United States General Accounting Office

GAO

Report to Congressional Requesters

October 1996

MEDICARE

HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance

GAO/HEHS-97-23

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-270167

October 22, 1996

The Honorable William S. Cohen
Chairman
The Honorable David H. Pryor
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Charles E. Grassley
The Honorable John B. Breaux
The Honorable Russell D. Feingold
The Honorable Ron Wyden
United States Senate

This report responds to your request that we review issues in marketing and enrollment for health maintenance organizations (HMO) serving Medicare beneficiaries and information that could be made available to assist beneficiaries in choosing an HMO. This report contains recommendations to the Secretary of Health and Human Services that would make more information about HMOs available to the public.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies of this report to appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. If you have any questions about this report, please call me at (202) 512-7114. Other major contributors are listed in appendix IV.

William J. Scanlon
Director, Health Financing and
Systems Issues

Executive Summary

Purpose

In previous years, the need for useful, comparative information on health maintenance organizations (HMO) serving Medicare beneficiaries was not a front-burner issue. Nearly all beneficiaries received care through a fee-for-service arrangement with benefits and cost-sharing provisions standardized nationwide. Today, however, almost 4 million beneficiaries have opted for HMOs, Medicare's predominant managed care alternative. Although HMOs must cover the benefits available under traditional fee-for-service Medicare, they differ from one another in the provision of additional benefits, required premiums, networks of providers, and ability to satisfy members. Because of these differences, beneficiaries need information to pick the plan right for them.

Some beneficiaries do not understand even the basic differences between traditional Medicare and HMOs and may confuse HMOs with supplemental "Medigap" insurance. Moreover, some HMO sales agents have misled or used other questionable marketing practices to enroll poorly informed beneficiaries.

For these reasons, Senator Pryor, the Ranking Minority Member of the Senate Special Committee on Aging—joined by Senator Cohen, Chairman, and by Senators Grassley, Breaux, Feingold, and Wyden—asked GAO to examine issues related to the marketing, education, and enrollment practices of health plans participating in the Medicare risk-contract HMO program. In this report, GAO reviews (1) the performance of the Health Care Financing Administration (HCFA), which administers the Medicare program, in providing beneficiaries sufficient information about Medicare HMOs and (2) the usefulness of readily available HCFA data to caution beneficiaries about poorly performing HMOs.

Background

Of the more than 4 million beneficiaries enrolled in Medicare managed care, 90 percent are in "risk-contract" HMOs.[1] Medicare pays these HMOs a fixed, per beneficiary fee, regardless of what the HMO spends for each enrollee's health care. These HMOs are called "risk" HMOs because the HMO assumes the financial risk of providing care for the amount Medicare pays.

Compared with traditional fee-for-service Medicare, risk HMOs typically cover additional benefits, cost beneficiaries less money, and offer freedom from complicated billing statements. Risk HMOs are required to cover all Medicare benefits, but many also provide additional services—such as

[1]Approximately 500,000 beneficiaries are enrolled in HMOs that are reimbursed by HCFA on a cost basis or in another form of managed care. See footnote 5 in ch. 1 for more details.

outpatient prescription drugs, routine physical exams, hearing aids, and eyeglasses—that are not covered under traditional Medicare. Although some HMOs charge a monthly premium, others do not. In all cases, however, beneficiaries must continue to pay a premium to Medicare—currently $42.50 per month—and any specified HMO copayments. In return for the additional benefits HMOs furnish, beneficiaries give up their freedom to choose any provider. If a beneficiary enrolled in an HMO seeks nonemergency care from providers other than those designated by the HMO, or seeks care without following the HMO's referral policy, the beneficiary is liable for the full cost of that care.

Although some sections of the country—primarily rural areas—have no Medicare HMOs, other sections are served by several. More than 50 percent of all Medicare beneficiaries can choose from among at least two HMOs. In some locations, beneficiaries can choose from among as many as 14 different HMOs. Because a single HMO may offer multiple products, each with its own combination of covered benefits and premium levels, the number of choices often exceeds the number of available HMOs.

Results in Brief

HCFA does not provide beneficiaries any of the comparative consumer guides that the federal government and many employer-based health insurance programs routinely distribute to their employees and retirees. For example, California's large public employee retirement system provides its members summary charts comparing the benefit packages and premium rates of available area plans. Medicare beneficiaries seeking similar information face a laborious, do-it-yourself process, including (1) calling a toll-free telephone number and requesting the names and phone numbers of the HMOs serving their area; (2) calling each of the HMOs to request marketing materials; and (3) poring over a stack of brochures, each formatted differently and in terminology that is not standardized, to compare the competing plans.

HCFA amasses volumes of information that could be packaged and distributed to help consumers choose among competing Medicare HMOs. For example, HCFA compiles, for its internal use, information on plans' premium requirements and benefit offerings that could be used to construct HMO benefit comparison charts. HCFA also compiles the data needed to calculate HMO disenrollment rates—an indicator of beneficiary satisfaction. HCFA could publish, from other data it routinely collects for oversight purposes, rates of enrollees' complaints and the results of certification visits to HMOs.

HCFA is developing comparison charts that will contain information on benefits and costs for all Medicare HMOs. HCFA does not plan to distribute these charts to beneficiaries but will post them in an electronic format on the Internet. HCFA expects the primary users of this information to be beneficiary advocates, insurance counselors, and government entities—not beneficiaries. None of the HMO-specific information HCFA routinely collects will be distributed directly to beneficiaries.

Of all the information HCFA gathers, disenrollment rates may be particularly useful in helping beneficiaries distinguish among competing HMOs. When GAO analyzed HCFA disenrollment data for the Miami and Los Angeles markets, it found that some plans have a much better record than others of retaining Medicare enrollees. (See fig. 1.) For example, nearly 1 in 3 Medicare applicants either canceled or left Miami's CareFlorida within the first 3 months, whereas only 1 in 10 of Health Options' or Prudential Health Care's Medicare applicants left this early. GAO observed a wide range in plans' total disenrollment rates as well, as shown in figure 2.

Figure 1: Percent of Applicants Leaving HMOs Within 3 Months—Highest and Lowest HMO Rates in Market Area in 1995

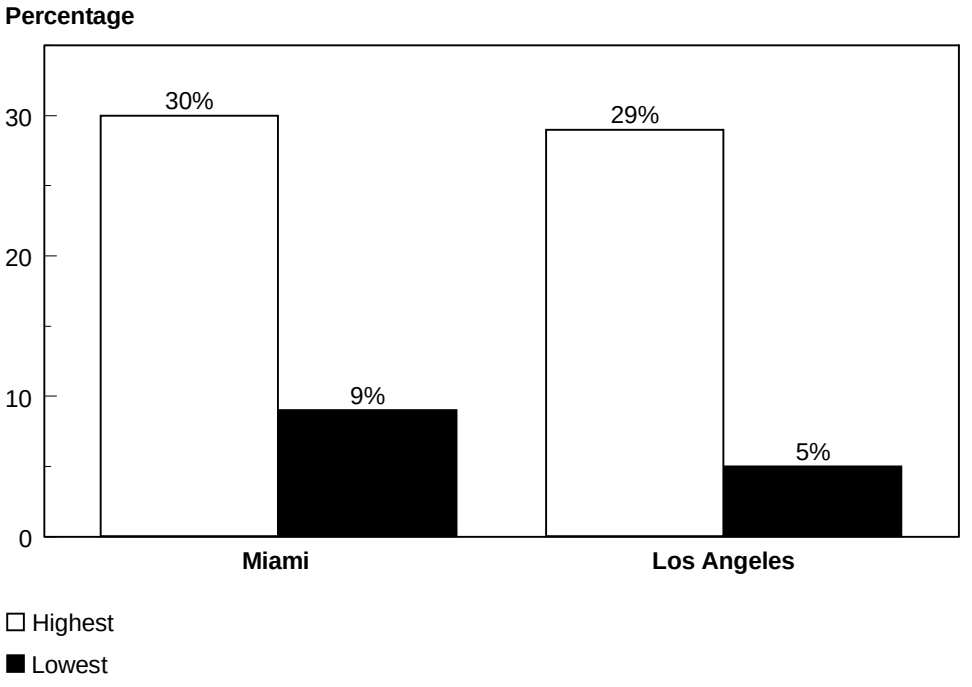
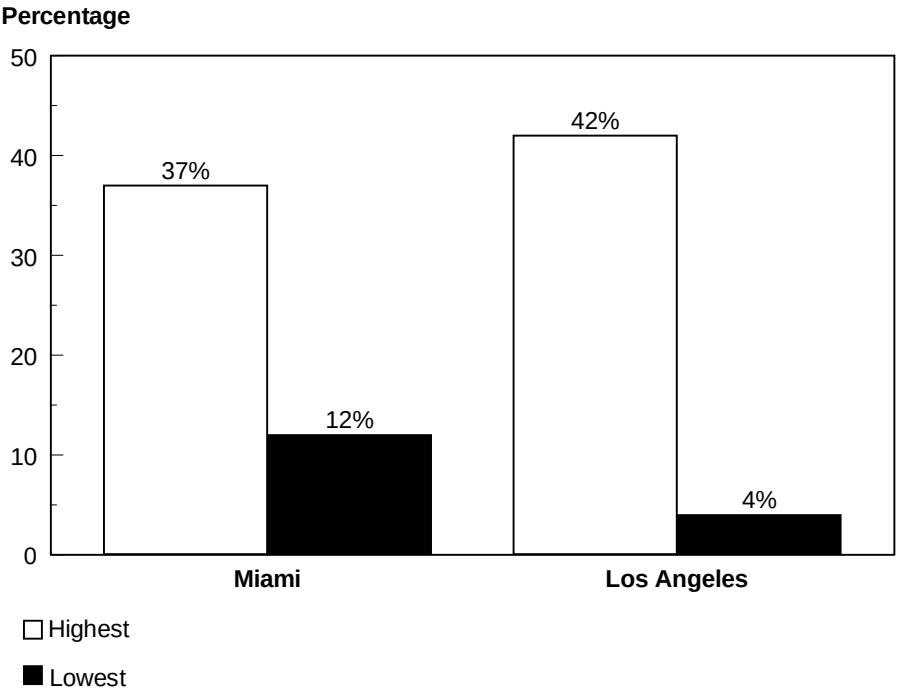


Figure 2: Total Disenrollment Rates—Highest and Lowest HMO Rates in Market Area in 1995



Disenrollment statistics do not distinguish among the many reasons for voluntary disenrollment (GAO excluded disenrollments due to death or loss of eligibility), but they can serve as caution signals. If disenrollment rates were publicized, informed beneficiaries could ask sales representatives tough questions and seek additional information before deciding to join an HMO with a disenrollment rate substantially higher than its competitors'. HMOs would also gain from the publicizing of disenrollment rates because they could then compare their performance with the competition.

Principal Findings

Medicare Does Not Share Available Health Plan Information With Its Beneficiaries

Though Medicare is the nation's largest purchaser of managed care services, it lags other large purchasers in helping beneficiaries choose among plans. The Federal Employees Health Benefits Program, the California Public Employees' Retirement System, Minnesota Medicaid,

Xerox Corporation, and Southern California Edison are all large health care purchasers that provide enrollees with comparative information such as premium rates, benefits, out-of-pocket costs, and member satisfaction survey results for available plans. By contrast, HCFA does not routinely provide beneficiaries any comparative information on the Medicare HMOs available in their area.

HCFA's San Francisco regional office has demonstrated that cost and benefit comparison charts can be readily constructed using data HCFA already collects. For the last 2 years, that office has produced comparison charts for the Los Angeles, San Francisco, Arizona, and Nevada market areas.[2] However, the office distributes these charts primarily to the HMOs, some news organizations, and federally supported insurance counselors.[3] Beneficiaries can request these charts from HCFA's regional office, but few beneficiaries know the charts exist. Even the volunteers staffing the insurance counseling offices may be unaware of the charts. When GAO staff called a Los Angeles insurance counselor and asked specifically about Medicare HMO information, GAO was not told about the comparison charts.

HCFA is working to develop "electronic" comparison charts for all Medicare HMOs. HCFA has not yet determined the format of these charts because it is still studying the information needs of beneficiaries. However, the agency plans initially to include information on HMOs' benefits and premiums and later add other information. By producing this information in an electronic form, HCFA will be able to update the information as the Medicare HMO market evolves. If this information exists only on the Internet, however, it may be relatively inaccessible to the very individuals who would find it useful.

For beneficiaries considering Medicare managed care for the first time or switching to a new plan, acquiring information on all area HMOs is time consuming. The toll-free number that beneficiaries are supposed to call to get a list of available plans appears in the back of their Medicare handbook. However, the handbook generally is mailed to only those individuals turning age 65 or to beneficiaries who specially request it. Even after finding the number, beneficiaries face challenges in obtaining and comparing HMO information. When GAO called all 14 Medicare HMOs in Los

[2]Recently, HCFA's regional office in Philadelphia began producing similar comparison charts.

[3]These counselors, many of whom are volunteers, are available through the federally supported but state-managed Information, Counseling, and Assistance (ICA) program. ICA counselors can provide beneficiaries with general information about Medicare, Medicaid, managed care plans, and various types of health insurance available to supplement Medicare.

