

# Disabled Medicare Beneficiaries In HMOs

The first comprehensive look at how disabled Medicare beneficiaries fare under Medicare managed care.

by Marsha Gold, Lyle Nelson, Randall Brown, Anne Ciemnecki, Anna Aizer, and Elizabeth Docteur

**ABSTRACT:** This study presents new data from a 1996 national survey of Medicare risk enrollees and disenrollees designed to profile access to care in Medicare health maintenance organizations (HMOs). The findings show that expanded benefits and low (or no) premiums are major features attracting disabled Medicare beneficiaries into Medicare HMOs. We found that most disabled persons enrolled in Medicare HMOs do not experience access problems. However, they are more likely than nondisabled Medicare HMO enrollees to experience such problems. We conclude by highlighting the importance of having information to monitor access to care for vulnerable subgroups such as disabled Medicare beneficiaries and to develop incentives to serve them well in Medicare HMOs.

DATAWATCH

149

RELATIVELY LITTLE IS KNOWN about Medicare's nonelderly (younger than age sixty-five) disabled population. Two recent studies highlight the general characteristics of nonelderly disabled Medicare beneficiaries, as well as their overall patterns of access and satisfaction within traditional Medicare.<sup>1</sup> We are aware of no broadly based studies that focus specifically on the experience of the nonelderly disabled population in Medicare managed care, by which we mean Medicare risk-contracting plans (Medicare health maintenance organizations [HMOs]). The absence of such analysis is particularly troublesome because the share of disabled beneficiaries enrolled in Medicare HMOs has grown relatively rapidly in recent years. Although existing studies are generally encouraging about access, quality, and beneficiary satisfaction in Medicare HMOs compared with fee-for-service Medicare, studies also suggest that when problems occur, they may be more likely to occur in vulnerable subgroups such as the chronically ill.<sup>2</sup>

Our estimates suggest that about 5 percent of nonelderly disabled

.....  
 Marsha Gold, Lyle Nelson, Randall Brown, Anne Ciemnecki, and Anna Aizer are, respectively, senior fellow, senior economist, senior fellow, survey director, and health policy analyst at Mathematica Policy Research. Elizabeth Docteur, a senior analyst with the Physician Payment Review Commission when this paper was developed, has since taken a position with the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Medicare beneficiaries were enrolled in HMOs in 1996, up from 3 percent in 1993.<sup>3</sup> Although the Medicare disabled now account for less than 6 percent of all Medicare HMO enrollees (compared with 12 percent of all Medicare beneficiaries), their share of HMO enrollment has doubled since 1990. Thus, learning more about their experience within Medicare HMOs is important.

## **Objectives And Data Sources**

This DataWatch describes the characteristics of nonelderly disabled Medicare beneficiaries in HMOs, the reasons why they chose to join HMOs, and their experience, particularly in terms of access and satisfaction. We also compare the characteristics and experiences of disabled Medicare beneficiaries enrolled in HMOs with what is known about disabled Medicare beneficiaries in general, using both recently published work and a new analysis of the Medicare Current Beneficiary Survey (MCBS). We then identify a number of critical issues for policy attention and further research.

The Medicare HMO data used here come from a recent national survey of 3,080 Medicare managed care enrollees and disenrollees that was sponsored by the Physician Payment Review Commission and conducted by Mathematica Policy Research. The sample was drawn from the population of Medicare beneficiaries who were enrolled for two or more months in Medicare risk plans in the twelve months ending in February 1996.<sup>4</sup> We stratified the sample by enrollment status, age, race, and plan size. We oversampled subgroups that might be vulnerable to problems with access to care, including disabled persons younger than age sixty-five, beneficiaries age eighty-five or older, African Americans, and disenrollees.<sup>5</sup> To compensate for oversampling, we weighted the sample to ensure that our estimates were representative of the national population of Medicare HMO enrollees and disenrollees.

Telephone interviews were conducted between May and July 1996. To enhance the response of vulnerable subgroups, proxy respondents were encouraged under stipulated procedures. Some questions were drawn from existing instruments, while others were newly constructed to capture other important dimensions of access to care identified by our expert consultants or from a conceptual framework we developed.<sup>6</sup> Topics included the reasons for enrollment or disenrollment, initial experiences with the plan, experiences making appointments and obtaining care, experience at the most recent physician visit, experience with the appeals process, satisfaction with the plan, and beneficiaries' characteristics, including demographics, health status, and attitudes.

