH CARE PROGRAM

SCE opened its first company clinic in the 1920's at a remote work site in Big Creek, where the Company began a long history of commitment to health care for all employees. Over the next years, 7 clinics were added and, in the 1950's, a pharmacy and laboratory. The emphasis on services was for employment-based needs and occupational health. This was expanded to non-occupational health services for both employees and dependents. The company provided an indemnity plan and several HMOs. In the late 1980s, SCE reviewed these options to try to manage cost better. This resulted in the development of a PPO by SCE which was self-administered. With concerns about continued cost escalation and more emphasis on quality, SCE changed the program to purchase health coverage through "retail" POS and HMO options effective on January 1, 1995. At the same time, a large medical group took over the management of the clinics and pharmacy.

The goals for the 1995 changes were to: improve the quality of the care provided by implementing integrated networks; continue to provide choices for employees and retirees—both at the plan and the individual physician level; promote prevention and primary care by contracting with networks coordinating care through a primary care physician; change SCE's role to that of *purchaser* rather than provider of services or merely a payer of services; and reduce cost over time.

For the SCE employees and retirees, these changes resulted in each health plan member having to review all the different options and decide on which option would best meet their needs. This involved an education process with information provided by SCE about the plans, a comparison of the networks, and actual meetings with plan representatives—sometimes including a plan clinician. The enrollment results were as follows:

1995 OPEN ENROLLMENT RESULTS

Health plan type	Number enrollees (employees, retirees, and dependents)	Percent of total
HMO	21,205	38
POS	26,904	49
Medicare coordinated benefit	5,600	10
Medicare risk	1,631	3
Total covered lives	55,340	

As you can see from the results, the enrollment in Medicare Risk is small despite the Medicare Risk plans' broad geographic area of access and an intense communication effort. This result is not surprising. Despite the market penetration of managed care in California, the myths about quality and access persist. Perhaps the most significant concern for the over-age-65 population is the possibility of changing physicians. This is the single most critical selection factor for the Medicare population—continue with the same physician. To assist with this, SCE made special arrangements for a "continuation of care provision" for a number of individuals with ongoing medical conditions. Over time, we expect enrollment in Medicare Risk plans to increase as the plans become more familiar to the retirees and as we can demonstrate, through our role as purchaser, the quality of the plans.

SCE ROLL AS PURCHASER

In the role as purchaser, SCE considers our role to evaluate health plan performance and facilitate consumer health education.

HEALTH PLAN ACCOUNTABILITY

The SCE approach to managing our relationship with our health plans involves a number of activities. For Health Plan Performance, we have *four specific areas for review.*

NCQA ACCREDITATION

First, we look at whether the plan is or is seeking accreditation by the National Committee for Quality Assurance (NCQA). The intensity of the accreditation process is an excellent measure of the plans commitment to quality improvement.

The accreditation process reviews the health plan quality assurance program, utilization management process, credentialing, preventive health services, members' rights and responsibilities, and medical records. The focus on continuous quality improvement and accountability are the foundation blocks we consider to be most important.

HEDIS REPORTING

Second, we require information reported through the Health Plan Employer Data and Information Set (HEDIS). This is a document with 60 measures in the areas of quality of care, membership and utilization, member access and satisfaction, finance, and health plan management activities which is a starting point toward comparability and measurement of health plan performance. Additionally, we are working with NCQA and other employers on the improvement of the measures for future editions of HEDIS. We promote the development of uniform measures that can be used by all purchasers, including Medicare.

We are working with NCQA, other employers, and health plans on a pilot data collection and reporting project for the HEDIS information. This project should lead to the development of a common data repository for HEDIS by all the health plans, and a single set of standard reports. HEDIS activity is designed to promote the use of comparable data and establish benchmarks to promote quality improvement. The use of a central data base makes reporting by each plan more uniform and potentially available from a single source, which enhances efficiency.

Future HEDIS work is designed to promote better measures of performance as the health care delivery system moves to outcome measures. SCE works with both the employer community and NCQA through committees to promote the enhancement of HEDIS during this dynamic period. Many large employers who provided health

benefits to retirees are looking to expand performance measures pertinent to the retiree population, so I believe it's in our mutual interest to collect information that will help measure not only the quality of care but the quality of caring in the delivery system. These data need to be incorporated into a single reporting system.

