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Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss Medicare beneficiaries' need for comparative information on health maintenance organizations (HMO) and steps the Health Care Financing Administration (HCFA) could take to meet that need promptly. Such information would be useful not only to the more than 4 million Medicare beneficiaries enrolled in HMOs, but also to the millions of beneficiaries expected to enroll in a managed care plan during the next several years. Although Medicare HMOs must cover all the benefits available under traditional fee-for-service Medicare, they differ from one another in additional benefits provided, required premiums, networks of providers, and ability to satisfy members. Because of these differences, beneficiaries need information to pick the plan that is right for them.

Last October, at the request of the Chairman, the Ranking Minority Member, and other members of the Senate Special Committee on Aging, we reported⁽¹⁾ on the marketing, education, and enrollment practices of Medicare risk HMOs.⁽²⁾ We also reviewed HCFA's performance in providing beneficiaries information about Medicare HMOs and the usefulness of readily available HCFA data to caution beneficiaries about poorly performing HMOs. To develop this information, we interviewed representatives from HCFA, large health care purchasing organizations, HMOs, and beneficiary advocacy groups; reviewed beneficiary case files; studied HMO marketing materials; and analyzed HMO data available to HCFA. In our report, we recommended several steps that the Secretary of Health and Human Services should take promptly to help Medicare beneficiaries make informed health care decisions. Today, I will discuss both our report's findings and HCFA's plans to provide beneficiaries with more information about HMOs.

In summary, we found that HCFA does not distribute to beneficiaries comparative consumer guides such as those the federal government and many employer-based health insurance programs routinely distribute to their employees and retirees. Without these guides, beneficiaries cannot easily compare HMOs. Marketing materials distributed by HMOs are of little help because HMOs describe their benefits and costs using different terms and formats.

Although beneficiaries lack information on HMOs, HCFA does not. HCFA amasses volumes of information that could be summarized, packaged, and distributed to help beneficiaries choose among competing Medicare HMOs. For example, HCFA compiles information that can be used to construct HMO benefit comparison charts. HCFA also routinely collects other information--such as disenrollment rates, beneficiary complaints about HMOs, and the results of HCFA's HMO monitoring visits--that could be provided to beneficiaries. Because some plans do a better job of retaining Medicare beneficiaries than others, disenrollment rates--an indicator of beneficiary satisfaction--may be especially

useful in helping beneficiaries distinguish among competing HMOs. For example, our analysis of HCFA's data showed that 1995 annual disenrollment rates ranged from 4 to 42 percent among Los Angeles HMOs and from 12 to 37 percent among Miami HMOs.

HCFA has initiatives, planned or under way, that will make some comparative HMO information available to beneficiaries. Although these initiatives are steps in the right direction, they are very small steps. With little additional time or effort, HCFA could do much more to help Medicare beneficiaries make informed selections among available HMOs. Specifically, HCFA should adopt the recommendations in our report by

- requiring standard formats and terminology in HMOs' informational materials;
- producing benefit and cost comparison charts with all Medicare HMO options available for each market area and ensuring that interested beneficiaries are notified of the charts' availability; and
- analyzing and widely distributing data it already collects--such as HMO disenrollment rates, complaint rates, and the results of HMO monitoring visits--that can help beneficiaries distinguish among competing HMOs.

BACKGROUND

Most beneficiaries live in areas where they can choose to receive Medicare benefits either through an HMO or through a traditional fee-for-service arrangement. HMOs are required to cover all Medicare benefits, but many also provide additional services, such as outpatient prescription drugs, routine physical exams, and hearing aids, that are not covered under traditional Medicare. Enrollees' cost varies as well; some HMOs charge a monthly premium but others do not.⁽³⁾ In return for the advantages offered by HMOs,

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.

Because of the additional benefits offered by HMOs and the relatively low out-of-pocket costs, growing numbers of Medicare beneficiaries are leaving Medicare fee-for-service and joining managed care plans. In fact, Medicare HMO enrollment is growing by about 85,000 beneficiaries per month. More than 11 percent, or 4.4 million, of the 38 million Medicare beneficiaries are now enrolled in "risk contract" HMOs. The Congressional Budget Office estimates that nearly 15 million beneficiaries will be enrolled in a risk HMO by the year 2007.