In total, 3,080 interviews were completed, for a 64 percent re-

sponse rate, which is similar to that in other recent surveys that faced similar challenges in locating persons by telephone.<sup>7</sup> Because of the oversampling, estimates for the Medicare disabled population are based on 419 persons (as compared with the 172 that we would have expected had we not oversampled). The response rate among the under-age-sixty-five disabled subgroup was 61 percent. About one of every nine interviews was completed by a proxy respondent.<sup>8</sup> Only 5 percent of those located and contacted refused to participate, a lower rate of refusal than among the elderly population.

We used the 1994 MCBS, the most current version then available, to develop comparison estimates for Medicare beneficiaries in the traditional Medicare fee-for-service program. We restricted our analysis to those living in metropolitan areas, since about 98 percent of all Medicare risk enrollees live there. The comparisons between HMO enrollees and fee-for-service beneficiaries were constrained because of the limited comparability between our survey and the MCBS in the questions on access and satisfaction. Also, the MCBS data cover an earlier time period than our survey covers and were collected through in-person interviews rather than telephone interviews. Despite these relatively serious limitations, we include some comparison (with caveats) here because of the considerable interest in this topic and to provide a context for the HMO findings.<sup>9</sup>

## Characteristics Of Disabled Beneficiaries

**Qualifications for Medicare disability.** Only a small share of all disabled persons qualify for Medicare disability.<sup>10</sup> Medicare coverage is limited to a subset of those who qualify for the Social Security Disability Insurance (SSDI) or Railroad Retirement programs, both of which use a relatively restrictive definition of disability based on inability to engage in substantial, gainful activity by reason of mental or physical impairment. With the exception of persons with end-stage renal disease, there is a two-year waiting period before persons are entitled to Medicare once they qualify for SSDI. During this time some persons die, while others improve and are able to return to work. Thus, SSDI data on the reasons for eligibility do not provide a representative profile of those who are entitled to Medicare because of a disability.

**Number of nonelderly disabled Medicare beneficiaries.** The share of Medicare beneficiaries who are disabled has not been stable over time, which reflects changes in SSDI policy. Since the early 1980s, the number of nonelderly disabled Medicare beneficiaries has been climbing.<sup>11</sup> There were 4.4 million in 1995.<sup>12</sup> Until the MCBS, the Health Care Financing Administration (HCFA) had limited information on the health characteristics of disabled Medicare beneficiaries. Using 1991 data from the first round of the MCBS, Margo Rosenbach profiled

this population.<sup>13</sup> Just under a third (31 percent) of those surveyed by the MCBS reported mental or psychiatric disorders, about half of whom (15 percent) said that this was their reason for becoming eligible. Among disabled Medicare beneficiaries, 38 percent reported hypertension, 35 percent arthritis, 23 percent heart conditions other than angina pectoris or chronic heart disease (which accounted for another 13 percent), 21 percent partial paralysis, 19 percent mental retardation, and 18 percent emphysema and various other pulmonary diseases.

## **Which Disabled Medicare Beneficiaries Join HMOs?**

**Comparison of disabled HMO and fee-for-service enrollees.** Disabled Medicare HMO enrollees are strikingly older and less likely to be institutionalized than disabled beneficiaries enrolled in fee-for-service Medicare (Exhibit 1). Disabled Medicare HMO enrollees are considerably less likely to be covered under a Medicaid buy-in arrangement and also are less likely to report either of the two functional limitations common to both surveys.<sup>14</sup> On average, disabled Medicare HMO enrollees rate their health status as somewhat better than do disabled persons in fee-for-service Medicare.

The most common reasons given by disabled Medicare HMO enrollees for their initial Medicare eligibility are back and spine conditions (21 percent), circulatory problems (15 percent), other orthopedic problems (that is, other than back or spine) (14 percent), mental illness (11 percent), and neurological problems (9 percent).<sup>15</sup> Our study does not lend itself well to identifying differences between Medicare HMO and fee-for-service beneficiaries on specific health characteristics and the reasons for their initial Medicare eligibility. However, the data presented in Exhibit 1 suggest that Medicare HMOs may be more attractive to some subgroups of the disabled Medicare population than they are to others.

