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Managed Care and the Impact on Senior Adults

Melissa Breville

MANAGED CARE AND THE IMPACT

ON SENIOR ADULTS

Melissa Breville, B.A.

A Culminating Project Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirement for the Degree of Master of Art

1996

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DEDICATON

A special thanks to my
husband Bob and my children
Vanessa and Sarah for
their help, understanding and support
during my course of study

and
A special thanks to my
dad and mom for their love, persistence
and belief that I could accomplish my goals in life.

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ABSTRACT

Managed care companies are advocating changes in the health care market and demanding changes in the delivery of health care services to the elderly. The managed care companies are focusing on wellness and prevention of illness for senior adults. Seniors are focusing on wellness and prevention by changing lifestyles as they gain knowledge about health care.

The managed care industry and elderly population are viewing health care as a basic right not a luxury. The collaboration of the elderly and managed care companies can yield results in improved health care access and delivery.

Because seniors have criticized health care organizations as providers of inadequate care, managed care companies are reviewing previous practices and failures in an attempt to deliver quality services at an affordable price. This paper will provide an overview of Medicare, Medicaid, Private Health Insurance, and Managed Care.

The purpose of the thesis is to explore the knowledge and attitudes of seniors toward managed care and the current system of health care. Attitudes and concerns about health care are evident in the survey results. The benefits of using a managed care plan will surpass the current health care payment system. Elderly adults have more benefit options at a lower cost with managed care companies.

Managed care has the right philosophy about health care, but they must be willing to listen to elderly consumers, physicians, and providers. They must also evaluate previous health care program's failures and successes. All of these components will be necessary to ensure quality and accessible health care for seniors.

CHAPTER I
INTRODUCTION

As the senior population ages, the health care needs of this group has increased. Significant health care changes cost a great deal. Most seniors are facing dilemmas in health care. Some of the dilemmas include: 1) quality of care, 2) cost of care, 3) access to care, and 4) limited benefits. Seniors are forced to settle for inadequate and reduced health care benefits.

Elderly Americans are trying to find solutions to the rising health care costs, and the solutions must guarantee quality and access to care. Current health care insurers are decreasing services but increasing cost. Medicare and Medicaid are rationing health care to the senior population, and private health insurance carriers are searching for ways to limit the amount of risk needed to insure the senior population.

Managed care plans, whether public or private, are attempting to provide cost effective health care to seniors. Some of the health care plans available to seniors are as inadequate as Medicare and Medicaid, but some new health care plans show more strength in the area of managed care. Other managed care plans are attempting to offer additional benefits not found in the traditional health care plans. Managed care is focused on the prevention and wellness of their members, so seniors are being forced to examine their current lifestyles, inherent eating habits and current health status.

The senior population growth spawns a need for increased levels of health care. The shift from acute illness to chronic illness overwhelms the health care community and health care insurers. Seniors who live longer pose serious problems to the current system for health care.

The managed care umbrella is attempting to bridge the gap in health care. Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) are the newest forms of managed care. Both plans offer benefits and limitations to beneficiaries. Controversy surrounds some of the plan options because of limited physician choice, geographic restrictions and quality. Diagnostic testing is also the subject of controversy. Most seniors fear the restrictions and quality of care, so enrollment is slow in the managed care plans.

Managed care plans in the St. Louis area have a unique opportunity to market services to seniors. Quality and choice are issues that need to be addressed when marketing services to seniors. Marketing professionals should understand and respect seniors' apprehension to managed care plans.

The purpose of this research is to understand the attitudes toward managed care. This research should also indicate some of the reasons that seniors may feel an apprehension toward managed care. Increasing enrollment in managed care plans is only possible through understanding and research. Education is imperative when seniors are selecting a managed care plan.

Education of the senior population will increase security about managed care plans. Several forms of education are necessary including group education, individual education, and enrollment education. According to Robert Enteen,

author of the book, Health Insurance, it is advisable to compile a checklist when seeking a managed care plan to meet the needs of the elderly. A sample checklist can be found in Appendix D.

One problem with existing programs is the ability to access services and coverage, so managed care organizations must assist seniors with program selection and enrollment processes. Paperwork that is difficult to understand prevents many seniors from accessing or participating in programs that enhances their overall health and wellness. Managed care companies that decrease paperwork and ease the enrollment process will enable more seniors to use their products. Success of managed care programs is possible with the help of education and research.