Angeles to request their marketing materials, information from only 10 plans was received after several weeks and several follow-up calls. Some plans were reluctant to mail the information but offered to send it out with a sales agent. Declining visits from sales agents, GAO finally obtained the missing brochures by calling the HMOs' marketing directors and insisting that the marketing materials be mailed.

Using marketing materials alone to compare HMOs' benefits and costs is extremely difficult because each plan uses different formats and terminology. One Los Angeles HMO's "summary of benefits" spanned 14 pages; another had only a 1-page summary. (See fig. 2.2 in ch. 2.) In the absence of standard formats and terminology, beneficiaries seeking information on mammography benefits, for example, had to look under "mammography," "X ray," or another category, depending on the particular brochure. Some HMOs used veiled language to note access restrictions. For example, one plan repeatedly claimed that "our primary care physicians can refer you to a specialist" but never clearly stated the HMO's policy that beneficiaries must obtain a referral before seeing a specialist. HCFA plans to implement the "National Managed Care Marketing Guideline" for HMO marketing materials starting in 1997. However, this guideline—as currently drafted—will not require standard formats or terminology.

HCFA has a wealth of data, collected for program administration and contract oversight purposes, that can indicate beneficiaries' relative satisfaction with individual HMOs. These indicators include statistics on beneficiary disenrollment and complaint rates. HCFA collects other HMO-specific information, including plans' financial data and reports from HCFA's periodic monitoring visits to HMOs. However, HCFA has released none of this potentially useful information directly to Medicare beneficiaries.

Publishing Disenrollment Rates Could Discourage Poor Marketing Practices

Because Medicare beneficiaries enrolled in HMOs may choose each month to switch plans or return to fee for service, an analysis comparing plans' disenrollment rates can suggest beneficiaries' relative satisfaction with competing HMOs. Despite the value of such an analysis, however, HCFA does not routinely or systematically compare HMOs' disenrollment rates. As a result, HCFA misses an opportunity to pursue leads suggesting which HMOs might be disproportionately responsible for marketing abuses or health care delivery problems. Moreover, by not publishing the rates, HCFA (1) misses an opportunity to show beneficiaries which plans have a good record of retaining Medicare enrollees and (2) hinders HMOs' efforts to benchmark their own performance.

GAO conducted its own analysis of HCFA disenrollment data and found that Medicare HMOs' ability to retain beneficiaries varies widely among HMOs in the same market. This finding is consistent with a 1988 GAO study comparing Medicare HMO disenrollment rates. For some HMOs in GAO's review, disenrollment rates were high enough to raise questions about whether the HMO's emphasis was on providing health care to enrollees or recruiting new enrollees to replace the many who disenrolled. In Miami, early disenrollment rates (beneficiaries who canceled or left within 3 months) ranged from Prudential Health Care's rate of 9 percent to CareFlorida's rate of 30 percent. Annual disenrollment rates (total number of disenrollees as a percentage of average total membership) for Miami HMOs ranged from Health Options's rate of 12 percent to PCA Health Plan's rate of 37 percent. GAO observed similar variation in Los Angeles, where early disenrollment rates ranged from Kaiser's 5 percent to United Health Plan's rate of 29 percent, and annual disenrollment rates ranged from Kaiser's 4 percent to Foundation Health's 42 percent. (See ch. 3 for details.)

Recommendations

In August 1995, GAO recommended that the Secretary of Health and Human Services (HHS), whose Department oversees HCFA, direct the HCFA Administrator to publish, among other things, the comparative HMO data it collects. In this report, GAO renews its previous recommendations and recommends specific steps that the Secretary should take to help Medicare beneficiaries make more informed health care decisions. Among these steps, GAO calls for

- standard formats and terminology in HMOs' informational materials;
- benefit and cost comparison charts with all Medicare HMO options available for each market area; and
- wide distribution of HMOs' disenrollment rates, complaint rates, and summary results of HCFA's site monitoring visits.

Agency Comments

HHS agreed with GAO that "Medicare beneficiaries need more information and that informed beneficiaries can hold plans accountable for the quality of care." HHS noted several HCFA initiatives that will eventually yield information to help beneficiaries choose plans right for their needs. GAO believes that these initiatives move in the right direction but that HCFA could do more for beneficiaries with information the agency already collects. The full text of HHS' comments appears in appendix III.

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Abbreviations

CalPERS	California Public Employees' Retirement System
DDST	Data Development and Support Team
FAcct	Foundation for Accountability
HCFA	Health Care Financing Administration
HCPP	Health Care Prepayment Plan
HEDIS	Health Plan Employer Data and Information Set
HHS	Department of Health and Human Services
HIP	HIP Health Plan of Florida
HMO	health maintenance organization
ICA	Information, Counseling, and Assistance Program
NCQA	National Committee on Quality Assurance
OIG	Office of Inspector General
PCA	PCA Health Plan of Florida
POS	point of service

Introduction

Between August 1994 and August 1996, enrollment in Medicare risk-contract health maintenance organizations (HMO) rose by over 80 percent (from 2.1 million to 3.8 million), and the number of risk-contract HMOs rose from 141 to 229. As managed care options become increasingly available to Medicare beneficiaries, the need for information that can help them make prudent health care decisions has become more urgent. The need for straightforward and accurate information is also important because in the past some HMO sales agents have misled beneficiaries or used otherwise questionable sales practices to get them to enroll.[4]

Traditional Fee-for-Service Medicare Available to All Beneficiaries

For most 65-year-olds, notice of coverage for Medicare benefits comes in the mail—a Medicare card from the Health Care Financing Administration (HCFA), which administers the Medicare program. Unless beneficiaries enroll in an HMO, HCFA automatically enrolls them in Medicare's fee-for-service program.

Medicare's fee-for-service program, available nationwide, offers a standard package of benefits covering (1) hospitalization and related benefits (part A), with certain coinsurance and deductibles paid by the beneficiary, and (2) physician and related services (part B) for a monthly premium ($42.50 in 1996), a deductible, and coinsurance. Medicare part B coverage is optional, though almost all beneficiaries entitled to part A also enroll in part B. Many beneficiaries in the fee-for-service program enhance their Medicare coverage by purchasing a private insurance product known as Medigap. Medigap policies can cost beneficiaries $1,000 a year or more and must cover Medicare coinsurance. Some policies also cover deductibles and benefits not covered under Medicare such as outpatient prescription drugs.

Medicare HMOs Typically Offer Additional Benefits but Restrict Provider Choice

Medicare beneficiaries may enroll in a Medicare-approved "risk" HMO if available in their area. Such a plan receives a fixed monthly payment, called a capitation payment, from Medicare for each beneficiary it enrolls. The payment is fixed per enrollee regardless of what the HMO spends for each enrollee's care. An HMO paid by capitation is called a risk-contract HMO because it assumes the financial risk of providing health care within a fixed budget. Although other types of Medicare managed care exist, almost

[4]Similar problems were identified over the sale of Medigap and long-term care insurance. See Medigap Insurance: Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment, (GAO/HRD-91-49, Mar. 5, 1991) and Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/T-HRD-91-14, Apr. 11, 1991).

90 percent of Medicare beneficiaries now in managed care are enrolled in risk-contract HMOs.[5]

Compared with the traditional Medicare fee-for-service program, HMOs typically cost beneficiaries less money, cover additional benefits, and offer freedom from complicated billing statements. Although some HMOs charge a monthly premium, many do not. (Beneficiaries enrolled in HMOs must continue to pay the Medicare part B premium and any specified HMO copayments.) HMOs are required to cover all Medicare part A and B benefits. Many HMOs also cover part A copayments and deductibles and additional services—such as outpatient prescription drugs, routine physical exams, hearing aids, and eyeglasses—that are not covered under traditional Medicare. In effect, the HMO often acts much like a Medigap policy by covering deductibles, coinsurance, and additional services.

In return for the additional benefits HMOs furnish, beneficiaries give up their freedom to choose any provider. If a beneficiary enrolled in an HMO seeks nonemergency care from providers other than those designated by the HMO or seeks care without following the HMO's referral policy, the beneficiary is liable for the full cost of that care. Recently, Medicare allowed HMOs to offer a "point-of-service" (POS) option (also known as a "self-referral" or "open-ended" option) that covers beneficiaries for some care received outside of the network.[6] This option is not yet widely available among Medicare HMOs.

[5]Fewer than 200,000 Medicare beneficiaries are enrolled in "cost" HMOs, plans that do not restrict provider choice but require beneficiaries to pay Medicare's coinsurance, deductibles, and other charges for care received outside the HMO network. Cost plans are so called because HCFA reimburses them for the reasonable cost of providing covered Medicare services. About 300,000 beneficiaries are enrolled in Health Care Prepayment Plans (HCPP)—a third type of Medicare managed care. HCPPs do not operate like risk or cost HMOs. For example, HCPPs may cover only Medicare part B services and may have restrictive enrollment policies.

[6]HCFA guidelines specify that "Plans can design enrollees' cost-sharing (premium, coinsurance, copayment, or deductible) for the POS benefit. However, HCFA will review enrollee cost-sharing to ensure that enrollees' charges for the POS benefit do not exceed the adjusted community rate [which HCFA uses to determine the HMO's payment]."

HMOs Market Continuously in Response to Beneficiaries' Freedom to Join and Switch Plans Monthly

Managed care plans' marketing strategies and enrollment procedures reflect Medicare beneficiaries' freedom to move between the fee-for-service and managed care programs. Unlike much of the privately insured population under age 65, beneficiaries are not limited to enrolling or disenrolling only during a specified "open season;" they may select any of the Medicare-approved HMOs in their area and may switch plans monthly or choose the fee-for-service program. Thus, HMOs market their plans to Medicare beneficiaries continuously rather than during an established 30- or 60-day period.[7] HMOs and their sales agents, not HCFA, enroll beneficiaries who wish to join a managed care plan.

Most beneficiaries have access to at least one Medicare HMO, and more than 50 percent of beneficiaries have at least two HMOs available in their area. In some urban areas, beneficiaries can choose from as many as 14 different HMOs. Each HMO may be distinguished from its competitors by its coverage of optional benefits, cost-sharing arrangements, and network restrictions. As a practical matter, the number of choices is likely to be greater than the number of HMOs because a single HMO may offer multiple Medicare products, each with its own combination of covered benefits and premium levels.

Objectives, Scope, and Methodology

In February 1996, Senator Pryor, the Ranking Minority Member of the Senate Special Committee on Aging asked us to examine issues related to the marketing, education, and enrollment practices of health plans participating in the Medicare risk-contract HMO program. Subsequently, he was joined by Committee Chairman Cohen and by Senators Grassley, Breaux, Feingold, and Wyden as corequesters. This report focuses on information that can help beneficiaries become discerning consumers. In particular, the report reviews (1) HCFA's performance in providing beneficiaries comparative information about Medicare HMOs to assist their decision-making and (2) the usefulness of readily available data that could inform beneficiaries and caution them about poorly performing HMOs.

Our study focused on risk-contract HMO plans, which (as of August 1996) enrolled almost 90 percent of Medicare beneficiaries enrolled in managed care. In conducting our study, we reviewed records at HCFA headquarters and regional offices and interviewed HCFA officials, Medicare beneficiary advocates, provider advocates, Medicare HMO managers, and representatives of large health insurance purchasing organizations. We

[7]Medicare HMOs are required by law to have at least one 30-day period each year when they accept new enrollees. In practice, most HMOs have a continuous, year-round open enrollment period.

also analyzed enrollment and disenrollment data from HCFA's automated systems. In addition, we reviewed beneficiary complaint case files and observed certain HCFA oversight and education activities. Finally, we reviewed relevant literature. Our work was performed between October 1995 and August 1996 in accordance with generally accepted government auditing standards. (For further detail on our data analysis methodology, see app. I.)

Beneficiaries Do Not Get the Information Needed to Help Them Choose an HMO

Though Medicare is the nation's largest purchaser of managed care services, it lags other large purchasers in helping beneficiaries choose among plans. HCFA has responsibility for protecting beneficiaries' rights and obtaining and disseminating information from Medicare HMOs to beneficiaries. HCFA has not yet, however, provided information to beneficiaries on individual HMOs. It has announced several efforts to develop HMO health care quality indicators. HCFA has, however, the capability to provide Medicare beneficiaries useful, comparative information now, using the administrative data it already collects.

Although Other Large Purchasers Offer Comparative Benefit Guides, HCFA Does Not

Unlike leading private and public health care purchasing organizations, Medicare does not provide its beneficiaries with comparative information about available HMOs. Other large purchasers of health care—for example, the Federal Employees Health Benefits Program, the California Public Employees' Retirement System (CalPERS), Minnesota Medicaid, Xerox Corporation, and Southern California Edison—publish summary charts of comparative information such as available plans, premium rates, benefits, out-of-pocket costs, and member satisfaction surveys. Table 2.1 compares the information provided by HCFA and these other large health purchasers.

Table 2.1: Comparative Information Provided to Prospective Enrollees by Selected Health Care Purchasers

Feature	Medicare	Minnesota Medicaid	FEHBP	CalPERS	Xerox	S. Cal. Ed.
Number of enrollees[a]	38.0 million	142,000	4.1 million	428,000	51,000	24,000
Maximum number of HMOs available to enrollees[b]	14	5	17	12	6	5
Information provided						
Available plans	X[c]	X	X	X	X	X
Detailed benefits		X[d]		X[d]	X[d]	X
Premiums, deductibles, copayments		Not applicable	X	X	X	X
Member satisfaction survey		X	X	X	X	X
Plan performance indicators				X	X	X

Note: FEHBP is Federal Employees Health Benefits Plan, Xerox is Xerox Corporation, and S. Cal. Ed. is Southern California Edison.