**Comparison of disabled and elderly HMO enrollees.** Disabled Medicare HMO enrollees differ from elderly Medicare HMO enrollees in ways other than those related to age (Exhibit 2). Nonelderly disabled Medicare HMO enrollees are less likely than elderly enrollees to be female, more likely to be African American, and more likely to have annual household incomes under \$10,000. Compared with the elderly, disabled Medicare HMO enrollees are less likely to be in California plans (29 percent versus 38 percent) but more likely to be in Florida plans (24 percent versus 17 percent) (not shown). Further, a larger share of nonelderly disabled than elderly Medicare HMO enrollees are new enrollees (43 percent versus 28 percent).<sup>16</sup> The nonelderly disabled also are more likely than the elderly to disenroll to fee-for-service Medicare (4.7 percent versus 2.7 percent). It is unclear when this difference is a function of the

**EXHIBIT 1**  
**Characteristics Of Disabled Medicare Beneficiaries (Under Age Sixty-Five) In Medicare HMOs Compared With Those In Fee-For-Service Medicare**

Characteristic	Medicare HMO, 1996 <sup>a</sup>	Medicare FFS, 1994 <sup>b</sup>
Age		
Under 18	— <sup>c</sup>	0.1%
18–44	19.6%	37.5
45–54	21.3	25.3
55–64	59.1	37.2
Percent female	43.6	39.2
Percent African American	13.8	19.7
Percent Hispanic	13.6	12.7
Percent institutionalized	0.5	10.2
Percent Medicaid buy-in <sup>d</sup>	13.1	37.6
Health status (self-reported)		
Excellent	10.2	7.5
Very good	14.4	11.3
Good	27.1	25.6
Fair	28.4	31.0
Poor	19.9	24.6
Has difficulty or unable to:		
Bathe or shower	11.0	24.2
Get in/out of bed or chair	6.0	28.2

**SOURCE:** See below.

**NOTES:** HMO is health maintenance organization. FFS is fee-for-service.

<sup>a</sup> Mathematica Policy Research (MPR)/Physician Payment Review Commission (PPRC) Survey of Medicare Risk Enrollees and Disenrollees, 1996 (unweighted sample = 419 cases).

<sup>b</sup> Based on the 1994 Medicare Current Beneficiary Survey as analyzed by the PPRC. Restricted to beneficiaries in urban areas to enhance comparability to Medicare HMO beneficiaries, most of whom reside in urban areas.

<sup>c</sup> Excluded from the MPR/PPRC survey sampling frame.

<sup>d</sup> Data from the Group Health Plan file, a census of all risk enrollees. Buy-in status does not fully account for beneficiaries eligible for Medicaid, as many of those who qualify on the basis of medical neediness are not covered under state buy-in arrangements.

larger share of new enrollees or when it is related to another factor.

Disabled Medicare HMO enrollees are much more likely than elderly HMO enrollees to report fair or poor health (Exhibit 2). More than a third of the nonelderly disabled Medicare beneficiaries in our survey said that they worry more about their health than other people their age do, a rate three times as high as that for the elderly. But differences in care-seeking behaviors are less striking. Forty-five percent of the Medicare disabled reported usually going to a doctor as soon as they start feeling bad, a small and not statistically significant difference from the elderly (40 percent). The disabled are more than twice as likely as the elderly to say that they typically visit a physician at least once a month (25 percent versus 11 percent).

**Why Disabled Medicare Beneficiaries Join HMOs**

**Costs and benefits.** The survey data show that costs and benefits are the major reasons why nonelderly disabled Medicare beneficiar-

## EXHIBIT 2 Comparison Of Disabled And Elderly Medicare HMO Enrollees

Demographic and socioeconomic characteristics	Nonelderly disabled	Elderly
Female	43.6% <sup>a</sup>	57.9%
Race		
African American	13.8 <sup>b</sup>	7.4
White	78.2	87.0
Other	8.0	5.6
Hispanic	13.6 <sup>a</sup>	7.7
Medicaid buy-in	13.1 <sup>a</sup>	3.5
Annual income		
Less than \$10,000	29.7 <sup>b</sup>	19.5
\$10,000–\$15,000	25.8	23.2
\$15,000–\$20,000	17.1	16.6
More than \$20,000	27.5	40.8
<b>Attitudes and typical service use</b>		
Health status (self-reported)		
Excellent	10.2 <sup>b</sup>	26.4
Very good	14.4	32.6
Good	27.1	27.5
Fair	28.4	9.9
Poor	19.9	3.6
Attitudes toward health care		
Worry more about their health than other people their age do	35.5 <sup>a</sup>	11.6
Avoid going to doctors	32.1	27.2
Usually go to a doctor as soon as they start feeling bad	44.7	40.3
Typical frequency of physician visits		
Never or almost never	5.1 <sup>b</sup>	8.5
1–2 times per year	21.4	29.5
3–11 times per year	49.1	51.2
Once per month	16.0	6.8
More than once per month	8.5	3.9
Sample size	419	2,661

**SOURCE:** Mathematica Policy Research/Physician Payment Review Commission Survey of Medicare Risk Enrollees and Disenrollees, 1996.