CHAPTER 2

LITERATURE REVIEW

Demographics

There is a great deal of concern over the widening gap between senior adults needing health care and the ability to pay for health care. The growing group of seniors is straining the current system and the resources available. The promised advances in technology, biomedical research and health related behavior changes will not guarantee adequate health care (Davis 306).

The population over the age of sixty-five accounted for only four percent of the total population in 1904, but this population will double by the year 2050. Adults living into their eighties and nineties will also increase in proportion. It is believed that the double growth in the population will double the need for health care services (Annis 198).

A dramatic change in demographics will take place in the next thirty years. The largest change will be in the elderly population, but many experts write that the surge of older adults will cause problems for all generations. It is estimated that the elderly population will exceed 59 million people, which is a nineteen percent increase from 1980. Research also indicates that the number of older women will triple over the next fifty years. Strong evidence indicates that the number of people living alone and needing home health care will increase substantially (Davis 306).

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The number of elderly adults needing health care in their homes will increase from 1.9 million to 2.7 million by the year 2000. Davis also predicts there will be a growth in the number of older adults suffering from chronic illness, which will cause strain on the existing system. The sharp increase will necessitate the increase in spending on long term care for older adults (Davis 307).

Health Care Expenditures

The growth in the population will escalate the expenditures necessary to accommodate elderly adult needs. Total expected health care needs will increase from 50 billion to 200 billion by the year 2000. Though a large portion of the health care expenditures will be supplemented by federal, state and local governments, expected growth will make it difficult to find the funding necessary to sustain adequate health care for the elderly (Davis 308).

The elderly consume a majority of health care in the United States, spending about 42.5 billion dollars on health care or thirty-seven percent of their available income. This amount reflects the enormous needs of the aging population. The older adult spends an average of $2,000 more per year in health care than someone under the age of sixty-five (Pifer and Bronte 301).

Elderly adults are more likely to need health care because of chronic illness. Health care expenditures will rise, so the elderly must have income or insurance that will meet the need not covered by traditional health insurance. If the older adult's income does not increase with the rate of health care inflation, they may be faced with accepting inadequate or no care (White 134).

Efforts to curtail the cost of health care is evident through increased utilization review, which is performed by hospitals and insurance companies. Utilization review departments, which have the task of reducing hospital days and cost without compromising quality of health care, use a Diagnosis Related Group method to determine the number of days a person should stay in the hospital. The days an elderly person is in the hospital has decreased in a ten year period. The average length of stay was 11.2 days per year in 1975 and today is only 3.1 days (Solomon 178).

Health care expenditures will continue to rise over the next several years. The past expenditure pattern should be an indication of the future increases in health care cost. Estimated health care expenditures may exceed seventeen percent of the senior adult income within the next few years, an increase which would devastate the older adult population (Bender 143).

Health care costs skyrocketed between 1975 and 1990. Expenditures of $133 billion in 1975 was relatively low compared to the $675 billion by the end of 1990. This change represents a thirty percent increase in health care costs in a fifteen year period (Ginzberg 52).

Health Care Needs

A shift within the elderly population has forced the rise in health care cost. Acute illnesses have diminished and chronic illnesses have risen. Chronic illness requires intermittent treatments on a regular basis. Many years ago, acute episodes were common and required treatment one time and for a short duration (Vierck 36).

Elderly adults are expected to experience health problems that limit normal daily activity. Chronic conditions that limits activities include : 1)arthritis, 2)rheumatism, and 3) heart conditions. These chronic conditions limit over fifty percent of the elderly population (Pifer and Bronte 97).

Heart disease is the leading cause of death in older adults. Some adults never experience pain or symptoms with cardiovascular disease, which strikes about seventy percent of the elderly population by the age of ninety. High blood pressure thought to be a factor in heart disease, coupled with an unhealthy lifestyle cause serious problems for seniors (Solomon 81).

Strokes in an older adult caused by a restricted blood flow in the brain, cause paralysis and loss of speaking capabilities. Stroke victims experience difficulty in swallowing, which can lead to pneumonia. Urinary incontinence is a side affect of the stroke. Strokes can bring on heart attacks and eventual death if not treated properly (Solomon 82).