[a]Includes enrolled beneficiaries, employees, and annuitants but not their dependents.

[b]Number of HMOs available varies by beneficiary location.

[c]Available only upon request.

[d]Standardized benefits.

A few purchasers also give enrollees information that helps them compare HMOs' provision of services in such areas as preventive health and care of chronic illness. For example, CalPERS publishes the percentage of members in each plan who receive cholesterol screening, cervical and breast cancer screening, and eye exams for diabetics. Some purchasers also provide indicators of physician availability and competence, such as percentage of physicians accepting new patients, physician turnover, and percentage of physicians who are board certified.

Comparative Benefits Information Available to HCFA Staff but Not to Medicare Beneficiaries

HCFA currently collects benefit and cost data in a standardized format from Medicare HMOs. HCFA's professional staff use the data to determine that each HMO is providing a fairly priced package of Medicare services or that Medicare is paying a fair price for the services provided.[8] HCFA could provide this benefit and cost information to beneficiaries with little additional effort.

Using these data, HCFA's regional office in San Francisco, on its own initiative, developed benefit and premium comparison charts 2 years ago for markets in southern and northern California, Arizona, and Nevada. However, distribution of these charts has been limited primarily to news organizations and insurance counselors.[9] Beneficiaries may request the charts, but few do because HCFA does not widely publicize the charts' existence. In fact, when we called a Los Angeles insurance counselor (without identifying ourselves as GAO staff) and asked specifically about Medicare HMO information, we were not told about the comparison charts. Recently, HCFA's Philadelphia office began producing and distributing similar charts. While HCFA's Office of Managed Care has been studying how to provide information to beneficiaries for a year and a half, the local initiatives in the San Francisco and Philadelphia offices demonstrate that HCFA could be distributing comparison charts to beneficiaries nationwide.

HMO Marketing Materials Not Required to Standardize Presentation or Terminology for Benefits

Although HMOs provide beneficiaries information about benefits and premiums through marketing brochures, each plan uses its own terminology to describe benefits, premiums, and the rules enrollees must follow in selecting physicians and hospitals. Despite HCFA's authority to do so, the agency does not require a standardized terminology or format for describing benefits.[10] HCFA does review HMO marketing and informational materials to prevent false or misleading claims and to ensure that certain provider access restrictions are noted. HCFA has not ensured that HMO

[8]These data, which come from the HMOs' adjusted community rate proposals, include whatever profit margin the HMO makes on its commercial business. If an HMO's Medicare payment rate exceeds what the HMO would charge commercially, it must use the difference (called "savings") to provide additional services or lower premiums to its Medicare enrollees or to reduce Medicare's payment rates.

[9]The Omnibus Budget Reconciliation Act of 1990 established a federally funded, state-managed Information, Counseling, and Assistance (ICA) program in response to concerns about the adequacy of available information on Medicare coverage limitations and supplemental (Medigap) insurance. ICA insurance counselors, many of whom are volunteers, can provide beneficiaries with general information about Medicare, Medicaid, managed care plans, and various types of health insurance.

[10]HCFA plans to implement the "National Managed Care Marketing Guideline" for all Medicare HMO marketing materials starting in 1997. However, this guideline—as currently drafted—will not require standard terminology and formats.

marketing materials are clear, however, because the agency does not require standard terminology or formats.[11] For example, one plan's brochure, to note its access restrictions, states that ". . . Should you ever require a specialist, your plan doctor can refer you to one" but never states that beneficiaries must get a referral before seeing a specialist.

In addition, each HMO develops its own format to summarize its benefits and premiums. As a result, beneficiaries seeking to compare HMOs' coverage of mammography services, for example, have to look under "mammography," "X ray," or another term, depending on the particular brochure. The length of some HMOs' benefit summaries varies widely. For example, some brochures we received from the Los Angeles market, which has 14 Medicare HMOs, contain a summary of benefits spanning 14 pages; others have only a 1-page summary. Such diverse formats—without a comparison guide from HCFA—place the burden of comparing the HMOs' benefits and costs exclusively on the beneficiary.

Beneficiaries Must Obtain and Distill Comparative Information Themselves

To collect, distill, and compare HMO information would, in some markets, require substantial time and persistence (see figs. 2.1 and 2.2). First, beneficiaries would need to find and call a toll-free number to learn the names of available HMOs. This telephone number appears in the back of the Medicare handbook. However, the handbook generally is mailed to only those individuals turning age 65 or to beneficiaries who specially request it. Next, beneficiaries would have to contact each HMO to get benefit, premium, and provider network details. Finally, they would have to compare plans' benefit packages and cost information without the benefit of standardized formats or terminology. This set of tasks is likely to be difficult for determined beneficiaries and may be too daunting for others.

[11]In contrast, federal law (P.L. 101-508) requires Medigap policies to be described using uniform language, definitions, and format.

Figure 2.1: Steps a Beneficiary Would Need to Take to Compare Benefits and Premiums of Competing HMOs

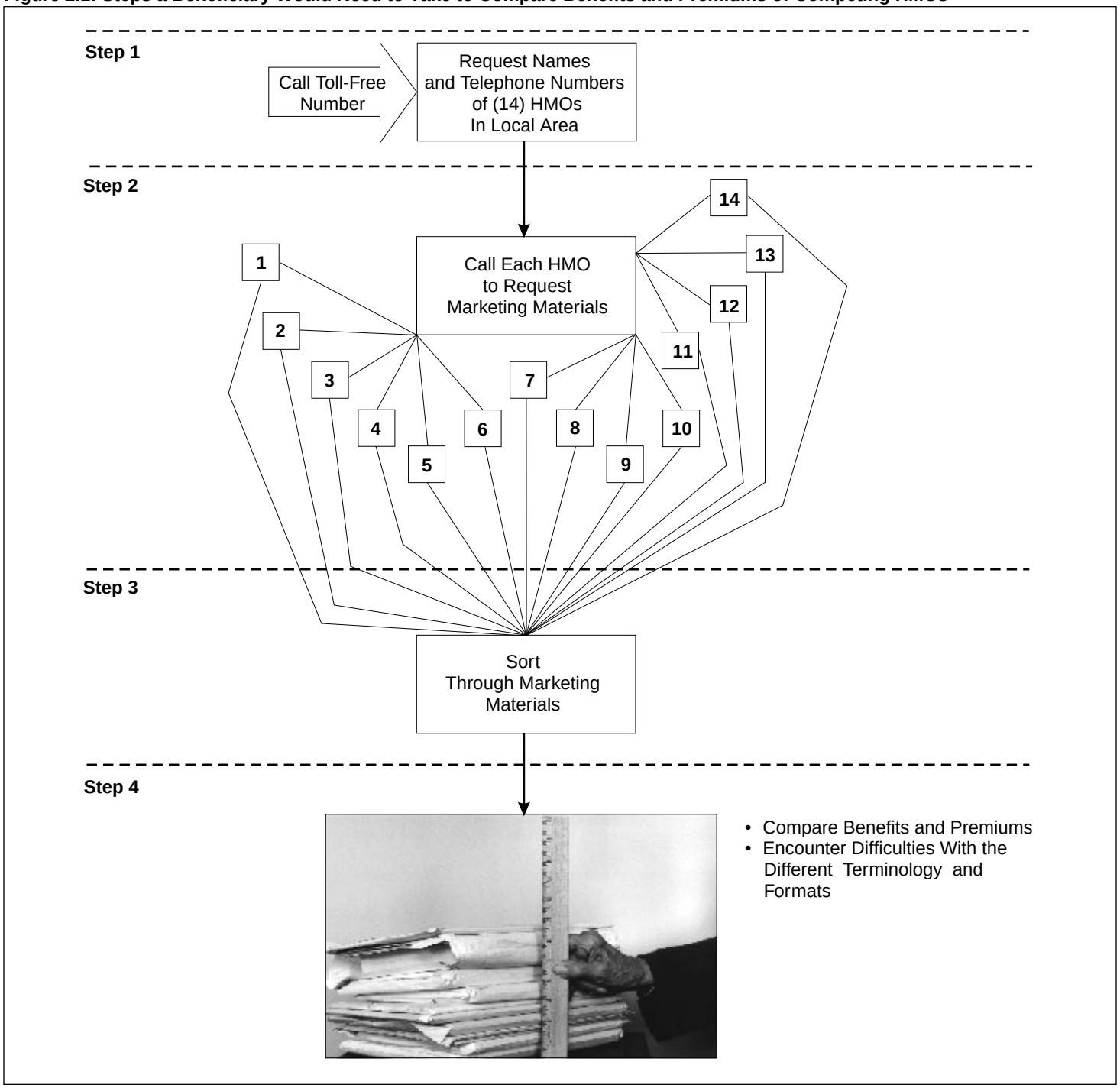
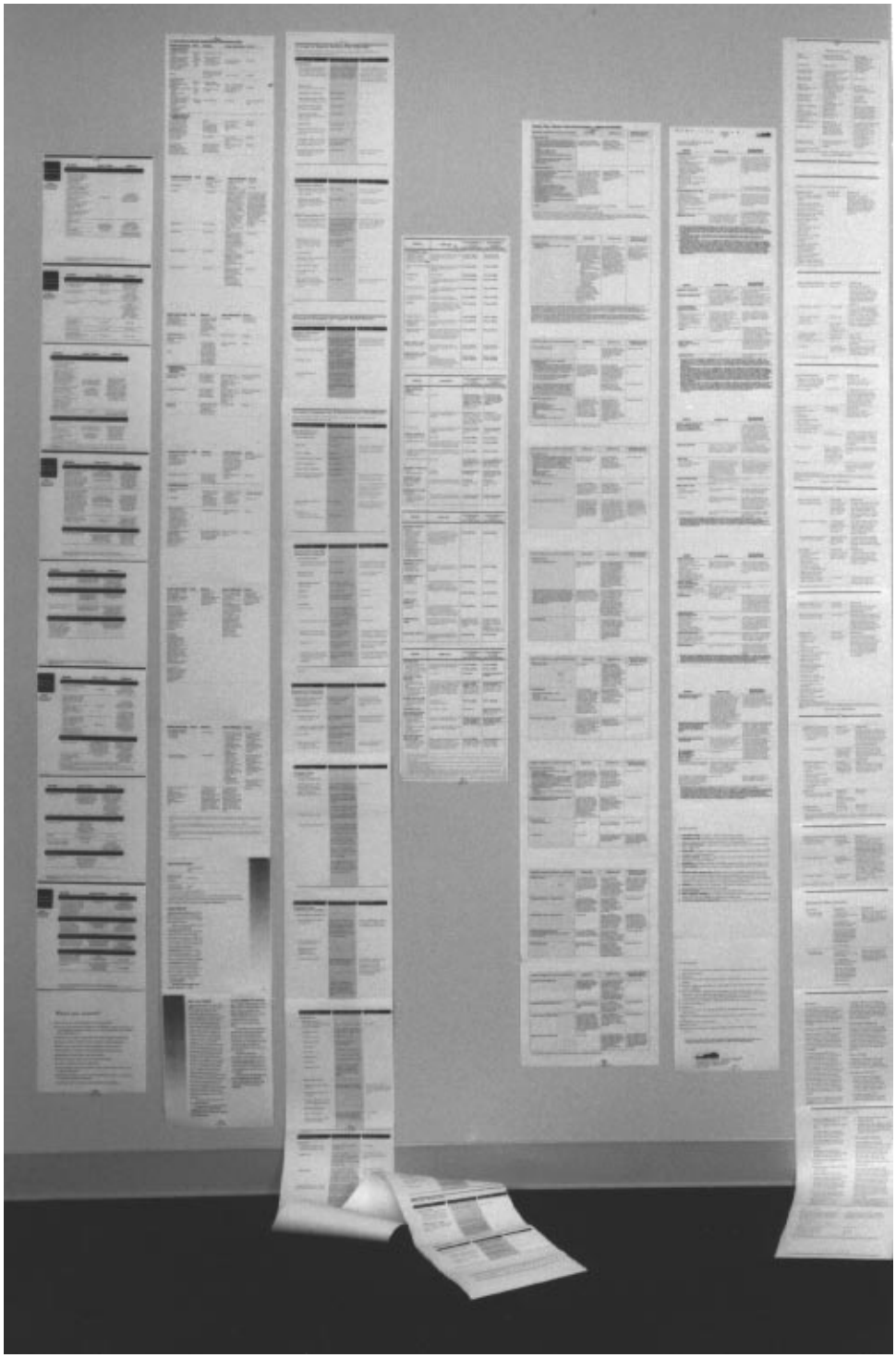


Figure 2.2: Beneficiary Compares Los Angeles' HMOs' Benefits Using a Single, Standardized Chart; in Contrast, Medicare-Approved HMO Brochures Cover the Wall



To test the difficulty of these tasks, we called all 14 Medicare HMOs in Los Angeles to request their marketing materials. After several weeks and follow-up calls, we had received information from only 10 plans. Some plans were reluctant to mail the information but offered to send it out with a sales agent. Declining visits from sales agents, we finally obtained the missing brochures by calling the HMOs' marketing directors, identifying ourselves as GAO staff, and insisting that the marketing materials be mailed. The materials gathered show that beneficiaries in the Los Angeles market would have to sort through pounds of literature and compare benefits charts of 14 different HMOs. (See fig. 2.2.)