MEDICARE DOES NOT DISTRIBUTE

HEALTH PLAN INFORMATION TO BENEFICIARIES

Medicare currently lags behind other large purchasers in helping beneficiaries choose among plans. The Federal Employees Health Benefits Program, the California Public Employees' Retirement System, 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 comparative information about the Medicare HMOs available in their area.

For the last few years, however, HCFA's regional office in San Francisco has produced HMO comparison charts for selected market areas.⁽⁴⁾ More recently, HCFA's regional office in Philadelphia has also produced comparison charts. The regional offices distribute these charts, however, mainly to HMOs, some news organizations, and federally supported insurance counselors in the Information, Counseling, and Assistance (ICA) program.⁽⁵⁾ Beneficiaries may request the charts from the regional offices, but few beneficiaries know the charts exist. Even the ICA insurance counselors, most of whom are volunteers, may be unaware of the charts. When GAO staff called a Los Angeles ICA insurance counselor and asked specifically about Medicare HMO information, the counselor did not mention that comparison charts were available.

Beneficiaries Face a Nearly Impossible

Task to Compare HMOs' Costs and Benefits

For beneficiaries considering Medicare managed care for the first time or switching to a new plan, getting information on area HMOs can be time consuming. Beneficiaries must first find the correct telephone number to request a list of area plans and then call each plan and request information. When our staff called all 14 Medicare HMOs in Los Angeles to request their marketing materials, information from only 10 plans was received after several weeks and many follow-up phone calls. Some plans were reluctant to mail the information but offered to send it with a sales agent. Declining visits from sales agents, we finally received the missing brochures by calling the HMOs' marketing directors and insisting the materials be mailed.

Using HMOs' marketing materials 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. All together, just the benefit summaries from the 14 Los Angeles HMOs operating in 1995 cover a 10-foot-wide wall. Moreover, terminology differs from plan to plan. A beneficiary reading the marketing materials from several HMOs may not be able to tell, for example, which HMO provides better prescription drug coverage. Most HMOs that offer a drug benefit place an annual limit or cap on the dollar amount covered. Two HMOs with seemingly identical \$1,000 annual drug limits may not offer equivalent benefits, however. One HMO may count its actual drug costs, including any discounts it receives, in computing its limit, while the other HMO may use generally higher manufacturers' list prices in computing its limit. Furthermore, HMO brochures make comparisons difficult by using a variety of terms--such as "preferred drugs," "covered drugs," "formulary drugs," "legend drugs," and "authorized drugs"--in describing their prescription drug benefit limits.

HCFA COULD PACKAGE AND DISTRIBUTE

AVAILABLE INFORMATION ON HMOs

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. In addition, HCFA collects other HMO-specific information, including plans' financial data and reports from monitoring visits to HMOs. However, HCFA does not routinely distribute this potentially useful information.

Publishing Disenrollment Rates

Could Help Beneficiaries Compare

Competing HMOs

Because Medicare beneficiaries enrolled in HMOs can vote with their feet each

month--switching plans or returning to fee-for-service--a comparison of HMOs' disenrollment rates can suggest beneficiaries' relative satisfaction with plans' service, benefits, out-of-pocket costs, and quality. If beneficiaries are about equally satisfied with HMOs in a market, these HMOs' disenrollment rates should be about the same. Despite the potential value of such information, however, HCFA neither routinely nor systematically compares HMO disenrollment rates. Thus, HCFA misses an opportunity to inform beneficiaries of plans with good records of retaining Medicare enrollees.

To illustrate the value of disenrollment rates as an indicator, we analyzed 1995 HCFA disenrollment data for two large managed care markets: Los Angeles and Miami. We found that Medicare HMOs' ability to retain beneficiaries varied widely among HMOs in the same market.⁽⁶⁾ For some HMOs, 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.