CUSTOMER SATISFACTION

Third, we are asking our employees and retirees about their experiences with the health plans through a customer satisfaction survey. (In addition, we asked retirees and employees about the level and types of information they received as a follow-up to open enrollment. We are establishing two consumer committees to have regular input and to be able to test ideas, especially for communications.)

The survey was sent to the sample of employees and retirees at the end of June with results expected by the beginning of September. We are sending a separate survey to our Medicare retirees. Both surveys are protected by copyright through CareData Reports, Inc. The types of questions include: comparison of your current plan to your previous plan; reason for selecting the current plan; whether individual has a primary care physician (PCP) prior to joining the plan and specific questions about specialist care including the referral process; use of any out-of-network services; prescription drug, hospital, and preventive service questions; plan administration and service.

These are all designed to be able to get the employee/retiree perception of service. We will use the information to help our employees and retirees during open enrollment and for our quality improvement and performance monitoring with the individual plans. This information will also complement the data we maintain through our internal systems on questions, problems, and issues with the plans.

One of the areas for improvement in HEDIS is customer satisfaction reporting. There are two questions in HEDIS which are reported by the plans. However, the questions used in the current surveys and the methodology for the survey selection and processes are not uniform across plans, so this data is not comparable. SCE, along with other employers and NCQA, is supporting the use of a common core set of survey questions for measuring satisfaction. The health plans should continue to use other surveys as part of their own quality improvement efforts.

Additionally, in California, the Pacific Business Group on Health has for five years collaborated with their member companies on a customer satisfaction survey. SCE has not yet participated in their survey but we will use the information as another benchmark for our survey results.

PERFORMANCE GOALS

Fourth, we have developed a set of performance goals for our discussion with the plans. This is helping us understand how the plans work, their commitment to quality improvement, and their understanding of the value we are seeking on behalf of our customer—the employee, retiree, or dependent. The goals provide the framework for our partnership dialogue, decisions about collaborative projects, and focus on quality in areas targeted to promote excellence in service (both clinical and customer-oriented). A copy of the goals is provided with this testimony. The goals are compiled from a number of sources based on our prior experience and the experiences of others. There are four broad categories:

Structure and philosophy: This section assesses what the plan-wide commitment is to total quality management. We look for integrated approaches to using information and provision of services as well as commitment at all levels to continuous improvement.

Service: The areas of access to providers (including gerontologists), availability of appointments, member services (information, complaint resolution, etc.), member satisfaction, and employer service are all reviewed in this section.

Clinical quality: The commitment to integrated care is reviewed with provider credentialing and monitoring, condition-specific continuum of care, prevention, mental health and substance abuse, prescription drugs, hospital care, and confidentiality. The key area is patient centered care or how the patient perspective is included in all clinical aspects of the treatment and communication processes.

Finance and information: Performance measurement, reporting to clinical and service providers on satisfaction, use of information in making business decisions, and financial reporting are all reviewed in this segment.

We provided our goals to the plans for review and comment. We then meet with the plans to go over the goals in detail. We are looking to establish relationships to work in partnership with the plans to improve quality of care and caring.

SCE works with other employers and organizations to collaborate on quality initiatives. We share this with the health plans and look for opportunities to include

the plans in these activities. This in turn influences our performance goals as we all share information and look for better ways to service our population.

CONSUMER HEALTH EDUCATION

To promote consumer involvement in health care, we have an ongoing communications effort coordinated with the health plans. We provide information on how to access services, common questions, and using preventive services. During our 1995 open enrollment, plan comparison for benefit design and cost were provided to all employees and retirees in addition to information from the health plans about the physicians and networks. A series of meetings, workshops, phone inquiry access lines, videos, and written materials were used. Most effective for the retirees were the meetings which allowed time for individual concerns to be addressed in a person-to-person manner. We followed up this enrollment process with a survey to get input on reactions. This information is forming the basis for our planning for 1996 open enrollment as well as quality improvement processes with the health plans.