Cancer is become prevalent in aging Americans. Breast cancer is found in women but can also be found in men. Lung cancer claims over one-half of all elderly persons' lives. Most older adults are treated with chemotherapy or radiation to eradicate the cancer. The survival rate depends on the spread of the disease (Solomon 85).

Prostate cancer is prevalent in men over the age of sixty. The survival rate of prostate cancer is good if detected early. Colon cancer is the most devastating cancer because it is most likely to spread throughout the body (Solomon 85).

Arthritis is a condition that affects the elderly and is most common over the age of sixty-five. The arthritic patient is treated with medication which may cause serious side effects. Surgery to correct arthritis pain and deformities has been helpful in recent years, but the medication to treat this condition is very costly to the elderly (Solomon 86).

Diabetes Mellitus increases significantly with age because blood sugar regulation is damaged. Diabetes also damages eyes, kidneys, circulation and nervous system impairments. Some older adults have lost extremities to diabetes. Most patients diagnosed with diabetes will be treated with insulin medications (Solomon 90).

Hip fractures, bone loss, and osteoporosis are problems experienced by older adults . Falls, which contribute to a number of fractures and broken bones, is believed to the leading cause of death in the elderly because of complications. A fall may occur because of an underlying problem such as Parkinson's disease and disability from previous heart, neurological and respiratory infections. Falls result in limited mobility and often times surgery (Solomon 92).

Alzheimer's disease, memory loss, dementia, and delirium are mental diseases that affect the aging population. Approximately five percent of elderly adults suffer from some form of dementia, and the numbers increase with age. Persons over the age of eighty -five years of age have a fifteen to forty percent chance of suffering from some type of dementia (Solomon 92).

Sensory losses are part of the normal aging process, but some sensory losses can be related to delayed treatment and diagnosis. Hearing loss is the most prevalent among older adults. Twenty-eight percent of people over the age of sixty-five and forty-eight percent over the age of eighty-five report substantial hearing loss. Vision problems occur in the form of glaucoma and cataracts. Statistics do not indicate how many incidents of vision loss are attributed to inadequate health care or diagnosis, but physicians recommend yearly screenings for persons over the age of sixty five to prevent further losses (Solomon 96).

Physician Health Care Delivery

Traditional health care delivery is by physicians, surgeons, specialists, inpatient facilities and various other professionals. The majority of health care services were delivered in the acute care setting. Strict guidelines, cost conscious administrators and advocates for health care forced the reduction of traditional health care costs and delivery systems (Ginzberg 103).

A decline in the number of physicians will be noticed by the year 2010. Most physicians will join managed care organizations. Focus will shift from the physician to alternative methods of treatment, and physicians will be encouraged and receive incentives to practice general medicine with certification in specialized medicine. The number of physicians specializing in the needs of the older adult will increase with the needs of the aging population (Wolfe 65).

Physicians determined seventy-five percent of all health care cost in 1990. A physician determines patient base, cost of service, surgeries, types of instruments used, follow up care and reimbursement structure, which allows the physician to operate in a manner that is not cost effective or efficient (Ginzberg 70).

The physician is the force behind hospitalizations, surgeries and high cost treatments. Physicians operate in a free society that allows them to charge and provide services at a cost they deem appropriate. Managed care companies are changing that philosophy by regulating the cost. Physicians have invested in outside medical services to guarantee income for the future. In the State of Florida, forty percent of all physicians have a financial interest in outpatient surgery and ambulatory care centers. All physicians realize their competition for patients is being regulated by outside sources (Annis 206).

The old delivery system of health care encouraged the physician to over utilize services, which provided higher incomes. Several review boards were established to regulate the physicians, but the review boards became obsolete because physicians were able to deliver more paperwork. As a result, quality was a concern. The patient became a secondary concern, and paperwork became the primary concern (Annis 206).

Modern health care reimbursements are ripe with fraud. Medicare is the leader in fraudulent claims, and physicians are the leading cause of the fraud. Physicians would provide claims for services that were not delivered or for inadequate care. When claims were questioned, physicians were able to deliver the required amount of paperwork allowing reimbursement for services not provided or inadequately provided (Annis 20).