**NOTE:** Unless otherwise noted, the difference between disabled and elderly is not statistically significant at the .05 level, using as appropriate a two-tailed test or a chi-square test.

<sup>a</sup> Difference between disabled and elderly is statistically significant at the .01 level, two-tailed test.

<sup>b</sup> Difference between disabled and elderly in their distribution across categories is statistically significant at the .01 level, chi-square test.

ies join HMOs. Costs and benefits exert more influence over the decisions of nonelderly disabled beneficiaries to enroll in Medicare HMOs than they do among elderly beneficiaries. Sixty percent of nonelderly disabled Medicare HMO enrollees reported that costs and benefits were the most important factors in their decision to enroll, whereas about half (47 percent) of elderly enrollees said that these were their most important reasons for enrolling.<sup>17</sup> Among the

disabled Medicare HMO enrollees, 77 percent pay no premium and 85 percent have pharmaceutical coverage, proportions similar to those for the elderly population. Although the benefits of Medicare HMOs are similar for both populations, HMO benefits may be more salient for the disabled because of their chronic conditions and their greater likelihood of being in fair or poor health.

The financial attractiveness of Medicare HMOs to disabled beneficiaries is not surprising because the disabled are more likely than the elderly are to report financial barriers to care in fee-for-service Medicare. Our analysis of the 1994 MCBS indicates that 26 percent of the disabled Medicare beneficiaries in fee-for-service Medicare said that they delayed care because of cost. The same percentage said that they had a health problem in the past year for which they thought they should have seen a physician and did not. Other studies have found that 24 percent report no usual source of care.<sup>18</sup>

**Other factors.** Among the nonelderly disabled Medicare HMO enrollees surveyed, 47 percent said that there were specific things about their plan that appealed to them because of their disability. Beneficiaries most often cited their doctor or plan as having special knowledge of treating their condition (29 percent); they also listed better prices on medications (21 percent), low cost (13 percent), general plan features (12 percent), and location (9 percent).

With new enrollees reflecting 43 percent of all disabled Medicare HMO enrollees, it is encouraging that virtually all new enrollees from among the disabled population (including plan switchers) said that they received a booklet explaining how the plan works (94 percent), received a list of participating doctors/clinics (96 percent), and received enough information to be comfortable using the plan (94 percent). However, only 34 percent said that they were encouraged by the plan to have a physical examination or health assessment, including only 39 percent of those who changed physicians upon entering the plan.

## Access To Care

Most disabled Medicare HMO enrollees do not report problems with access to care; however, the share that does experience access problems is higher than that among the elderly. Twelve percent of disabled Medicare HMO enrollees reported having trouble making medical appointments in their plan, and almost half of these (47 percent) said that, therefore, they gave up trying. More than 80 percent of those who gave up said that this had occurred more than once. About one of five disabled Medicare HMO enrollees experienced at least one of a set of problems we asked about, almost twice as many as among the elderly (Exhibit 3). Ten percent of the dis-