In September 1995, we will distribute copies of Health Pages, a consumer magazine, to all of our retirees and employees. A copy of the edition produced in Pittsburgh accompanies this testimony. Health Pages provides both general health care information as well as specific information about physicians, hospitals and health plans in a market area. We have worked with one health plan to establish a pilot project to work with retirees on what questions they should be asking, what to expect from the doctor visit, and other consumer coaching to improve patient-physician encounters.

CONCLUSIONS

In conclusion, SCE uses a four-step approach to measuring performance and improving quality for our health plan members. We try to collaborate with others and to effect change through our purchaser initiatives. We encourage the development of common standards for all purchasers to use and promote the performance reporting work already under way in the private sector. We encourage the Federal oversight of Medicare HMOs to build on this work by the private purchasers.

The CHAIRMAN. Let me thank all of you. I didn't want to cut you short except I could feel the anxiety level being raised by my colleagues because they all have other commitments. In fact, I am due on the floor to offer an amendment to the ABM Treaty of the DOD bill.

I have a series of questions that would probably take all of you an hour to answer but what I'd like to do is provide them to you in writing and then perhaps you could just respond for the record. They would address Dr. Jampol's point of service, should we make it optional, make it mandatory, what are the costs, look at some of the things you're doing in terms of the accreditation process. All of these questions, hopefully, will be helpful to my colleagues as we start to examine exactly what needs to be done and what kind of legislation is going to be necessary, if any, what sort of oversight needs to be done by HCFA, and what sort of actions are being taken by the industry.

We didn't spend a good deal of time discussing the kinds of abuses that you heard earlier in terms of the high pressure sales pitches that are being made, the disenrollment rates, or what is the industry doing to self-regulate. For example, we've had many hearings dealing with durable medical equipment, as one example, where 95 percent of all the suppliers are top-rated professionals who care about the quality of the products they serve their clientele or customers and they have been very concerned about the few bad apples in the system that give the entire industry a black eye. They have been very aggressive in working with our staff to promote legislation that will hopefully curb that. So it would be important for the industry itself to take a very progressive and aggres-

sive role in making sure that as we move toward greater HMO utilization that there is an increase in self-regulation and self-disciplinary actions being taken.

I do want to thank Mary Gerwin who is the Chief of Staff of the Aging Committee. She has helped a great deal in putting this together, along with Priscilla Hanley and Helen Albert of my staff. As you can see, the staff is dominated by women—we tend to get more work done that way. This is not to be in any way critical of Ken Cohen, who is no relation, on Senator Pryor's staff, and Theresa Forster, you've been just terrific in working with the majority.

Senator Pryor may have indicated earlier to you, we've always worked together. This is a completely nonpartisan panel. As such, we have, over the years, really made it a goal in dealing with issues affecting the elderly, that there are no party lines that we are not trying to develop or exploit any differences of opinion. That has been true particularly here in looking at this issue of HMOs.

We're going through a very controversial discussion on where we are going with our health care system and it's not going to be easy to sort out all the pros and cons. As I indicated in my opening statement, I believe HMOs are going to be utilized at a greater and greater level. There are some problems associated with HMOs, like there are in any facet of our health care industry as such, and we've got to deal with those in the most constructive fashion that we can. I think that your testimony, along with those who testified earlier today, will make a major contribution in doing that.

Thank you for being so patient. I apologize for the delay but we have very little control over our system. To you, Ms. Mercure, in terms of having a long-term strategy, I would be the first to confess that there is very little long-term strategizing that takes place in the U.S. Congress, whether it applies to defense, whether it applies to any other facet of our business—finance, tax, health, all of these issues. We tend to take a very short-term view. The only long-term strategy seems to be one taken by our constituents and that is to have a long-term strategy of controlling the length of terms of Members of Congress.

Absent that, I have to agree with you, we don't look very far into the future and we are, not incapable, but it's more difficult to formulate long-term policies when you have a system which turns over every 2 years or every 6 years, and you have the fundamental rule, one Congress cannot bind another Congress. As a result, we have difficulty holding onto a coherent policy for any length of time.

I was talking a moment ago in jest but to the extent that we have even greater turnover and more turbulence in terms of members coming in and going out, you will have even greater difficulty holding onto long-term policies because the membership is going to change so radically or rapidly in a very short period of time. That makes it that much more difficult.