Although HCFA has been studying ways to provide comparative benefits information nationwide since mid-1995, it has decided not to distribute printed information directly to beneficiaries. Instead, HCFA plans to make information on benefits, copayments, and deductibles available on the Internet. HCFA expects the primary users of this information to be beneficiary advocates, insurance counselors, and government entities—not beneficiaries. As of September 6, 1996, HCFA expected the information to be available electronically by June 1997—at the earliest.

HCFA Could Readily Provide Indicators of Beneficiary Satisfaction and Other Plan-Specific Information

HCFA has a wealth of data, collected for program administration and contract oversight purposes, that can indicate beneficiaries' relative satisfaction with individual HMOs. The data include statistics on beneficiary disenrollment and complaints. HCFA also collects other information that could be useful to beneficiaries, including HMOs' financial data and reports from HCFA's periodic monitoring visits to HMOs. As noted, however, HCFA does not routinely distribute this potentially useful information.

Disenrollment Data

Because of Medicare beneficiaries' freedom to disenroll from managed care or change plans in any month, disenrollment data objectively measure consumer behavior toward and indicate their satisfaction with a specific HMO.[12] Disenrollments may be more reliable than some other satisfaction measures—such as surveys—because disenrollment data do not depend on beneficiary recollection.

[12]Medicare disenrollments measure actual behavior and reflect ongoing choices of individual beneficiaries. Disenrollment data are less useful as a satisfaction indicator for commercial (non-Medicare) HMO enrollees. Commercial enrollees typically cannot change plans monthly and have fewer choices available when changing plans is allowed. Furthermore, commercial disenrollment may occur when an employer decides to change the HMO with which it contracts. Consequently, the disenrollment that results does not necessarily indicate enrollee dissatisfaction.

Enrollment and disenrollment data, although collected primarily to determine payments to HMOs, can be used to construct several useful indicators of beneficiary satisfaction, such as the

- annual disenrollment rate: total number of disenrollees as a percentage of total enrollment averaged over the year,
- cancellation rate: percent of signed applications canceled before the effective enrollment date,
- "rapid" disenrollment rate: percent of new enrollees who disenroll within 3 months,
- "long-term" disenrollment rate: percent of enrollees who disenroll after 12 months,
- rate of return to fee for service: percent of disenrollees who return to traditional Medicare rather than enroll in another HMO, and
- retroactive disenrollment rate: percent of disenrollments processed retroactively by HCFA (typically done in cases of alleged beneficiary misunderstanding or sales agent abuse).

Disenrollment rates that are high compared with rates for competing HMOs can serve as early warning indicators for beneficiaries, HMOs, and HCFA. (See ch. 3 for a discussion on interpreting these indicators and an analysis of disenrollment rates for HMOs serving the Miami and Los Angeles markets.) Disenrollment rates have already been used to help measure membership stability and enrollee satisfaction in the Health Plan Employer Data and Information Set (HEDIS), developed by large employers, HMOs, and HCFA under the auspices of the National Committee on Quality Assurance (NCQA). However, HEDIS' measure of disenrollment behavior is limited to a single indicator—an annual disenrollment rate. HCFA could perform a more extensive analysis of the disenrollment data available now.

Complaint Data

The relative volume of beneficiary complaints about HMOs is another satisfaction indicator that HCFA could readily provide beneficiaries.[13] HCFA regional staff routinely receive beneficiary complaints of sales abuses, the unresponsiveness of plans to beneficiary concerns, and other more routine service and care issues. Regardless of the type of complaint, a comparison of the number of complaints per 1,000 HMO members can give beneficiaries a view of members' relative satisfaction with area HMOs. Although some HCFA regional offices already track complaints through the Beneficiary

[13]Some states, including Florida and New York, routinely provide complaint rates to the public.

Inquiry Tracking System, HCFA has no plans to make these data consistent across regions or provide beneficiaries complaint volume information.

HMO Financial Information

HCFA could readily report on various HMO financial indicators. Large employers and HMOs have already incorporated several financial indicators—such as plans' total revenue and net worth—into the current Health Plan Employer Data and Information Set (HEDIS 2.5). HEDIS 2.5 also requires HMOs to report the percentage of HMO revenues spent on medical services—known to insurers as the medical "loss ratio." Xerox Corporation, for example, publicizes medical loss ratios to help employees compare the plans it offers. In addition, federal law establishes loss ratio standards for Medigap insurers. HCFA routinely collects financial information from HMOs in standard formats it jointly developed with the National Association of Insurance Commissioners in the early 1980s. HCFA uses these data to monitor contracts for compliance with federal financial and quality standards.

HCFA Monitoring Visit Results

HCFA could also report the results of periodic visits to verify HMO contract compliance in 13 separate dimensions, such as health services delivery, quality, and utilization management; treatment of beneficiaries in carrying out such administrative functions as marketing, enrollment, and grievance procedures; and management, administration, and financial soundness.

After each visit, HCFA records any noncompliance with standards but does not make these reports public unless a Freedom of Information Act request is made. In contrast, NCQA, a leading HMO accreditation organization, has begun distributing brief summaries of its site visit reports to the public. NCQA's summaries rate the degree of HMO compliance on six different dimensions, including quality management and improvement, utilization management, preventive health services, medical records, physician qualifications and evaluation, and members' rights and responsibilities.

Although HCFA Has Plans for Consumer Information, Beneficiaries Await Basic Comparative Data

HCFA has authority to obtain and distribute useful comparative data on health plans. Although HCFA is not now providing these data to beneficiaries and the marketplace, it is studying several future options, including joint efforts with the private sector. Eventually, these efforts could yield comparative plan information on satisfaction survey results, physician incentives, measures of access to care, utilization of services, health outcomes, and other aspects of plans' operations. The following are examples of these efforts:

- HCFA is developing a standard survey, through HHS' Agency for Health Care Policy and Research, to obtain beneficiaries' perceptions of their managed care plans. This effort aims to standardize surveys and report formats to yield comparative information about, for example, enrollees' experiences with access to services, interactions with providers, continuity of care, and perceived quality of care.
- HCFA has been developing regulations since 1990 to address financial incentives HMOs give their physicians. HCFA's regulations, published in 1996 and scheduled to be effective beginning in January 1997, will require HMOs to disclose to beneficiaries, on request, the existence and type of any physician incentive arrangements that affect the use of services.
- HCFA is working with the managed care industry, other purchasers, providers, public health officials, and consumer advocates to develop a new version of HEDIS—HEDIS 3.0—that will incorporate measures relevant to the elderly population. It is also working with the Foundation for Accountability (FAcct) to develop more patient-oriented measures of health care quality.

The HEDIS and FAcct initiatives are aimed at generating more direct measures of the quality of medical care and may require new data collection efforts by plans. These initiatives may eventually provide Medicare beneficiaries with objective information that will help them compare available plans. However, HCFA could do more to inform beneficiaries today. For this reason, we stress the importance of such measures as disenrollment rates, complaint rates, and results of monitoring visits, which can be readily generated from information HCFA routinely compiles.

Publishing Disenrollment Rates Could Discourage Poor Marketing Practices

Public disclosure of disenrollment rates could help beneficiaries choose among competing HMOs and encourage HMOs to do a better job of marketing their plans and serving enrollees. Nonetheless, HCFA does not routinely compare plans' disenrollment rates or disclose such information to the public.

Because Medicare beneficiaries enrolled in HMOs can vote with their feet each month—by switching plans or returning to fee for service—comparing plans' disenrollment rates can suggest beneficiaries' relative satisfaction with competing HMOs. For this reason, we analyzed HCFA disenrollment data and found that Medicare HMOs' ability to retain beneficiaries varies widely, even among HMOs in the same market. In the Miami area, for example, the share of a Medicare HMO's total enrollment lost to voluntary disenrollment in 1995 ranged from 12 percent—about one in eight enrollees—to 37 percent—more than one in three enrollees.[14]

Relative Disenrollment Rates Indicate Beneficiary Satisfaction

Although all HMOs experience some voluntary disenrollment, disenrollment rates should be about the same for all HMOs in a given market area if beneficiaries are about equally satisfied with each plan.[15] An HMO's disenrollment rate compared with other HMOs in the same market area, rather than a single HMO's disenrollment rate, can indicate beneficiary satisfaction with care, service, and out-of-pocket costs.

High disenrollment rates may result from poor education of enrollees during an HMO's marketing and enrollment process. In this case enrollees may be ill informed about HMO provider-choice restrictions in general or the operation of their particular plan. High disenrollment rates may also result from beneficiaries' dissatisfaction with access or quality of care. Alternatively, high disenrollment rates may reflect a different aspect of relative satisfaction—beneficiaries' awareness that competing HMOs are offering better benefits or lower premiums. While statistics alone cannot distinguish among these causes, a relatively high disenrollment rate should caution beneficiaries to investigate further before enrolling.

[14]The disenrollment rates reported here exclude beneficiaries who were involuntarily disenrolled due to death or loss of part B entitlement. See app. I for a complete discussion of our rate calculation methodology.

[15]HMOs serving a larger geographic area may have slightly fewer disenrollments than competing HMOs serving a smaller area. This may be due to beneficiaries moving out of the smaller area. HMOs in Los Angeles do vary in the geographic area they cover, but these differences could not explain the substantial differences in disenrollment rates we observed. In Miami, all HMOs cover the same territory so out-of-service-area moves should affect all HMOs' disenrollment rates about equally.

Beneficiaries Voluntarily Disenroll From HMOs for Many Reasons

Medicare beneficiaries voluntarily disenroll from their HMOs for a variety of reasons: many who leave are dissatisfied with their HMOs' service, but others leave for different reasons. A 1992 study reported that 48 percent of disenrollees from Medicare HMOs cited dissatisfaction as their reason for leaving, 23 percent cited a misunderstanding of HMO services or procedures, and 29 percent cited some other reason—such as a move out of the HMO's service area.[16] Some commonly cited reasons beneficiaries disenroll include

- dissatisfaction with the HMO's provision of care,
- did not know had joined an HMO,
- did not understand HMO restrictions when joined,
- reached HMO's annual drug benefit limit and enrolled in a different HMO for continued coverage of prescription drugs,
- attracted to competing HMO offering lower premiums or more generous benefits,
- moved out of HMO service area, and
- personal physician no longer contracts with HMO.

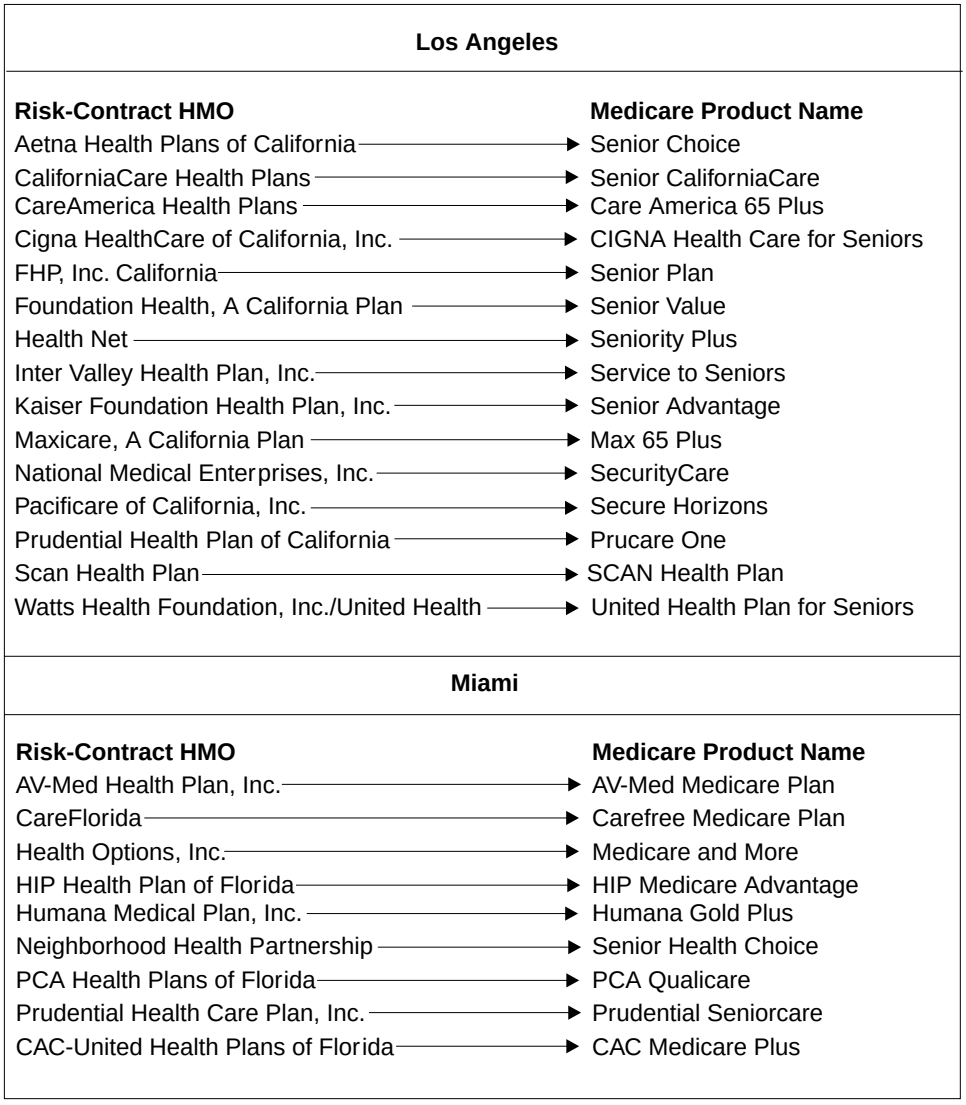
HMOs' Differing Disenrollment Rates Suggest That Beneficiary Satisfaction Varies Widely

Health plans' retention of their members varies widely, as illustrated by our analysis of these rates for the Miami and Los Angeles markets.[17] (See fig. 3.1 for the names of these HMOs and their associated Medicare products.) For some HMOs, disenrollment rates were high enough to raise questions about whether the HMO's business emphasis was on providing health care or on marketing to new enrollees to replace the many who disenroll.