Traditional Health Care Reimbursement

Medicare

The past payment system for health care cost includes Medicare, Medicaid, private insurance and private funds. Medicare is the largest payer of services for persons over the age of sixty-five. Several years ago, Medicare benefits were created to supplement the cost of health care needs. The Medicare Part A benefit is responsible for paying approved hospital charges for adults over the age of sixty-five (Ginzberg 53).

Medicare Part B was activated about seven years after Medicare Part A. The Medicare Part B plan was established to help reimburse physicians for their cost not paid by the patient. Medicare Part A is funded by payroll tax deductions, and Medicare Part B is funded by premiums deducted from monthly social security checks and government funds (Ginzberg 53).

The Medicare program was created as a result of lost benefits by retiring workers. The early years of Medicare required all individuals to participate in a means test to determine eligibility. Means testing was based on an individual's financial status. Elderly adults saw the means test as a poor reflection on their financial stability. Many aging Americans did not apply for the benefits, so in 1965, Lyndon B. Johnson pushed for legislation that would guarantee access to health care without means testing (Ginzberg 54).

Medicare is funded by a payroll deduction. The growth in the older adult population is soaring, and the number of young Americans is stagnant. The result of this unequal shift will cause inadequate care for the elderly through the payroll deduction system. A quarter of the nation's payroll tax will fund Medicare in the year 2000. Fifty percent of the payroll tax will be needed to fund Medicare in the year 2030. The payroll tax will need to increase to seventy percent by the year 2060 (Annis 199).

It is not unreasonable to believe that most young Americans will not voluntarily fund this system. If there is not substantial education about Medicare, it is possible that the lack of knowledge could cause an intergenerational war. Entitlement programs, regardless of their longevity, could suffer severe economic setbacks (Annis 199).

Seniors know about Medicare because of media coverage and longevity of the program. The fact is that one in five senior Americans claim they know a great deal about Medicare while three quarters claim they know little or nothing about Medicare. Some elderly Americans believe Medicare is the answer to their health care problems. Education of the aging population will be necessary (Solomon 157).

The elderly are eligible for Medicare at the age of sixty-five. Some senior citizens automatically qualify for the benefit, while others must apply for the benefit. Persons that have not worked enough quarters to be eligible for Medicare must pay for the Medicare benefit. Solomon recommends that people over the age of sixty-five apply for Medicare benefits three months prior to their sixty-fifth birthday (Solomon 157).

Participating providers in the Medicare program are reimbursed at eighty percent of the Medicare approved charges. The enrollee is responsible for twenty percent of the charges. This rule only applies if the physician accepts Medicare as payment in full. If a physician does not accept Medicare payment in full and the charges exceed the allowable by fifteen percent, the patient is responsible. Selecting a physician and provider that accepts Medicare payment in full ensures little out of pocket expense. Forty percent of all physicians accept Medicare payment in full for services rendered (Solomon 161).

Medicare charges high deductibles and co-insurance amounts to fund the program. Many seniors will be paying a deductible of $716.00 per benefit period. The benefit period may begin several times per year if the patient suffers from different episodes of illness (Enteen 204).

Medicare also uses reserve days. The reserve days are primarily to be used when the senior is hospitalized for more than sixty days in a benefit period. A person is responsible for a $358.00 co-insurance amount. When a reserve day is used, it can never be regained. The sixty reserve days must last a lifetime on Medicare (Ginzberg 58).

Medicare provides services to seniors, but the cost can be astronomical if reserve days are used and the patient uses several benefit periods. Most seniors find they do not have adequate funds to pay for medical services. Some seniors apply for a Medicaid program or supplemental coverage (Solomon 118).

Medicaid

The American Medical Association (AMA) rejected the Medicare proposal for health care because it lumped everyone into a category based on age rather than the ability to afford services. American Medical Association members supported the Kerr-Mill legislation that became the Medicaid program. Members believed that Medicaid would help people who were unable to afford expensive health care treatments (Annis 102).

President Eisenhower supported and signed the Kerr-Mill legislation, which provided matching funds to states for state administered programs that helped the elderly and poor afford health care services. Some states received a matching fund on a fifty-fifty basis while other states received eighty-five percent federal funding and fifteen percent state funding. The amount of federal funding depended on the financial stability of the state (Annis 50).