Annual disenrollment rates⁽⁷⁾ varied substantially among HMOs operating in the same market. Among the 13 Los Angeles HMOs⁽⁸⁾ we analyzed, Foundation Health's 42 percent disenrollment rate was the highest in 1995. (See fig. 1.) Four other plans, however, had disenrollment rates exceeding 20 percent. In contrast, several HMOs had disenrollment rates of 10 percent or less. Kaiser Foundation Health Plan had the lowest rate--4 percent. The seven Miami HMOs active for all of 1995 showed a similar, although slightly less extreme pattern.

Figure 1: Los Angeles Medicare HMOs' Annual Disenrollment Rates, 1995

Note: Annual disenrollment rates are the number of beneficiaries who disenrolled--excluding members who died or lost Medicare part B eligibility--in 1995 compared with the average number of enrollees in 1995.

Source: GAO analysis of HCFA disenrollment data.

Beneficiaries who leave an HMO within a 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. Consequently, rates of early disenrollment may indicate beneficiary confusion and marketing problems. In our early disenrollment calculations we included both cancellations--beneficiaries who signed an application but canceled before the effective date--and "rapid disenrollment"--beneficiaries who left within 3 months of enrollment.

Our analysis showed a wide variation in plans' early disenrollment rates. In 1995, Medicare HMOs in Los Angeles had early disenrollment rates ranging from 5 to 29 percent. (See fig. 2.) For Miami HMOs, early disenrollment rates ranged from 9 to 30 percent. That is, nearly one out of three beneficiaries who signed an application with Watts Health Foundation, Inc. (Los Angeles) or CareFlorida (Miami) canceled the application or left the plan shortly after the effective date.

Figure 2: Los Angeles Medicare HMOs' Rates of Early Disenrollment, 1995

Source: GAO analysis of HCFA data.

Disenrollment rates do not indicate the reason for beneficiary dissatisfaction. Out-of-pocket costs, access, or quality issues can all affect beneficiaries' decisions to disenroll. However, we found such large variations within market areas that, even as gross indicators, disenrollment rates can provide valuable information to beneficiaries trying to distinguish among seemingly identical HMOs. Furthermore, if disenrollment rates are published, then health plans may begin to compete on the basis of service and member retention as well as price and drug benefits. In fact, at least one Medicare HMO with low disenrollment advertises its member retention rate. Because beneficiaries do not know about competing plans' member retention (or disenrollment) rates, however, they cannot use this information to compare plans.

HCFA'S CONSUMER INFORMATION INITIATIVES

FALL SHORT OF REACHABLE GOALS

HCFA has several initiatives to compile information on Medicare HMOs, make that information available, and increase consistency among HMOs' marketing materials. These initiatives include

-- making a database of HMO information available on the Internet;

- issuing National Marketing Guidelines for HMOs to follow when preparing materials distributed to beneficiaries;
- conducting a satisfaction survey of HMO enrollees; and
- compiling selected HMO performance measures from the Health Plan Employer Data and Information Set 3.0 (HEDIS 3.0),⁽⁹⁾ including data from a longitudinal study of HMO enrollees' health status.

Although these initiatives are a step in the right direction, many of them fall short in one way or another. For example, HCFA's planned Internet HMO database may have limited value to beneficiaries. Although the information will be available, it may not reach beneficiaries who want it. Many beneficiaries may lack Internet access or the computer sophistication necessary to use the database. HCFA realizes that relatively few Medicare beneficiaries "surf the Web." HCFA expects that HCFA regional offices, the Aging Network, insurance counselors, and beneficiary advocates will be the primary users of the database and will distribute the information to beneficiaries. Such a system can break down, however, as we discovered when we called the Los Angeles ICA office seeking information on HMOs.

HCFA's National Marketing Guidelines initiative may not ensure that beneficiaries can readily compare HMOs using plans' marketing materials. As currently drafted, the guidelines will not require HMOs to use standard formats and terminology in their marketing materials. Because adherence to the model formats in the guidelines is to be voluntary, plans may continue to produce and distribute very dissimilar marketing materials--like we obtained from the Los Angeles HMOs.