**EXHIBIT 3**  
**Medicare HMO Access To Care: Comparison Of Disabled And Elderly Enrollees**

<b>Making appointments</b>	<b>Disabled</b>	<b>Elderly</b>
Had trouble making medical appointments in plan	12.0% <sup>c</sup>	8.0%
Gave up making an appointment because of the trouble they encountered (among those who encountered trouble)	47.4 <sup>d</sup>	23.6
Number of times gave up trying to make an appointment		
Once	18.0	31.7
2-5	67.9	53.0
6 or more	14.1	15.3
<b>Specialty care</b>		
Plan primary care physician failed to refer enrollee to a specialist when enrollee thought it was needed	9.5 <sup>c</sup>	6.0
Consequences of not being referred to specialist <sup>a</sup>		
None	24.1	57.3
Condition worsened	38.1	16.1
Recovery delayed/still do not feel well	17.7	8.9
Paid for care out of pocket	14.6	13.4
Decided to leave plan	2.8	3.9
Went to emergency room	2.8	0.0
Other	0.0	0.2
<b>Inpatient hospital care</b>		
Admitted to a hospital while in plan	25.7 <sup>d</sup>	16.7
Plan physician failed to admit enrollee to a hospital when enrollee thought it was needed <sup>b</sup>	3.4 <sup>c</sup>	1.3
Plan physician discharged enrollee from hospital before enrollee felt ready (among those hospitalized) <sup>b</sup>	10.0	5.8
<b>Home health care</b>		
Received home health care services while in plan	8.7	7.5
Felt more home health care was needed than plan provided (among those with any use)	39.8 <sup>d</sup>	15.7
Felt more home health care was needed from plan but did not receive any such care <sup>b</sup>	0.7	0.4
<b>Delays obtaining care</b>		
Experienced delays in obtaining care while waiting for plan approval	10.8 <sup>d</sup>	4.4
Consequences of delays		
None	28.4 <sup>e</sup>	44.7
Condition worsened	48.0	25.4
Recovery delayed/still do not feel well	15.4	12.6
Paid for care out of pocket	1.4	12.0
Other	6.8	5.2
<b>Medical records</b>		
Plan or plan physician lost or misplaced medical records, including test results <sup>b</sup>	5.0% <sup>c</sup>	1.8%
<b>Summary measure</b>		
Enrollees who reported any of the above access problems (other than trouble making appointments)	19.8 <sup>d</sup>	11.5

**SOURCE:** Mathematica Policy Research/Physician Payment Review Commission Survey of Medicare Risk Enrollees and Disenrollees, 1996.

**NOTE:** HMO is health maintenance organization.

<sup>a</sup> The sample sizes for this comparison are relatively small (n = 33 for disabled enrollees and n = 154 for elderly enrollees), and the chi-square test is not significant.

<sup>b</sup> Data on the consequences of this access problem are not presented because fewer than twenty disabled sample members reported the problem.

<sup>c</sup> Difference between disabled and elderly enrollees is statistically significant at the .05 level, two-tailed test.

<sup>d</sup> Difference between disabled and elderly enrollees is statistically significant at the .01 level, two-tailed test.

<sup>e</sup> Difference between disabled and elderly enrollees in their distribution across categories is statistically significant at the .05 level, chi-square test.

abled said that their plan's primary care physician did not refer them for specialty care they thought they needed, with disabled enrollees much more likely than elderly enrollees to report that this had adverse consequences. Although few reported problems with access to hospital services, three times as many disabled as elderly beneficiaries said that they were not admitted when they felt they needed to be, and twice as many felt that they were discharged too soon. Most disabled enrollees, like most elderly enrollees, received home health services if they felt they needed them. However, 40 percent of the disabled enrollees who received home health care felt that they needed more care than they got (more than twice as many as among the elderly). Disabled enrollees also were more likely to report experiencing delays while waiting for plan approval. Half (48 percent) said that their condition worsened as a result, compared with one-quarter of elderly enrollees. Seven percent of all disabled Medicare HMO enrollees in the study reported using the services of a medical specialist outside their plan in the past year, and 16 percent reported using any out-of-plan services.

The greater incidence of access problems reported by disabled Medicare HMO enrollees apparently cannot be explained simply by their greater need for services. We defined need as either those who received a service or thought they should have. Among the beneficiaries we defined as having a need for a specialty referral, the nonelderly disabled were twice as likely as beneficiaries ages sixty-five to eighty-four to report not receiving a referral they thought they needed (16.1 percent versus 8.4 percent). Among those we defined as having a need for home health care, the disabled were more than twice as likely as beneficiaries ages sixty-five to eighty-four to report not receiving the home health care they thought they needed (44.0 percent versus 18.1 percent), with 25.1 percent of those age eighty-five and older reporting not getting needed home health care. Among the oldest old (age eighty-five and older), 17.7 percent said that they were not admitted to the hospital when it was needed, compared with 9.3 percent of the nonelderly disabled and only 2.7 percent of the elderly ages sixty-five to eighty-four.

According to our analysis of data from the MCBS, disabled Medicare beneficiaries also are disproportionately likely to experience access problems in fee-for-service Medicare: 14 percent of disabled beneficiaries reported problems getting care in the past year, compared with 3 percent of elderly beneficiaries. Our analysis shows that disabled Medicare beneficiaries enrolled in HMOs are more likely than those in fee-for-service to experience access problems (21-25 percent versus 14 percent).<sup>19</sup> However, the gap in access problems between disabled and elderly Medicare beneficiaries in

HMOs is less than that in the fee-for-service system.