Medicaid is confused with Medicare, but Medicaid provided some distinct differences from the Medicare program. The Medicaid health insurance plan is administered by the state and is designed to serve a specific income level. Medicaid covers extended stays in a skilled nursing facility. Medicaid is considered charity, but Medicaid is the only program that is federally and state funded and will assist with the total health care needs of the elderly (Solomon 162-163).

Medicaid programs vary from state to state with each state determining their eligibility guidelines. Reimbursement to providers of Medicaid services may also find payment structures different in each state and changing from year to year. The Medicaid program is complex, which results in low utilization of services (Solomon 162-163).

The Medicaid program has problems. Elderly people must be destitute before they can become eligible for benefits. Seniors do not want to work all their lives to be classified as destitute when they are older. Older adults may lose homes and assets by using the Medicaid program (Merrill 119).

Medicaid provides five basic medical services. The services may include hospital inpatient and outpatient care, physician services, laboratory, X-ray and skilled nursing care. There are fourteen discretionary services that are also available through Medicaid (Ginzberg 53).

Medicaid spends about a third of its funds on the elderly. State Medicaid programs discourage involvement by forcing the older adult to fill out complicated paperwork. A program that is confusing and complicated reduces access to services. Physician involvement is a problem in the Medicaid program and sometimes forces physicians to practice in neighborhoods with higher income ratios. Medicaid reimburses physicians and providers at low rates and does not provide incentives for physicians and providers to participate in the program, so it excludes many choices for patients (Solomon 88).

Private Insurance

The birth of private health insurance took place during the depression. Prior to the depression, people believed they could save enough money to pay for health care cost. When the depression hit, health care costs wiped out people's savings. Combating this problem is only possible by creating a health insurance plan. The first private health insurance plan created was Blue Cross (Merrill 16).

A detailed description of the insurance industry development can be found in Appendix B. The most significant growth in the insurance industry was when Ford Kimball purchased health insurance for a group of teachers at Baylor University. Baylor University agreed to provide care for employees if they paid a fixed amount. Kimball was asked to present his ideas on health care at a national convention of the American Medical Association, which is thought to have launched the first significant gain in private health insurance enrollment (Atchley 146).

Hospital payments decreased by thirty percent during the depression, and hospitals experienced huge operating deficits. Baylor University developed a plan to charge fifty cents a month in return for a certain number of hospital days per employee. The creation of private insurance guaranteed that hospitals would receive payment for services rendered (Merrill 17).

A hospital was guaranteed payment but not access to patients. Health insurance plans were created to protect the provider, and not the patient. The idea of guaranteeing payment grew quickly in the United States (Merrill 18).

Blue Cross was the leader in hospital funding. Approximately twenty-seven of the thirty-nine plans were owned by Blue Cross and hospital providers. Hospital board members dominated the Blue Cross Board of Directors.

This ensured continued support of both entities. The structure prevented cost controlling and growth (Merrill 18).

With health insurance companies and hospital providers setting the cost and controlling the growth, it was commonplace for the elderly to receive denial of health care coverage. Private health insurance plans are confusing to many including the elderly. Plans are multiplying by the hundreds, with some offering comprehensive benefits and others providing limited services. A private health insurance plan is based on a fee-for-service, which allows seniors to choose their own physicians and place of service. The traditional fee-for-service plan allowed seniors to maintain a relationship with certain physician. Plans allowed physician choice, but cost was attached to that choice (Boland 168).

Costs associated with these plans include high deductibles and co-payments. Senior adults can be responsible for about twenty-five percent of the total bill. Private plans do not cover routine physical exams and preventative services. Many of the advanced treatments for disease are considered experimental and are not covered (Boland 169).

Managed Care

Private health care coverage has changed. Managed care is a private health insurance that delivers care in a different way. Several plans fall under the managed care umbrella. Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO) are the newest managed care providers. The differences in the organizations are apparent. The concept of gatekeeping is

noticeable in both organizations but varies according to the particular managed care plan. Preferred Provider Organizations exist mainly in the workplace. Health Maintenance Organizations recognized the need for health insurance benefits and are offering health care services to the general public (Churchill 81).