The initial HMO enrollee satisfaction survey results may be of limited value because the initial survey excludes beneficiaries who were so dissatisfied with their health plan that they disenrolled.⁽¹⁰⁾ HCFA plans to conduct the survey--known as the Consumer Assessments of Health Plans Study--this summer and release the results in the fall. However, HCFA will survey only beneficiaries who have been continuously enrolled in the same plan for 12 months or more. In the two markets we studied, we found that PCA, CareFlorida, Foundation, Prudential (Los Angeles), and Watts lost more than 25 percent of their members (excluding deaths and loss of eligibility) in 1995. HCFA's survey will miss these Medicare beneficiaries.

We have similar concerns about HCFA's planned longitudinal study of HMO enrollee health status. HCFA plans to gather self-reported health status data from a sample of HMO enrollees and then resurvey those same enrollees 2 years later to determine if their health status has improved, stayed the same, or deteriorated. HCFA intends to compare health outcomes in specific HMOs using the survey results. This survey, however, will miss beneficiaries who become ill and leave because they are dissatisfied with the care they received in their health plan. Moreover, because the study is longitudinal, HCFA does not expect these data to be available until 1999.

CONCLUSIONS

Medicare beneficiaries need more and better information so that they can make informed decisions when choosing a health plan. Though Medicare is the nation's largest purchaser of managed care services, it lags behind other large purchasers in providing comparative information to beneficiaries. The need for this information grows more urgent each month as tens of thousands of beneficiaries join the already 4 million beneficiaries who have opted for the advantages of Medicare managed care. HCFA is moving in the right direction to make information available, but we believe the agency could do much more with relatively little expenditure of time or effort. Requiring that HMOs use standard terminology and

formats to describe benefits, producing comparison charts and ensuring that interested beneficiaries know how to get such charts, and analyzing and publishing comparative data already available (such as disenrollment rates) would greatly enhance the ability of Medicare beneficiaries to be wise consumers of managed care.

Mr. Chairman, this concludes my prepared statement. I am pleased to answer any questions you or other members of the Committee may have.

For more information on this testimony, please call James C. Cosgrove, Assistant Director, Health Financing and Systems Issues, on (202) 512-7029. Other major contributors to this statement include Charles A. Walter, Marie E. Cushing, George M. Duncan, and Wayne J. Turowski.

RELATED GAO PRODUCTS

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

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).

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1. Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance
(GAO/HEHS-97-23, Oct. 22, 1996).

2. Risk HMOs assume the financial risk of providing care for the monthly capitated amount Medicare pays.

3. Beneficiaries must continue to pay a monthly premium to Medicare for part B (currently, \$43.80 per month).

4. However, the regional office has not yet issued 1997 comparison charts--even though the capitation rates Medicare pays to HMOs, and thus their premiums and benefits, changed on January 1, 1997.

5. The ICA program is federally supported but state-managed. ICA counselors can provide beneficiaries with general information about Medicare, Medicaid, managed care plans, and various types of health insurance available to supplement Medicare.
6. We excluded from our analysis disenrollments due to beneficiary death or loss of Medicare part B eligibility.
7. Annual disenrollment rates represent the percentage of an HMO's average Medicare enrollment lost to disenrollment after excluding disenrollments due to death or loss of Medicare part B eligibility.
8. One Los Angeles HMO was excluded from our analysis because it had fewer than 100 members.
9. HCFA's selected HEDIS 3.0 measures include: effectiveness of care, access to/availability of care, health plan stability, use of services, cost of care, informed health care choices, and health plan descriptive information. HCFA helped develop and fund the National Committee for Quality Assurance's efforts to develop Medicare-specific clinical effectiveness measures included in HEDIS 3.0.
10. According to HCFA's recently published regulations on physician incentive plans in managed care settings, HMOs with providers that have been determined to be at substantial financial risk will be required to conduct a survey of current and recently disenrolled members. Plans that are not required to do a survey under the physician incentive regulations are not required to conduct a disenrollment survey.