Medicare HMOs appear to be better than the fee-for-service system at providing preventive care: 51 percent of disabled Medicare beneficiaries in HMOs received a flu shot during the previous winter compared with 36 percent in fee-for-service Medicare. Disabled female Medicare beneficiaries in HMOs also were more likely than those in fee-for-service to have had a mammogram in the past year (65 percent versus 33 percent), although the spread may be accounted for at least partly by differences in age distribution.

## **Satisfaction With Care**

Generally, the disabled Medicare HMO enrollees are satisfied with the care they receive and have perceptions that are similar to those reported by elderly HMO enrollees (Exhibit 4). Forty-one percent of disabled Medicare HMO enrollees said that, overall, the health care covered by their plan is excellent; only 6 percent said that it is fair or poor. Medicare HMOs scored particularly well in terms of paperwork requirements. However, although the share of enrollees who rated features of their plan as fair or poor tended to be small (typically less than 10 percent and never more than 16 percent), disabled enrollees were somewhat more likely to hold this view than elderly enrollees were. This applies to measures of value for premium and out-of-pocket costs as well as to clinical features of care. For example, disabled beneficiaries were less satisfied than the elderly were with choice of physicians, ease of obtaining care, and quality of care. Yet 89 percent of disabled enrollees said that they would recommend their plan to a family member or friend. Although one of four disabled enrollees would not make such a recommendation to someone with a serious or chronic health problem, there is virtually no difference between disabled and elderly beneficiaries on this.

## **Conclusions And Policy Implications**

This study provides a first and relatively comprehensive look at how disabled Medicare beneficiaries fare in Medicare managed care. The results of our study can be interpreted in many ways. Our interpretation is that while most disabled Medicare HMO enrollees fare relatively well (that is, they do not report access problems and would recommend their plan), HMOs can do considerably better in serving this population. Disabled Medicare HMO enrollees are significantly more likely than nondisabled Medicare HMO enrollees to experience access problems, and more report fair or poor satisfaction with various aspects of care. The gap between the disabled and the elderly in the percentage experiencing access problems appears to be smaller in Medicare HMOs than in fee-for-service Medicare, but the available

**EXHIBIT 4**  
**Satisfaction With Care And Plan For Disabled And Elderly Medicare HMO Enrollees**

<b>Summary measures</b>	<b>Disabled</b>	<b>Elderly</b>
Overall health care covered by plan		
Excellent	41.1%	43.3%
Very good/good	52.6	52.8
Fair/poor	6.3	3.9
Overall value of care for the cost of copayments, deductibles, and other out-of-pocket expenses		
Excellent	45.2 <sup>a</sup>	50.3
Very good/good	43.6	44.3
Fair/poor	11.2	5.4
Amount of paperwork required		
Excellent	68.4	73.5
Very good/good	28.4	24.8
Fair/poor	3.2	1.8
Would recommend plan to family or friends	88.9 <sup>b</sup>	93.8
Would recommend plan to family or friends with a serious or chronic health problem	75.4	74.3
<b>Ease of obtaining care</b>		
Convenience of office location		
Excellent	47.2	48.0
Very good/good	46.1	48.6
Fair/poor	6.7	3.5
Availability of medical information by phone		
Excellent	36.0 <sup>a</sup>	35.6
Very good/good	50.0	57.4
Fair/poor	14.1	7.0
Waiting time between making appointment and visit		
Excellent	39.0 <sup>a</sup>	32.5
Very good/good	48.9	59.8
Fair/poor	12.1	7.7
<b>Quality of care</b>		
Amount of time with primary care physician during visit		
Excellent	40.5 <sup>a</sup>	35.4
Very good/good	48.9	58.2
Fair/poor	10.7	6.4
Thoroughness of exams		
Excellent	40.7 <sup>c</sup>	38.5
Very good/good	50.0	56.3
Fair/poor	9.8	5.2
<b>Choice of physicians</b>		
Ease of seeing primary care physician of enrollees' choice		
Excellent	43.1 <sup>a</sup>	44.6
Very good/good	47.8	51.2
Fair/poor	9.0	4.2
Choice of specialists available		
Excellent	45.0 <sup>a</sup>	44.7
Very good/good	42.1	48.8
Fair/poor	13.0	6.5

**SOURCE:** Mathematica Policy Research/Physician Payment Review Commission Survey of Medicare Risk Enrollees and Disenrollees, 1996.

**NOTE:** HMO is health maintenance organization.

<sup>a</sup> Difference between disabled and elderly enrollees in their distribution across categories is statistically significant at the .01 level, chi-square test.

<sup>b</sup> Difference between disabled and elderly enrollees is statistically significant at the .01 level, two-tailed test.