[16]Frank W. Porell and others, Factors Associated with Disenrollment from Medicare HMOs: Findings from a Survey of Disenrollees (Boston: Health Policy Research Consortium of Brandeis University, 1992).

[17]The wide variation in HMO disenrollment rates is consistent with our earlier findings. In 1988, we reported that "about one of six people enrolled in 95 risk-based HMOs across the country . . . terminated their enrollment within 1 year. The variation in disenrollment rates was substantial, ranging from about 3.5 percent for the 10 HMOs having the lowest rates to about 36 percent for the 10 HMOs having the highest rates." Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Figure 3.1: Los Angeles and Miami Risk HMOs and Their Associated Medicare Products



1995 Disenrollment Rate Reached 37 Percent for One Miami HMO, 42 Percent for One Los Angeles HMO

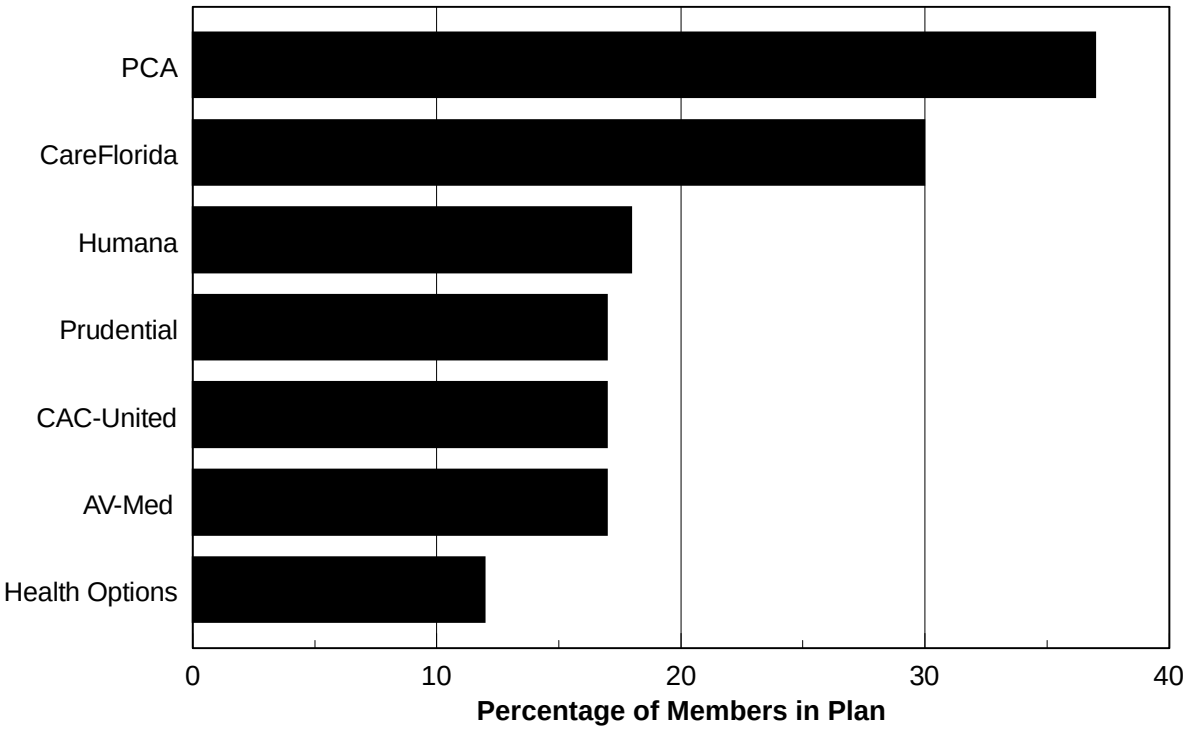
The voluntary disenrollment rates[18] of the seven[19] plans active in the Miami market for all of 1995 varied substantially as measured by the percentage of an HMO's average Medicare enrollment lost to disenrollment. (See fig. 3.2.) PCA Health Plan of Florida's (PCA) disenrollment rate reached 37 percent; two other HMOs (HIP Health Plan of Florida (HIP) and CareFlorida) had disenrollment rates of 30 percent or higher. In contrast, Health Options had a disenrollment rate of 12 percent. The remaining five plans had a median disenrollment rate of about 17 percent. To keep total enrollment constant, HMOs must replace not only those members who leave voluntarily, but also those members who die.[20] Thus, PCA had to recruit new enrollees equal in number to 41 percent of its membership just to maintain its total enrollment count.

[18]Consistent with HCFA's definition in its online database system, voluntary disenrollment includes all disenrollments except those due to death or loss of eligibility.

[19]We could not compute an annual disenrollment rate for two HMOs in Miami because they did not operate for a full 12 months during 1995. HIP operated for the last three quarters of 1995 and had quarterly disenrollment rates of 12 percent, 13 percent, and 8 percent. Neighborhood operated for the last two quarters of 1995 and had disenrollment rates of 11 percent in both quarters. If we annualized these rates to make them comparable to the HMOs shown on the chart, HIP and Neighborhood would both have disenrollment rates of 44 percent.

[20]Some members are involuntarily disenrolled because of their loss of Medicare eligibility, but this affects a relatively small number of beneficiaries.

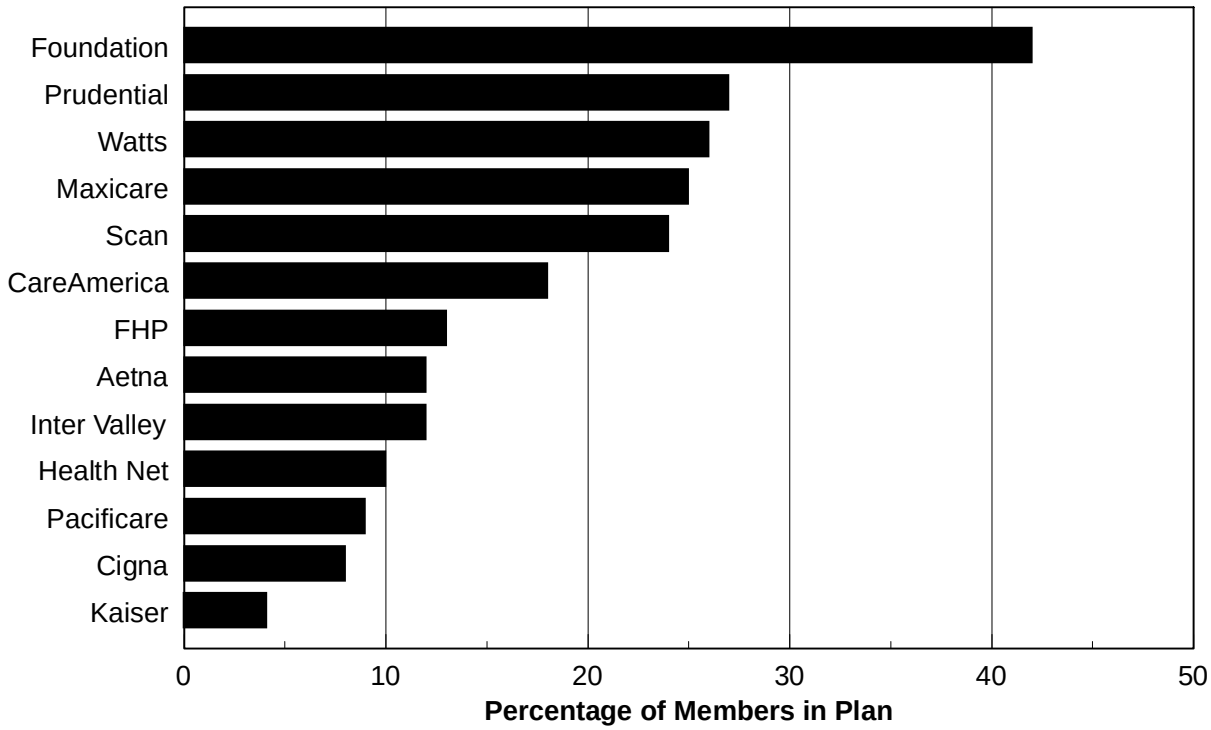
Figure 3.2: Miami HMOs' Total Disenrollment Rates, 1995



Note: Total disenrollment rates are the number of beneficiaries who disenrolled in 1995 compared with the average number of enrollees in 1995. We divided disenrollment—excluding disenrollment due to death or loss of eligibility—in each quarter by the average enrollment during that quarter to get a quarterly disenrollment rate and then summed the rates from four quarters to get each HMO's annual disenrollment rate. For example, an HMO that lost 5 percent of its Medicare membership in the first quarter, 7 percent in the second quarter, 6 percent in the third quarter, and 7 percent in the fourth quarter would have an annual disenrollment rate of 25 percent.

The Los Angeles market, like Miami's, showed substantial variation in HMOs' disenrollment rates. (See fig. 3.3.) Los Angeles' rates, in fact, varied slightly more than Miami's. Foundation Health had the highest disenrollment rate (42 percent); Kaiser Foundation Health Plan (Kaiser) had the lowest (4 percent).

Figure 3.3: Los Angeles HMOs' Total Disenrollment Rates, 1995



Nearly One in Three New Enrollees Left Miami HMO Within 3 Months of Joining

Although reasons for disenrollment vary, beneficiaries who leave within a very short time are more likely to have been poorly informed about managed care in general or about the specific HMO they joined than those who leave after a longer time.[21] Consequently, early disenrollment rates may better indicate beneficiary confusion and marketing problems than total disenrollment rates.

Our analysis showed wide variation in plans' early disenrollment rates. In our calculations we included both cancellations—beneficiaries who signed an application but canceled before the effective enrollment date—and "rapid disenrollment"—beneficiaries who left within 3 months of enrollment.

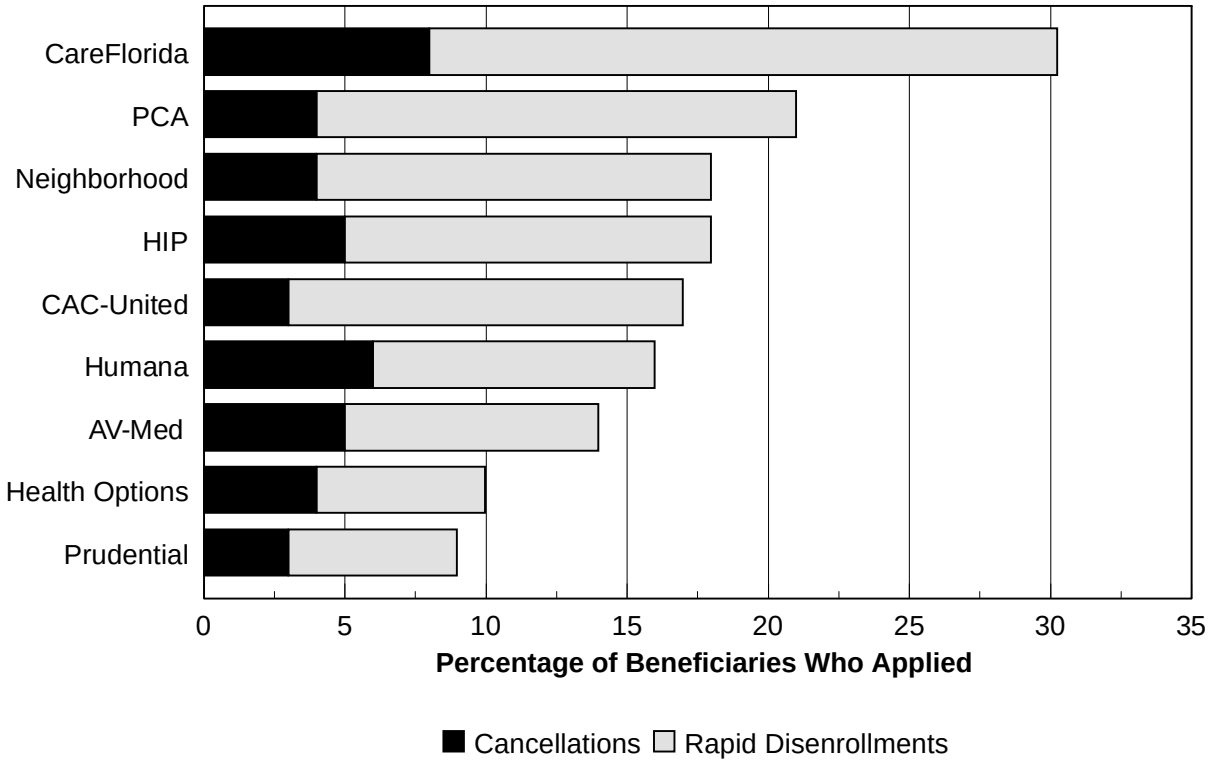
[21]A 1992 study of beneficiary disenrollment found that 24.1 percent of the beneficiaries who disenrolled within 3 months did not realize they had enrolled in an HMO. In contrast, only 8 percent of those who disenrolled after 2 years did not realize they had been enrolled in an HMO. See Porell and others.