Gatekeeping is a term used to monitor the patient and sometimes the physician. The physician is responsible for making sure the patient is properly taken care of. As gatekeeper, the physician is responsible for maintaining costs while providing quality services. There is a great deal of concern over the ability of a physician to be a gatekeeper in something that will produce income for himself or herself (Churchill 83).

A Preferred Provider Organization is a fee-for-service plan with a group of providers. The providers have contracted with the insurance company to provide services at a discounted rate. Using preferred providers guarantees low co-payment and deductibles. The cost for the plan will depend on the employer, but seniors will pay the same price regardless of health status if other employees are paying a specified rate (Raymond 169).

Preferred Provider Organizations are provider driven. This model responded to the market several years ago. The new market pressure demands a consumer driven model. Current Preferred Provider Organizations are designed to increase the market share of health care entities while providing quality service. Physicians and providers find this concept lucrative since it increases their market share in exchange for discounting fees (Boland 9)

A Preferred Provider Organization provides regional and local care. Groups forming the preferred network are capturing a large part of the health care market. Capturing the employer market doe not help elderly consumers unless they are currently employed. The Preferred Provider Organization is an alternative to traditional health care, but it does not provide the necessary services to the elderly (Inlander 186).

A Preferred Provider Organization can and does limit services based on pre-existing conditions. Enrollees who do not enroll during open enrollment periods are subject to physicals and diagnostic testing. Review of records and medical histories are done if a patient exhibits symptoms that are related to certain diseases. Elderly adults complaining of heart problems will go through extensive review before the services are paid. If the Preferred Provider Organization finds that symptoms may have occurred prior to the actual episodes, coverage will be denied (Boland 188).

Denied services for the elderly are devastating. Some seniors do not have adequate resources to pay for services. Older adults may also be using physicians who are not familiar with their history; therefore, the care and results are diminished. Elderly patients are also finding that physicians are limiting the number of new patients accepted for care. The combined problems suggest that an older adult does not benefit from a Preferred Provider Organization (Biracree 89). Preferred Provider Organizations are part of the managed care team, but they will not be able to provide adequate health care services for the elderly, since most are employer sponsored and most seniors have left the work force (Biracree 90).

Health Maintenance Organizations

Health Maintenance Organizations are the fastest growing segment of the managed care market. This managed care group is composed of hospitals, doctors, and other medical personnel who serve an enrolled group. The enrolled group pays a fixed fee in return for health care services (Solomon 110).

Health maintenance organization allows providers to bid for the right to provide services, which enables the health maintenance organization to provide more physician choice. Competitive bidding of physicians also allows health maintenance organizations to screen and select physicians that meet managed care company criteria (Raymond 2).

A health maintenance organization is set apart from other health care plans because of the focus on prevention and primary care. Physicians benefit from keeping their patients well. A physician is prepaid for services provided. The physician is paid an annual salary and must budget services within that payment structure (Raymond 3).

Health Maintenance Organizations provide services in a specific geographic region. A member must access services within the geographic area to receive maximum payment of services. Members are allowed to access services outside their geographic area if it is considered life threatening. The person not suffering from a life threatening situation will be forced to pay large amounts for emergency health care services. Some seniors do not realize that if they wish to seek

emergency treatment, they must first contact their primary physician for approval. limiting the geographic area and primary physician approval are two ways managed care organizations provide better communications (Raymond 16)

There are several different types of health maintenance organizations. Staff models are owned by health centers and clinics. All employees are salaried and paid by the health maintenance organization. Services are provided under one roof, which provides convenience and accessibility for the patient. Seniors may find that waiting for appointments under this model could take several days to several weeks (Boland 9).

Group models are one or more physicians practices not owned by a health maintenance organization. The models are independent partnerships and professional organizations. Primary physicians are available only in the office and referrals must be made to specialists outside the office. A limited number of physicians and some inconveniences plague this group, but most patients report overall satisfaction (Boland 9).

The staff model and group model provides better communications and coordination of benefits. Patients report being satisfied with the quality and services. Most models are in the group category, but group and staff model managed care organizations are growing at a tremendous rate. Seniors will also find that some physicians work with several managed care companies (Boland 9).