<sup>c</sup> Difference between disabled and elderly enrollees in their distribution across categories is statistically significant at the .05 level, chi-square test.

(though limited) data suggest that both groups may be more likely to experience access problems in HMOs than in fee-for-service. Some of the difference is undoubtedly attributable to differences in methods between the two surveys used in the comparison, but our sense is that the difference is large enough that it is unlikely to be fully explained by this.

While disenrollment rates for disabled Medicare HMO enrollees are higher than those for the elderly, few disenroll, and nine of ten would recommend their plan to a family member or friend. Financial barriers to obtaining care are a serious problem for disabled Medicare beneficiaries in fee-for-service; while Medicare HMOs do not remove all financial barriers, they lower them greatly. Disabled Medicare beneficiaries who join HMOs obviously value this. Whether Medicare HMOs will continue to provide these benefits if Congress takes action to reduce the current payments to HMOs (and hence the ability to offer zero premiums and fund supplemental services) is an open question.

This study has important policy implications. First, it illustrates the value and importance of having monitoring systems that provide estimates of access to care in managed care plans for vulnerable subgroups such as disabled Medicare beneficiaries. Because disenrollment rates are so low, they alone are unlikely to provide a complete measure of access. Second, this study highlights the need for health plans, providers, and policymakers to become more knowledgeable about the health care needs of disabled persons and the services involved in meeting these needs. Particular attention should be paid to access to home health care and specialists.

Finally, our work suggests the need for further policy development and research on how health care needs and spending vary within the disabled Medicare population as well as between these persons and other Medicare beneficiaries. Our findings illustrate the substantial heterogeneity of the disabled Medicare population, a fact that is not well recognized by many policymakers. There is a need to identify barriers that make enrollment in Medicare HMOs more difficult or less attractive for some disabled Medicare beneficiaries, such as those who are jointly eligible for Medicaid. In addition, it is not clear whether the variability in the disabled Medicare population is well captured by current rate-setting techniques, which adjust payments for the disabled by relatively simple demographic factors.<sup>20</sup> Further research on this point would be useful, assuming one policy goal is to provide incentives for Medicare HMOs to serve the Medicare disabled population and be rewarded for doing so.

---

*The views expressed in this DataWatch are those of the authors, and no endorsement by Mathematica Policy Research (MPR) or the Physician Payment Review Commission (PPRC) is intended or should be inferred. An earlier version of this paper was presented*

at the National Research Conference on Managed Care and Disability organized by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, 20–22 November 1996, in St. Michaels, Maryland. Funding for the survey on which this DataWatch is based was provided through a contract from the PPRC. The preparation of the paper was funded by MPR. The authors are grateful for the contributions of many staff at the institutions associated with the project on which this paper is based, including Karen CyBulski, Sara Yang, Meghan Bloome, Daryl Hall, Sharon Clark, Kathleen Donaldson, and many others at MPR; David Colby and Sally Trude at the PPRC; and Bill Marton and Andreas Frank at ASPE.

## NOTES

1. See M.H. Davis and E. O'Brien, "Profile of Persons with Disabilities in Medicare and Medicaid," *Health Care Financing Review* (Summer 1996): 179–211; and M.L. Rosenbach, "Access and Satisfaction with the Disabled Medicare Population," *Health Care Financing Review* (Winter 1995): 147–167.
2. See R.S. Brown et al., "Do Health Maintenance Organizations Work for Medicare?" *Health Care Financing Review* 15, no. 1, (1993): 7–24; and J. Ware et al., "Differences in Four-Year Health Outcomes for Elderly and Poor, Chronically-Ill Patients Treated in HMO and Fee-for-Service Systems," *Journal of the American Medical Association* 276, no. 13 (1996): 1039–1047.
3. HMO estimates calculated from the Group Health Plan (GHP) file obtained from the Health Care Financing Administration (HCFA) to reflect those enrolled in a risk HMO for at least two months between 1 March 1995 and 1 March 1996. Data for 1993 based on Davis and O'Brien, "Profile of Persons."
4. A more detailed description of the sample design and survey instrument is given in L. Nelson et al., *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, Selected External Research Series Number 7 (Washington: Physician Payment Review Commission, November 1996). See also L. Nelson et al., "Access to Care in Medicare HMOs, 1996," *Health Affairs* (March/April 1997): 148–156.
5. *Ibid.* We also oversampled plan switchers and those enrolled in plans with fewer than 100,000 Medicare enrollees. See Nelson et al., *Access to Care in Medicare Managed Care* for details.
6. These consultants included Lucy Fisher of the Group Health Foundation, Marshall McBean of the University of Minnesota, Sheldon Retchin of the Medical College of Virginia, and Shoshanna Sofaer of The George Washington University. For a description of the framework and its rationale, see E. Docteur, D. Colby, and M. Gold, "Shifting the Paradigm: Monitoring Access in Medicare Managed Care," *Health Care Financing Review* (Summer 1996): 5–21.
7. The GHP file used as the sample frame does not include telephone numbers. Hence, researchers must use a variety of external techniques for locating persons by telephone, including look-up services and mailed responses requesting a reply to an 800 number. There were no statistically significant differences between responders and nonresponders in age distribution, sex, or whether elderly beneficiaries had ever been entitled to Medicare because of a disability. Nonresponders were more likely than responders to be African American, institutionalized, and covered by Medicaid.
8. The under-age-sixty-five disabled population was only slightly more likely than beneficiaries ages sixty-five to eighty-four to need a proxy to respond for them (6.8 percent versus 5.3 percent). In general, beneficiaries who responded by proxy were more likely than other beneficiaries to be age eighty-five or