In 1995, Medicare HMOs in the Miami market had

- cancellation rates of 3 to 8 percent,
- rapid disenrollment rates of 6 to 23 percent, and
- combined cancellations and rapid disenrollments of 9 to 30 percent.

As figure 3.4 shows, nearly one in three beneficiaries who signed a CareFlorida application and more than one in five beneficiaries who signed a PCA application either canceled or left within the first 3 months. In contrast, only about 10 percent of Health Options' and Prudential's applicants left this early.

Figure 3.4: Canceled Applications and Rapid Disenrollments in the Miami Market, 1995

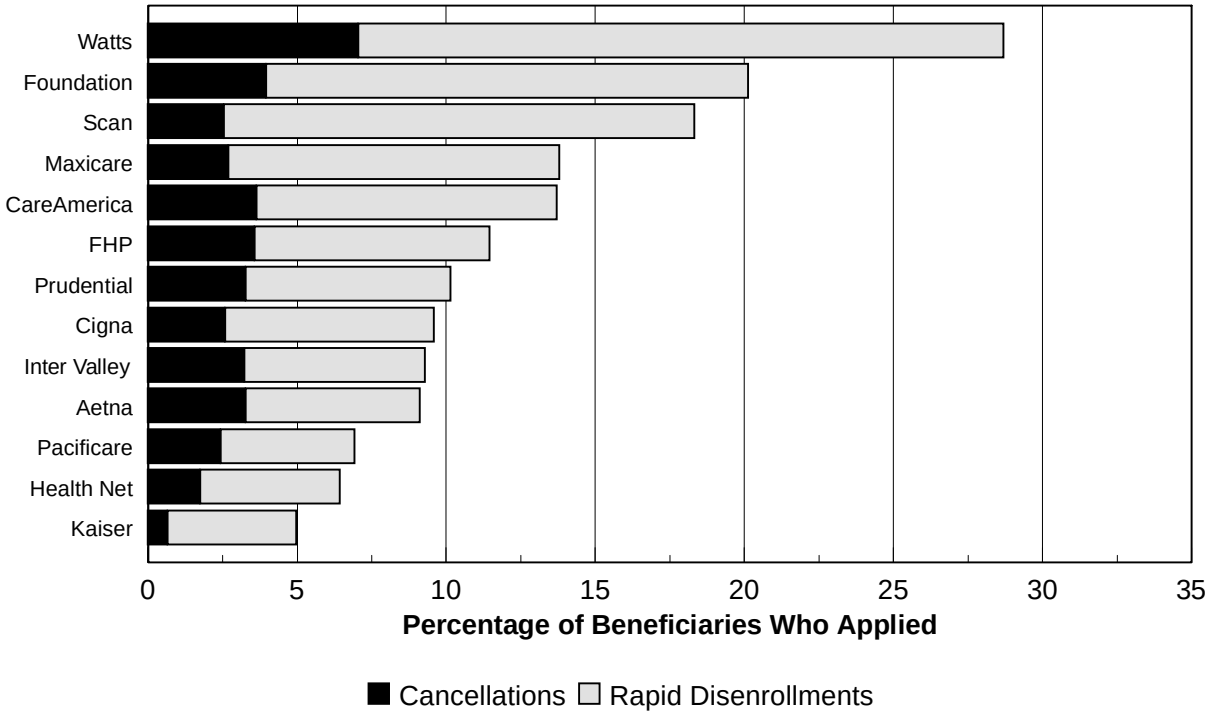


In 1995, Medicare HMOs in the Los Angeles market had

- cancellation rates of 1 to 7 percent,
- rapid disenrollment rates of 4 to 22 percent, and
- combined cancellations and rapid disenrollments of 5 to 29 percent.

As figure 3.5 shows, a few Los Angeles plans lost beneficiaries at a rate significantly higher than the market average, and a few performed notably better than the market average. The broad middle group of plans lost between about 9 and 14 percent of new applicants before the 3-month time frame.

Figure 3.5: Canceled Applications and Rapid Disenrollments in the Los Angeles Market, 1995



Beneficiary Confusion, Abusive Sales Practices Help Explain High Disenrollment Rates

The substantial variation in early disenrollments suggests that some HMOs do a better job than others of representing their plans to potential enrollees. Two 1991 HHS Office of Inspector General (OIG) studies[22] support this idea. According to the studies, about one in four CareFlorida enrollees did not understand that they were joining an HMO, and one in four did not understand that they would be restricted to HMO physicians after they enrolled. In contrast, only about 1 in 25 Health Options enrollees failed to understand these fundamentals. OIG reported that CareFlorida's disenrollment rates among beneficiaries enrolled less than a year were the highest in the Miami market for the federal fiscal years 1988 and 1989. This pattern persists, as our analysis of 1995 early disenrollment data shows.

Complaints to HCFA regional offices of beneficiary confusion primarily fall into one of two categories: (1) mistaking the HMO application for a Medigap insurance application and (2) not understanding that HMO enrollees are restricted to certain providers. Confusion, whether the result of beneficiary ignorance of Medicare's HMO option or intentional misrepresentation by HMO sales agents, exposes beneficiaries to unanticipated health expenses. Beneficiaries may also face months of uncertainty about their insured status and which specific providers they must see to have their health expenses covered.

Beneficiaries May Confuse HMOs With Supplemental Medigap Insurance

A typical complaint, according to HCFA staff, involves beneficiaries who find themselves enrolled in an HMO when they thought they were signing up for a Medicare supplemental policy. For example, in February 1995, a husband and wife signed an application for a South Florida HMO. They continued using their former physicians, who were not with the HMO, and incurred 17 separate charges in May 1995 for a knee replacement, including related services and a hospital stay. When Medicare denied payment, the couple found they were enrolled in the HMO. The HMO also denied payment, so the couple disenrolled, through the HMO, effective May 31. Still facing unpaid claims, they contacted HCFA in mid-June and complained that the sales agent had "talked real fast" and misrepresented the HMO plan as supplemental insurance. They allege he later told them they "didn't read the fine print." They complained that neither the government (Medicare) nor the sales agent explained the consequences of enrollment, and they would not have enrolled if they had known they would be giving up fee-for-service Medicare. In late July, HCFA retroactively disenrolled the couple and eventually paid their bills under fee-for-service

[22]Marketing Practices of South Florida HMOs Serving Medicare Beneficiaries, HHS OIG, OEI-04-91-00630 (Washington, D.C.: Nov. 1991) and Miami Area HMOs: Medicare Enrollment Patterns, HHS OIG, OEI-04-91-00640 (Washington, D.C.: Nov. 1991).

Medicare. The HMO told HCFA that the sales agent had been terminated because of past concerns.

Beneficiaries May Not Understand HMO Restrictions

Another leading category of complaints, according to HCFA staff, involves new HMO enrollees who do not understand HMO restrictions on access to care. In 1995, OIG reported[23] that nearly one in four Medicare enrollees did not answer affirmatively when asked if they had a good knowledge from the beginning of how the HMO would operate; and one in four did not know they could appeal HMO denials of care they believe they are entitled to. Furthermore, 1 in 10 did not understand that they would need a referral from their primary care physician before they could see a specialist. The following complaint to HCFA about a Miami HMO illustrates beneficiary confusion over HMO restrictions.

CareFlorida marketed its plan to an 81-year-old woman who subsequently enrolled in the plan effective February 1994, although she traveled regularly to a distant state. In her first months of membership, she visited her doctor, who was with the HMO. When she later visited a non-network physician who had also been her regular provider, Medicare denied her claims. She then requested to disenroll and told HCFA that if she had understood the requirement to visit specific providers, she would not have enrolled in the HMO. HCFA disenrolled the beneficiary from the plan effective with her use of non-network providers. This left her responsible for about $700 in out-of-plan charges.

Other typical misunderstandings cited by HCFA staff and local insurance counselors include not understanding restrictions on access to specialists or other services nor restrictions to a specific medical group in an HMO's provider network.

Some HMO Sales Practices Are Clearly Abusive

Medicare regulations prohibit certain marketing practices, such as activities that mislead, confuse, or misrepresent; door-to-door solicitation; and gifts or payments used to influence enrollment decisions. These prohibitions are to help protect beneficiaries from abusive sales practices. Although HCFA staff could not measure the frequency of sales abuses, they expressed concern about continuing complaints of apparent abuses by sales agents.

[23]Beneficiary Perspectives of Medicare Risk HMOs, HHS OIG, OEI-06-91-00730 (Washington, D.C.: Mar. 1995).

A recurring complaint, according to HCFA staff, is from beneficiaries whose signatures on enrollment forms are acquired under false pretenses. Many of these beneficiaries mistakenly believed that the form they signed—actually an enrollment form—was a request for more information or that it confirmed attendance at a sales presentation. In 1991, HCFA investigated the marketing practices of an HMO after receiving complaints and noting a high rate of retroactive disenrollments. The complaints alleged that sales agents were asking beneficiaries to sign a form indicating the agent had made a presentation. In fact, the document was an enrollment form.

A recent case documented by HCFA staff is one in which at least 20 beneficiaries were inappropriately enrolled in an HMO after attending the same sales seminar in August 1995. The beneficiaries thought they were signing up to receive more information but later discovered the sales agent had enrolled them in the plan.

In other cases, beneficiaries' signatures were forged. In January 1995, for example, a beneficiary was notified by his medical group before an appointment that he was now enrolled in another plan. The beneficiary had no idea how this could be as he had not intended to change plans. Though the beneficiary signs with an "X," the new enrollment application was signed with a legible cursive signature. HCFA re-enrolled the beneficiary into his former plan but took no action against the plan or sales agent.

HCFA's Regulatory Approach Does Not Protect Beneficiaries From HMOs Not Meeting Federal Standards

HCFA's failure to take effective enforcement actions and to inform beneficiaries allows problems to persist at some HMOs. Historically, HCFA has been unwilling to sanction the HMOs it cites for violations found repeatedly during site monitoring visits. In 1988, 1991, and 1995, we reported on the agency's pattern of ineffective oversight of HMOs violating Medicare requirements for marketing, beneficiary appeal rights, and quality assurance. Table 3.2 illustrates the weakness of HCFA's responses in addressing one Florida HMO's persistent problems. In the absence of HMO-specific performance indicators, beneficiaries joining this HMO have no way of knowing about its problem-plagued history spanning nearly a decade. Our reports show that this is not an isolated example.

Table 3.2: HCFA Regulatory Actions Not Successful in Improving Performance of a Miami HMO With Persistent Problems

Time frame	HMO performance	HCFA response to HMO monitoring visit findings
1987	CareFlorida[a] granted Medicare contract.	Not applicable
Oct. 87-Sept. 89	Disenrollment rates highest in Miami market—29% within 6 months, 46% in 12 months, according to HHS OIG analysis.	Not applicable
Jan.-Oct. 1990	41% of CareFlorida enrollees surveyed by HHS OIG report door-to-door marketing—a prohibited practice. Also, one in four CareFlorida enrollees said they didn't know they had enrolled in an HMO.	Not applicable
Feb. 1991	Deficiencies in marketing, enrollment, and quality assurance found during HCFA monitoring visit.	Requires corrective action plan.
July 1992	HMO has not corrected 1991 deficiencies. Additional deficiencies found by HCFA during monitoring visit.	Questions HMO management capability to execute contract; requires new corrective action plan.
Aug.-Sept. 1994	HMO has not corrected 1992 deficiencies in marketing, appeals and grievance, and quality assurance. Additional deficiencies during HCFA monitoring visit.	Requires new corrective action plan.
Oct. 1994	CareFlorida is acquired by Foundation Health Plan.	Not applicable
1995	CareFlorida highest in cancellations (8%) and rapid disenrollments (23%); second highest in annual rate of disenrollments (30%) among Miami HMOs, according to GAO analysis.	Not applicable
Feb. 1996	CareFlorida changes name to Foundation Health—A South Florida Plan.	Not applicable
June 1996	HMO has not corrected many prior deficiencies; additional deficiencies, including failure to ensure access to health services, found during HCFA monitoring visit.	Requires new corrective action plan; warns HMO that these findings may jeopardize contract or require sanctions.

[a]Until March 1990, this plan was named Heritage Health Plan of South Florida, Inc.

Analyzing and Publishing Disenrollment Rates Could Improve HCFA Oversight and Encourage HMOs to Improve Performance

Disenrollment and complaint statistics can help identify HMOs whose sales agents mislead or fail to adequately educate new enrollees. However, HCFA does not routinely and systematically analyze these data.[24] HCFA has uncovered problems with HMOs' sales operations during routine visits to monitor contract compliance or when regional staff have noticed an unusual amount of complaints or disenrollments.