Health maintenance organization plans allowed Medicare enrollees to receive benefits. The group also provided extended benefits not found under Medicare guidelines. Most plans provided comprehensive coverage, prescription drug benefit and small office co-payments to enrollees (Raymond 87).

Caution should be exercised when a Medicare patient selects a health maintenance organization. Medicare members found they were locked into a specific benefit plan. Seniors who traveled found the programs to be of little help in meeting their health care needs, because traveling reduced or eliminated benefits because they were considered out of network. Services delivered out of network required higher out of pocket expenses (Boland 34).

According to Boland, enrollees must know their health care needs. Selecting an insurance plan is only possible when seniors understand the components and restrictions of the plan. It is recommended that potential members develop a questionnaire to answer their questions about the delivery of services (369).

Quality of care is determined by each member and industry surveys. Most health maintenance organizations are viewing quality as a primary concern of their enrollees. Providing excellent and comprehensive care is the only way enrollment was increased in health maintenance organizations. Many seniors who find quality in question return to Medicare Part B for additional coverage (Boland 369).

Health maintenance organizations began focusing on senior health a few years ago. Health care professionals recognized the expected surge in the

population. The majority of the health maintenance organizations also realized that preventing the onset of certain illnesses may be the only way to reduce the number of seniors suffering from chronic illness (Raymond 195).

Senior adult physicians recommended that aging adults pay close attention to their healthy habits and the importance of routine check ups. It is important that seniors are comfortable with their physician. Seniors find themselves seeking the advice of physicians more frequently when they begin to age. Health maintenance organizations realized that many seniors would switch physicians before finding the physician that could meet their health care needs, so health maintenance organizations allow members to switch physicians up to four times per year (Raymond 169).

Physicians believe that providing comprehensive, quality and appropriate medical care is essential in maintaining quality of life. Primary care physicians have a responsibility to patients to make them feel comfortable and cared for. The physician network believes that a variety of specialists are necessary to provide a continuum of care (Pifer and Bronte 69).

Experts agree that health maintenance organizations are capable of meeting the needs of the elderly. Most believe that programs tailored to seniors would allow the elderly population the opportunity to build a relationship with health maintenance organizations and providers of care. Health maintenance organizations are the closest attempt to deliver quality and comprehensive services to the elderly (Solomon 240).

CHAPTER 3

METHOD AND PROCEDURE

Managed care is a growing industry in health care. Many senior programs are being developed to supplement the gaps in Medicare and Medicaid. The purpose of the managed care survey was to gather information from the senior adult population to determine their knowledge and attitudes toward managed care (See Appendix C). Many billing managers in the field of health care believe that older adults do not want managed care as their health care insurance, but most were in agreement, that seniors do not understand managed care.

The survey participants were selected after meeting one initial requirement, that a participant be over the age of fifty. No other survey criterion was necessary to complete the survey.

A nineteen question survey was developed. Sixteen of the questions required yes and no answers, and three questions were ranked according to preference of the participants. One question was discarded because participants did not understand the question and believed it required more than a yes or no answer.

Thirty-eight people participated in the survey. All participants were guaranteed confidentiality. Participants were also told that the survey would not be used to encourage or discourage their participation in a managed care plan. Participants were selected at random from a home health agency in the St. Louis area. All participants were currently receiving some type of home health services.

Participants scheduled appointments at their convenience, and the survey

was conducted in their home. Several demographics were compiled during the survey: 1) age, 2) marital status, 3) race, 4) diagnosis, 5) income, and 6) managed care affiliations. If a participant indicated they were affiliated with a managed care plan, the participant was asked which managed care plan he or she was currently enrolled in. All demographic charts compiled during the survey process can be found in the survey results section.

Appendix D was created after the initial survey. The reason it was created was to enable seniors to ask the correct questions about managed care. This checklist is very easy to understand and should be asked in the presence of the managed care representative. The checklist is also a tool to evaluate the suitability or effectiveness of the insurance plan. Comparison of checklists and benefit listings should be done prior to selecting a health maintenance organization.

CHAPTER 4

SURVEY RESULTS

Table I

The average age of participants was 72.0 years with the majority of participants in the 70-75 age category. The next largest group was 80-85 years old. Research indicates that this will be the largest growing group of elderly in the year 2000 and beyond.