- older, covered by Medicaid, and institutionalized.
9. HCFA is now revising the MCBS to enlarge the HMO sample and address content issues that limit the comparability of responses between those in HMOs and those in fee-for-service.
  10. A.M. Pope and A.R. Tarlov, eds., *Disability in America: Towards a National Agenda for Prevention* (Washington: National Academy Press, 1991); Davis and O'Brien, "Profile of Persons with Disabilities;" and Rosenbach, "Access and Satisfaction."
  11. See *1994 Data Compendium* (Baltimore: Health Care Financing Administration, March 1994).
  12. Davis and O'Brien, "Profile of Persons with Disabilities." Once persons reach age sixty-five, they are included in the HCFA count of covered elderly. Six percent of the elderly in Medicare HMOs we surveyed were originally eligible for Medicare because of disability.
  13. Baseline data on demographic, insurance, health status, and access measures were collected in this first round of interviews. See Rosenbach, "Access and Satisfaction."
  14. Information on Medicaid buy-in status for those we surveyed was obtained from the GHP file. Thus, the survey does not fully measure those who are dually eligible for Medicaid. Nationally, about 20 percent of those who are dually eligible for Medicare and Medicaid are not buy-ins.
  15. Among the rest, respiratory conditions accounted for 5 percent of the sample, vision problems 4 percent of the sample, and digestive system problems and mental retardation 3 percent each. Of the remainder, 9 percent have a variety of conditions, and information is not available for 5 percent.
  16. These estimates are from the GHP file, which is a census of all risk enrollees. New enrollees were in a risk plan 1 March 1996 but not 1 March 1995 or at any other point during that year. Disenrollees to fee-for-service were not enrolled in a risk plan 1 March 1996 but were enrolled for at least two months during the previous twelve months. All others in our sample were either continuously enrolled in the same Medicare risk plan throughout the year or had switched from one to another.
  17. Because the disabled were more likely than the elderly to be new enrollees than continuing enrollees, we also computed an adjusted rate for the elderly that used weights based on the enrollment status mix of the disabled and found that it had no effect.
  18. M. Rosenbach and J. Huser, "Utilization, Access, and Satisfaction with Care among Noninstitutionalized Medicare Beneficiaries: A Baseline Analysis," in *Health Care Financing Administration: Third Annual Report to Congress on Monitoring Utilization and Access to Service for Medicare Beneficiaries under Physician Payment Reform* (Washington: HCFA, 1993).
  19. Again, because of differences in the design of the MCBS and the MPR/PPRC surveys, it is difficult to make HMO/fee-for-service comparisons. Our analysis of the HMO data collected in the MPR/PPRC survey involves measures computed from a series of questions about specific access problems and thus is likely to yield more reported problems than the single global fee-for-service item used in the MCBS.
  20. The current Medicare capitation rate-setting system adjusts payments for risk-based HMOs to account for differences in the age, sex, Medicaid, and institutional status of disabled beneficiaries. Among those not institutionalized, rates are considerably lower for those not enrolled in Medicaid and increase about twofold between the youngest age group (under age thirty-five) and the oldest age group (ages sixty to sixty-four) for the disabled. They then drop sharply for elderly beneficiaries ages sixty-five to sixty-nine and increase at a slower rate from there. (Rates for disabled persons who are institutionalized decrease with age.)