The HHS OIG recently[25] recommended that systematically developed disenrollment data be used in conjunction with surveys of beneficiaries to improve HCFA's monitoring of HMOs. The OIG found that higher disenrollment rates correlated with higher beneficiary survey responses of poor service. Enrollees who said they got poor service and whose complaints were not taken seriously were more likely to come from HMOs with higher disenrollment rates. In contrast to the other surveyed HMOs, those with the five highest disenrollment rates were 1.5 times more likely to have beneficiaries report poor service (18 percent versus 12 percent).

Although HCFA can identify HMOs with sales and marketing problems, it lacks the information to identify specific sales agents who might be at fault. HCFA does not routinely require HMOs to match disenrollment and complaint statistics to individual sales agents. In fact, HCFA made clear in 1991 that oversight standards for sales agents dealing with Medicare beneficiaries would be left largely to the states. States' regulation and oversight of sales agents vary, although 32 states require HMO sales agents to be licensed.[26] Representatives of the Florida Department of Insurance and its HMO monitoring unit said their oversight, beyond agent licensing, consisted of responding to specific complaints. One official commented that sales agents have to do something egregious to have their licenses revoked.

HCFA's HMO manual suggests specific practices that HMOs could employ to minimize marketing problems. These suggestions include verifying an applicant's intent to enroll through someone independent of the sales

[24]Some HCFA regions have begun to analyze disenrollment data, but their analyses are limited to the data available in standard HCFA reports, called "McCoy reports." The format of these reports is inflexible and hinders comparisons of HMOs. For example, McCoy reports cannot be used to determine rapid disenrollment rates as defined in our analysis. An estimate of this rate for each plan can be constructed but only after performing several mathematical computations. The extent to which McCoy reports are used as a monitoring tool varies by HCFA region and monitoring staff.

[25]Medicare Risk HMO Performance Indicators, HHS OIG, OEI-06-91-00734 (Washington, D.C.: Oct. 1995).

[26]The National Association of Insurance Commissioners' model act on HMOs emphasizes licensing for sales agents.

agent, using rapid disenrollment data to identify agents whose enrollees have unusually high rates, and basing commissions and bonuses on sustained enrollment. HCFA staff said that some plans have implemented sales oversight like that suggested by HCFA, but others have not. Regional staff noted that plans are more likely to implement HCFA suggestions if they are trying to get approval for a contract application or service area expansion. Some HCFA regions have succeeded more than others in getting HMOs to improve their oversight of marketing agents.

Publishing disenrollment data could encourage problem HMOs to reform their sales practices and more closely monitor their agents. Agents' compensation often includes incentives such as commissions for each beneficiary they enroll. HMOs could structure their compensation to give agents a greater incentive to adequately inform beneficiaries about managed care in general and their plan in particular. For example, some HMOs pay commissions on the basis of a beneficiary's remaining enrolled for a certain number of months. Several HMOs expressed concern that they did not know how their disenrollment rates compared with those of their competitors. Plan managers have told HCFA staff and us that comparative disenrollment information is useful performance feedback.

Medicare HMOs do not compete on the basis of retention rates (low disenrollment rates) because these rates are not publicized. Publishing the rates would likely boost enrollment of plans with high retention rates and encourage plans with low retention rates to improve their performance.

Conclusions and Recommendations

Conclusions

Millions of Medicare beneficiaries face increasingly complex managed care choices with little or no comparative information to help them. HCFA has not used its authority to provide comparative HMO information to help consumers, even though it requires standardized information for its internal use. As a result, information available to beneficiaries is difficult or impossible to obtain and compare. In contrast, other large purchasers—including the federal government for its employees—ease their beneficiaries' decision-making by providing summary charts comparing plans.

In addition, by not providing consumers with comparative information, Medicare fails to capitalize on market forces and complement HCFA's regulatory approach to seeking good HMO performance. In an ideal market, informed consumers prod competitors to offer the best value. Without good comparative information, however, consumers are less able to determine the best value. HMOs have less incentive to compete on service to beneficiaries when satisfaction or other indicators of performance are not published. Wide distribution of HMO-specific disenrollment and other data could make Medicare's HMO markets more like an ideal market and better ensure that consumers' interests are served.

HCFA could also make better use of indicators to improve its oversight of HMOs. By establishing benchmarks and measuring HMOs' performance against them, HCFA could focus on plans whose statistics indicate potential problems—for example, on HMOs with high disenrollment rates.

Recommendations

In August 1995, we recommended that the Secretary of HHS direct the HCFA Administrator to develop a new, more consumer-oriented strategy for administering Medicare's HMO program. One specific recommendation called for HCFA to routinely publish (1) the comparative data it collects on HMOs and (2) the results of its investigations or any findings of noncompliance by HMOs. Although HCFA has announced plans to gather new data, it has no plans to analyze and distribute to beneficiaries the data on HMOs it currently collects. Therefore, we are both renewing our previous recommendations and recommending specific steps that the Secretary of HHS should take to help Medicare beneficiaries make informed health care decisions.

The Secretary should direct the HCFA Administrator to

- require standard formats and terminology for important aspects of HMOs' informational materials for beneficiaries, including benefits descriptions;
- require that all literature distributed by Medicare HMOs follow these standards;
- produce benefit and cost comparison charts with all Medicare options available for each market area; and
- widely publicize the availability of the charts to all beneficiaries in markets served by Medicare HMOs and ensure that beneficiaries considering an HMO are notified of the charts' availability.

The Secretary should also direct the HCFA Administrator to annually analyze, compare, and distribute widely HMOs'

- voluntary disenrollment rates, including cancellations, disenrollment within 3 months, disenrollment after 12 months, total disenrollment, retroactive disenrollment, and rate of return to fee for service;
- rate of inquiries and complaints per thousand enrollees; and
- summary results of HCFA's monitoring visits.

Agency Comments and Our Response

HHS agreed that "Medicare beneficiaries need more information and that informed beneficiaries can hold plans accountable for the quality of care." HHS noted several HCFA initiatives that will eventually yield information to help beneficiaries choose plans right for their needs. We believe that these initiatives move in the right direction but that HCFA could do more for beneficiaries with information the agency already collects. The full text of HHS' comments appears in appendix III.

HHS outlined HCFA's efforts to produce HMO comparison charts that will initially contain HMO costs and benefits and later may also include other plan-specific information—such as the results of HMOs' satisfaction surveys. HCFA expects advocates and insurance counselors, not beneficiaries, to be the primary users of this information. HCFA plans to make the charts "available to any individual or organization with electronic access." Information in an electronic form can easily be updated—a distinct advantage in a market that is evolving as quickly as Medicare HMOs. Providing the information in an electronic format, however, rather than in print, may make it less accessible to the very individuals who would find it useful.

HHS noted that HCFA is developing the "National Managed Care Marketing Guideline," partly in response to beneficiary complaints of confusion and

misunderstanding caused by Medicare HMOs' marketing practices. The guideline, to be implemented beginning in January 1997, will detail specific content areas to be covered in all Medicare HMO marketing materials. The guideline, as currently drafted, however, will not require standard formats or terminology and thus may not alleviate many of the difficulties beneficiaries now face when comparing HMOs' marketing materials.

Regarding our recommendation that disenrollment data be made available to beneficiaries, HHS stated that HCFA is evaluating different ways to express and present disenrollment rates. HHS cautioned that a careful analysis of disenrollment is necessary before meaningful conclusions can be drawn. We did not find such an analysis to be difficult or overly time consuming. Our recommendation is to publish disenrollment rates and let beneficiaries decide if, as we found in Los Angeles, a 42-percent annual disenrollment rate is meaningful in a market where competing HMOs have disenrollment rates of 4 percent.

In short, HHS stated that HMO-specific information currently collected by HCFA could not be made publicly available until additional evaluation, data analysis, or development of data systems are complete. Even after this work is completed, however, the agency has no plans to distribute HMO-specific information directly to beneficiaries or ensure that they know such information is available. Thus, although HHS stated that one of HCFA's highest priorities is that beneficiaries "receive timely, accurate, and useful information about Medicare," HCFA has no plans to ensure that beneficiaries interested in HMOs receive any comparative information.

Disenrollment Analysis Methodology

We analyzed and reported[27] disenrollment rates for all Medicare risk HMOs operating in the Los Angeles and Miami areas in 1995.[28] We selected these two cities because (1) they have large numbers of both Medicare HMOs and enrollees and (2) Los Angeles and Miami are located in different HCFA regions (HCFA Region IX monitors Los Angeles HMOs, HCFA Region IV monitors Miami HMOs). Of all beneficiary applications submitted to Medicare risk HMOs nationwide in 1995, approximately 26 percent were submitted to HMOs in Los Angeles and Miami. At the end of 1995, Medicare HMO enrollees in these two metropolitan areas represented 32 percent of all Medicare HMO enrollees.[29]

Data Sources

We used data from HCFA's Managed Care Option Information (McCoy) System and the enrollment and cancellation files. The Data Development and Support Team (DDST) in HCFA's Office of Managed Care helped us gain access to these data. (DDST manages Medicare HMO enrollment/ disenrollment data and calculates payment for risk HMOs.)

Annual Disenrollment Rates

We used quarterly profiles from the McCoy System, an online database used by HCFA staff to update beneficiary information and generate reports on Medicare HMOs, to obtain the number of each HMO's total disenrollments for each quarter in 1995. Because data on the number of disenrollments due to death and loss of eligibility were only available on a monthly basis, we used McCoy monthly disenrollment rate reports to compute the total number of deaths and loss of eligibility in each quarter. We then subtracted quarterly deaths and loss of eligibility from quarterly total disenrollment to obtain quarterly voluntary disenrollment:

voluntary disenrollment for quarter Q_i =
(total disenrollment in Q_i - death and ineligibles in Q_i)

where $_i$ = 1 to 4

[27]Although not reported, our preliminary analysis of several other major markets (Boston, Chicago, Denver, Minneapolis, Philadelphia, San Francisco, and Seattle) showed substantial variation in disenrollment rates—some as wide as those found in Los Angeles and Miami.

[28]One plan, California Care, was excluded from our analysis because it had less than 100 members during most of 1995.

[29]The Humana Medical Plan contract service area extends beyond the Miami market area. Because of data limitations, we could not compute Humana's voluntary disenrollments separately for the Miami area. Thus, the disenrollment rates reported for Humana reflect average beneficiary behavior for its entire Florida contract. Had we been able to isolate disenrollment in Miami from the rest of Humana's contract area, our analysis would have covered 29 percent, instead of 32 percent, of all Medicare HMO enrollees.

We computed quarterly average HMO Medicare membership by adding the ending membership of the previous quarter to the ending membership of the current quarter and dividing by 2:

average membership for quarter Q_i =
[(ending membership in Q_{i-1} + ending membership in Q_i)/2]

We then calculated the quarterly disenrollment rate by dividing the average membership into the voluntary disenrollments for the current quarter:

disenrollment rate for quarter Q_i =
(voluntary disenrollment for quarter Q_i/average membership for quarter Q_i)

Finally, we added the rates from each of the four quarters together to determine the total annual disenrollment rate for 1995:

total annual disenrollment rate = (sum of disenrollment rates for Q_1 through Q_4)

Cancellation and Rapid Disenrollment Rates

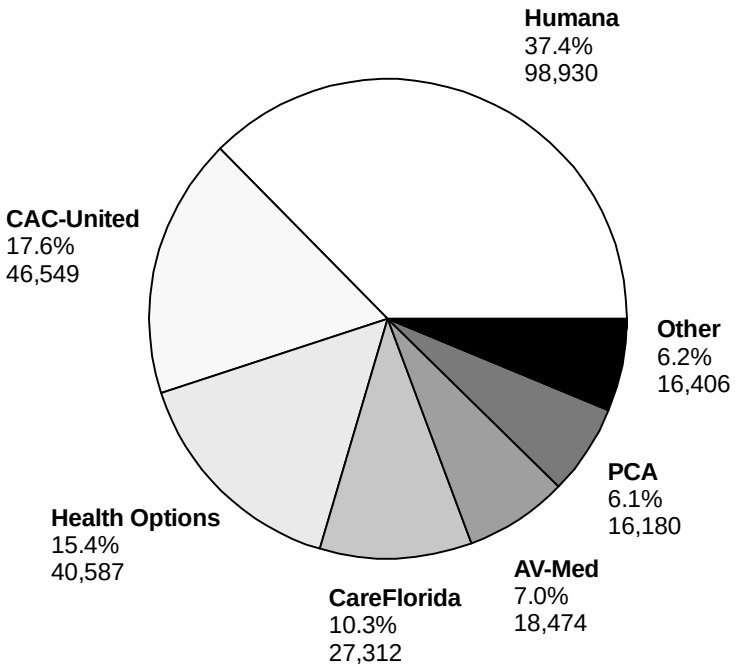
To determine the number of 1995 applicants who canceled or disenrolled within 3 months, we first identified Medicare beneficiaries who applied to HMOs in 1995. Using the enrollment and cancellation files, we identified which beneficiaries canceled their applications or disenrolled within 3 months. We excluded beneficiaries who died or lost their eligibility. We then calculated the percentage of applicants who canceled or disenrolled within 3 months:

Percentage of applicants who canceled or disenrolled within 3 months =
[(cancellations + (disenrollments within 3 months) - (deaths and ineligibles within 3 months)]/ (1995 applicants - deaths and ineligibles)

We conducted our review of disenrollment data between March and August 1996 on the basis of data extracted from HCFA's databases during April and May of 1996 and in accordance with generally accepted government auditing standards.