I'm not waxing to an eloquent statement about why we should not have term limits, but let me say it's going to create its own sense of problems. With or without term limits, you're going to see a pretty dramatic turning over of membership in the U.S. Congress for sometime to come. That will complicate our problem.

I thank all of you for coming. The Committee will now stand adjourned.

[Whereupon, at 12:38 p.m., the Committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

STATEMENT ON BEHALF OF THE AMERICAN LUNG ASSOCIATION AND THE AMERICAN THORACIC SOCIETY

These comments are submitted to the Senate Special Committee on Aging on behalf of the American Lung Association and its medical section, the American Thoracic Society in reference to the committee's August 3, 1995, hearing on Federal Oversight of Medicare HMO's.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society—a 12,500 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research—the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

The ALA/ATS would like to take this opportunity to bring to the attention of the Committee its concerns regarding access to specialty care for the chronic lung disease patient enrolled in Medicare. Under the proposed Medicare reform plan, which focusses principally on enrolling Medicare recipients into managed care plans, the access to specialty care question is paramount for our constituents who suffer from lung disease.

LUNG DISEASE AMONG THE MEDICARE POPULATION

The prevalence of chronic lung disease varies with age, but for most categories chronic lung disease hits hardest in individuals 65 years of age and older. For instance, the prevalence of chronic bronchitis is the highest in those over 65, where 61.7 persons per 1,000 in the 45-to 64-year-old group and nearly doubling to 29.8 per 1,000 after age 65. In addition, those over age 65 experience the second highest prevalence of asthma—48.2 per 1,000.

With these statistics in mind, it is only natural that the ALA/ATS be concerned with how Medicare recipients with chronic lung disease are treated under Medicare reform. If current proposals prevail, there will be an increasing number of Medicare recipients enrolled in managed care. The ALA/ATS wants to make sure that those with chronic lung disease will receive the same quality care and access to specialty care in HMO's they receive under the present Medicare fee-for-service system.

THE NEED FOR ACCESS TO SPECIALTY CARE

In order to maintain optimal functioning in the face of a disabling condition such as chronic lung disease, patients require a wide range of health-related services. Medical treatment is, of course, primary. In terms of physician care, the patient's family physician usually makes a tentative diagnosis of chronic lung disease. In most instances, a consultation with a pulmonary specialist is suggested. In some cases, because of the extent of the patient's disease, referral to a pulmonary specialist is necessary.

Specialists serve a dual role in clinical practice: as a primary physician for a person with chronic disease and a as a consultant for acute illness where the patient has been referred to the specialist. A gatekeeper system that too strictly requires permission or referral for every visit to a specialist would be a large detractor to access for people with chronic lung problems. Appropriate management of moderate to severe asthma by a specialist, for example, is more likely to result in fewer costly hospitalizations that care of those same cases by a general internist or family practioner who does not have the extensive training to work with asthma. Further, pulmonary physicians are generally able to assume full care for the patient whose primary problem is lung related and more often do so at the patient's request.

The American Lung Association and the American Thoracic Society are dedicated to ensuring that Medicare recipients who have chronic lung disease have access to

the appropriate specialty care. Therefore, the ALA/ATS supports the federal government's continued oversight role over Medicare HMO's and, further recommends including specific language mandating an out-of-service option for managed health care plans in any Medicare reform bill. If this is not done, access to providers who are specialists for individuals with chronic diseases (e.g. a specialist acting in the primary care provider role) may continue to be denied, or severely restricted in the interest of cost savings. In addition, financial disincentives for specialty referral must be eliminated and referrals always must be based on the best interest of the patient, not the financial interests of the health plan.

CONCLUSION

With the ever increasing number of Medicare recipients enrolling in managed care plans and considering proposed legislative plans to encourage this trend, Congress should make sure that the issues of access to specialty care is thoroughly reviewed. Continued access to specialty care is of extreme importance to those with chronic diseases, especially chronic lung disease. It is the hope of the American Lung Association and the American Thoracic Society that the committee will seriously and carefully consider these comments as it further explores the federal government's oversight responsibility of Medicare HMO's.

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