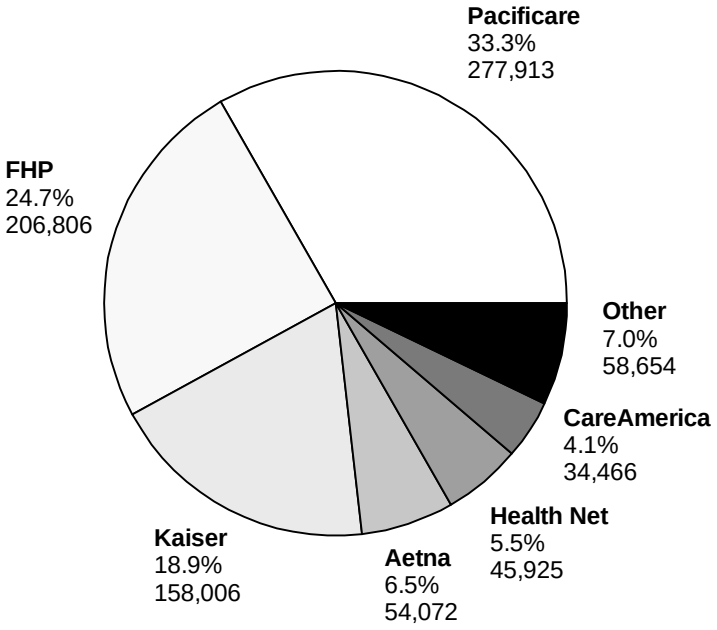
Miami and Los Angeles HMO Market Shares

Figure II.1: Miami HMO Market Shares



Note: The section of the pie chart labeled "Other" consists of three plans with 3 percent or less of the Miami Medicare risk market: (1) HIP, with 8,154 members or 3.08 percent of the market; (2) Prudential, with 6,927 members or 2.62 percent of the market; and (3) Neighborhood, with 1,325 members or .50 percent of the market. The total number of members in each plan is as of December 31, 1995, from HCFA McCoy Profile Reports processed on April 22, 1996.

Figure II.2: Los Angeles HMO Market Shares



Note: The section of the pie chart labeled "Other" consists of eight plans with less than 2 percent of the Los Angeles Medicare risk market: (1) Inter Valley, with 13,574 members or 1.62 percent of the market; (2) Watts, with 12,753 members or 1.53 percent of the market; (3) Cigna, with 10,822 members or 1.29 percent of the market; (4) Foundation, with 8,572 members or 1.03 of the market; (5) Scan, with 8,402 or 1.01 percent of the market; (6) Maxicare, with 2,231 or .27 percent of the market; (7) Prudential, with 1,920 members or .23 percent of the market; and (8) CaliforniaCare, with 380 members or .05 percent of the market. The total number of members in each plan is as of December 31, 1995, from HCFA McCoy Profile Reports processed on April 22, 1996.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

OCT 4 1996

Mr. William J. Scanlon
Director, Health Financing
and Systems Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Scanlon:

Enclosed are the Department's comments on your draft report, "Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

June Gibbs Brown
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services (HHS) on the General Accounting Office (GAO) Draft Report, "Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance"

One of the highest priorities of the Health Care Financing Administration's (HCFA) is assuring that our beneficiaries receive timely, accurate, and useful information about Medicare. We share GAO's view that Medicare beneficiaries need more information and that informed beneficiaries can hold plans accountable for the quality of care. We have several initiatives underway to ensure that beneficiaries receive information necessary to compare fee-for-service or managed care options and enable them to choose the right plan for their needs.

Plan Comparability Charts

Currently, HCFA produces managed care plan comparability charts in several HHS regions. We will be implementing a more systematic approach early next year. HCFA will be making available current, comparative information on cost and benefits, and other plan information for all plans. This information will use consistent language and descriptions for beneficiaries' use as they select how and where they choose to receive their Medicare benefits. The materials will primarily reside in an electronic format, which is easily updatable and economical. The information will be available to any individual or organization with electronic access. Primary users will be Information, Counseling, and Advocacy Program counselors, the Aging Network, beneficiary advocacy groups, HCFA Regional Offices and other Federal, State and local governmental entities. The materials can be downloaded and customized for local consumption. The project is consistent with HCFA strategies aimed at providing beneficiaries with objective, current consumer information.

This initiative was developed within the existing budget. Under the President's 1996 Balanced Budget Proposal, the costs associated with the preparation and dissemination of such materials would be financed by managed care and Medigap plans, and the initiative would be expanded.

HCFA has developed a chart format for this project which contains a comparison of benefits between managed care and fee-for-service, and among managed care plans in a given market. These charts will have a core set of basic plan-specific information relating to premiums, copayments, service areas, and benefits. The chart is presently undergoing a period of cognitive testing as part of an ongoing effort to identify information needs of beneficiaries.

HCFA databases contain all of this basic information. However, there is no existing way of blending this data into a useful format without extensive programming. The development of this database combining comparable materials has just been completed and is presently undergoing review and validation.

Although early efforts will yield only "basic" plan information, additional information elements will be added periodically. It is our intent to include beneficiary satisfaction information and quality indicators in subsequent revisions as that type of information becomes available and is validated through our Beneficiary Satisfaction Survey, to be implemented in 1997.

Member Satisfaction Surveys

In April 1996, HCFA entered into an interagency agreement with the Agency for Health Care Policy and Research to develop a Medicare module to be added to their Consumer Assessment of Health Plan Study. This member survey is currently in the process of cognitive and field testing and will be available for implementation in 1997. HCFA, in its upcoming January 1, 1997, contract cycle, will require Medicare HMOs to administer this survey in 1997. The results of this survey will be included in the comparability charts when they become available.

HEDIS Performance Measures

In 1996, HCFA funded the National Committee on Quality Assurance to develop Medicare-specific clinical effectiveness measures to be included in HEDIS 3.0 (Health Plan Employer Data Information Set). HEDIS 3.0, including Medicare-specific measures, will be finalized in October of this year. All Medicare contracts signed or renewed on or after January 1, 1997, will require Medicare HMOs to report on HEDIS 3.0 measures.

For Medicare, HEDIS 3.0 will include the following clinical measures: flu shots, mammography screening, eye exams for diabetics, beta blocker treatment after a heart attack, follow-up after hospitalization for mental illness, advising smokers to quit, and health of seniors (an outcome measure based on functional status.) The results of these reports will be summarized and also included in our comparability charts.

National Marketing Guidelines

HCFA has an effort underway to improve the usefulness, clarity and consistency of marketing materials given to Medicare beneficiaries by HMOs. HCFA will be implementing a "National Managed Care Marketing Guideline" as of January 1, 1997. This guideline will be distributed to all Medicare managed care contractors and all HCFA Regional Offices and will detail what specific content areas have to be covered

in all marketing materials developed and used by Medicare managed care contractors. The guideline will also include several illustrations for each subject content area of the guideline, e.g., model enrollment, denial, and disenrollment materials.

The "National Managed Care Marketing Guideline" initiative was developed in response to the following areas of concern: 1) beneficiary and advocacy group complaints of confusion and misunderstanding based on Medicare managed care plan marketing practices, 2) Medicare managed care contractor complaints regarding a lack of uniform interpretation of managed care marketing regulations by HCFA reviewers, 3) Medicare managed care contractor complaints regarding the long review times for marketing materials submitted to HCFA, and 4) HCFA concerns over the high personnel resources required to review managed care marketing materials.

Comments from a wide variety of sources are being solicited, and a final edition of the "National Managed Care Marketing Guideline" will be disseminated and implemented by January 1, 1997. An evaluation of the "Guideline" utilization will be completed by April 30, 1997.

We note that the President's 1996 Balanced Budget Proposal included a provision to have enrollment in managed care plans occur through a third party designated by the Secretary, rather than through the plans. Third party enrollment is a way to ensure that beneficiaries are aware of the implications of enrollment.

Medicare Transaction System

With the development of HCFA's Medicare Transaction System, HCFA's overall approach to consumer services will change. Under MTS, HCFA will develop a vehicle for recording information received from beneficiaries, as well as methods for categorizing and analyzing this information. This will allow HCFA to address problems that are identified. One specific area where this will occur is beneficiary complaints about managed care entities. HCFA's regional offices receive and investigate complaints. With MTS, HCFA will have the ability to identify common complaints and categorize them according to contracting organizations. In addition, HCFA will be able more readily to analyze complaint information to directly investigate contracting organizations. We will also be better able to provide this information to beneficiaries.

HCFA is also developing a system under MTS to track and report on the results of its monitoring reviews. Currently, the information HCFA has on the results of its monitoring activities is not aggregated in an automated fashion. We are now developing a system to automatically and uniformly gather, analyze and present the information resulting from our reviews in such a way, that when shared with the beneficiaries, will provide a fair context for them to consider when making health care

decisions across plans. Under the MTS system, HCFA will have the capability to gather this data uniformly from monitoring reviews done across the country, and be able to not only report on the types of areas of non-compliance found, but also upon their frequency. HCFA will then be able to make the information available to beneficiaries.

Appeals

HCFA is interested in providing beneficiaries with information that will not only help in making choices among health plan options, but that will also serve as a consumer protection tool. One such area is information to help assess whether HMOs and CMPs are regularly providing all medically necessary services. A potential source of data that could be used to assess this type of performance is appeals data. At this time, the only appeals data available are reconsiderations that come to HCFA's reconsideration contractor, and not those appeals closed at the plan level. Therefore, we are developing requirements for contracting health plans to submit standardized, plan-level appeals data. After implementation and assessment of the data base, a determination of what type of measures will be valid, reasonable and helpful to the public will be made in consultation with beneficiary advocacy groups and the managed care industry. Simple appeals rates by health plan may or may not be the indicator used because of the potential inverse relationship between these rates and beneficiary knowledge and education about appeal rights. HCFA plans to implement the appeals reporting requirements during the 1997 contract year.

Current Beneficiary Information Efforts

While we develop these new initiatives, we continue to give accurate and useful information to our beneficiaries. In 1994 we re-organized our managed care operations and created the Beneficiary Access and Education Team (BAET). This team is responsible for the development, creation, and distribution of managed care informational materials. Some of the materials developed by the BAET are:

1. Medicare Managed Care Booklet

A booklet entitled "Medicare Managed Care" originally published in 1995 was recently revised and reprinted in August 1996. This booklet clearly states how a managed care plan works, what the advantages and disadvantages are for an enrollee, how managed care differs from fee-for-service, enrollment/disenrollment procedures, and also provides a listing of all state Health Insurance Information and Counseling Programs.

One million copies of the revised booklet were printed. The initial distribution list included state Health Insurance Counseling Programs, Social Security Administration District Offices, American Association of Retired Persons, Area Agencies on the Aging, HCFA Regional Offices, disability groups, carriers and intermediaries, hospitals, State

Insurance Departments, libraries, managed care plans, and other beneficiary advocacy groups. The Government Consumer Information Center in Pueblo, Colorado will be receiving 100,000 copies of this booklet to respond to requests they have received. The Center will also conduct an evaluation of this booklet which will be available on the Internet.

2. Your Medicare Handbook

"Your Medicare Handbook 1996", which was sent to all current beneficiaries in May 1996 and will be sent to all new enrollees, includes a new section that highlights managed care and is more comprehensive and informative than previous editions.

3. Medicare Managed Care Resources Directory

HCFA has distributed each year for the past four years the "Medicare Managed Care Resource Directory" which is a comprehensive listing of all Medicare managed care plans by region and state, as well as other very useful information for beneficiaries. This directory includes a statement of beneficiary rights, descriptive material on Medicare Select, explanation of out-of-network/point of service, marketing caveats, description of the beneficiary as an informed consumer, and information on appeals, grievances and complaints. The directory includes additional listings to help the beneficiary which include: State Insurance Counseling Services, State Insurance Departments, and Medicare Peer Review Organizations. This document is on the Internet and is updated quarterly.

This directory is distributed to beneficiary advocacy groups, Social Security Administration district offices, Health Insurance Counseling Programs, Area Agencies on Aging, and other beneficiary related organizations. We believe these materials have been of great value to our beneficiaries and can be accessed through the Internet.

Finally, the GAO Report recommends that we make disenrollment data available to beneficiaries. We currently use plan specific disenrollment data generated by our systems to assist us in determining which plans need more focused reviews or monitoring. But our review of these disenrollment data indicates that there are a number of reasons that beneficiaries disenroll, and that a careful analysis in the context of the particular plan's activities and the market in which the plan operates needs to be conducted before any meaningful conclusions can be drawn. For example, a high rate of disenrollment from a plan in the northern part of our country when compared to a plan in the southern part of the country would need to take into account the "Snowbird" phenomenon. We are currently evaluating the different ways in which disenrollment rates, across plans, can best be expressed and presented, so that beneficiaries can use them, in conjunction with other plan-specific data, to make good choices among plans.

This involves working with beneficiaries and beneficiary advocacy groups. We plan on eventually including appropriate disenrollment data in the Comparability Chart.

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Related GAO Reports

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-63, Jan. 18, 1996).

Health Care: Employers and Individual Consumers Want Additional Information on Quality (GAO/HEHS-95-201, Sept. 29, 1995).

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/T-HEHS-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).

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/T-HRD-91-14, Apr. 11, 1991).

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

Federal Employees Need Better Information for Selecting a Health Plan (MWD-76-83, Jan. 26, 1976).

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