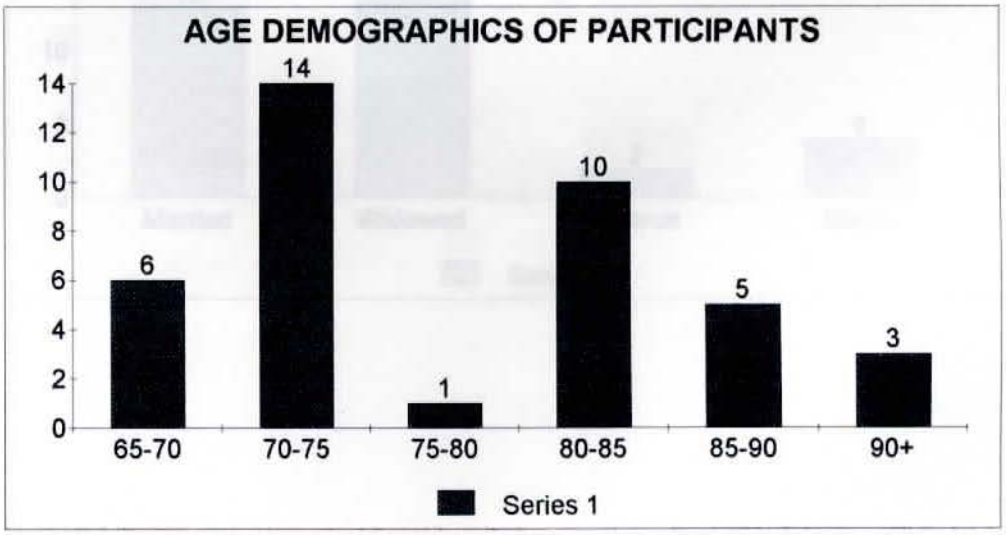


Table II

The marital status of participants demonstrated a growing trend of people living alone because of death. Thirteen participants reported being married, which is equal to 34 percent. Widow or widower individuals comprised the largest portion of the survey group. Nineteen participants reported widow or widowed status, which is equivalent to 50 percent of the survey group. Older adults reporting divorce numbered 2, equaling 5 percent. Four participants reported being single or never married; therefore, 10 percent of the survey group accounts for the single category.

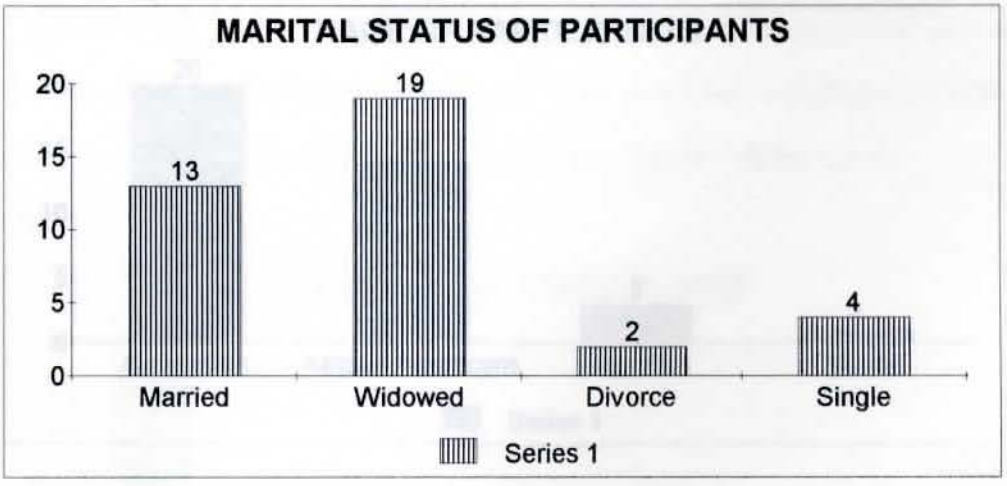


Table III

This table gave demographic information according to race, a significant factor in this survey. Twenty participants were Caucasian, which is equal to 53 percent. African Americans were the second largest category with fourteen participants, equaling 37 percent. Hispanic and Oriental participants totaled four, which was equivalent to 10 percent of the survey group.

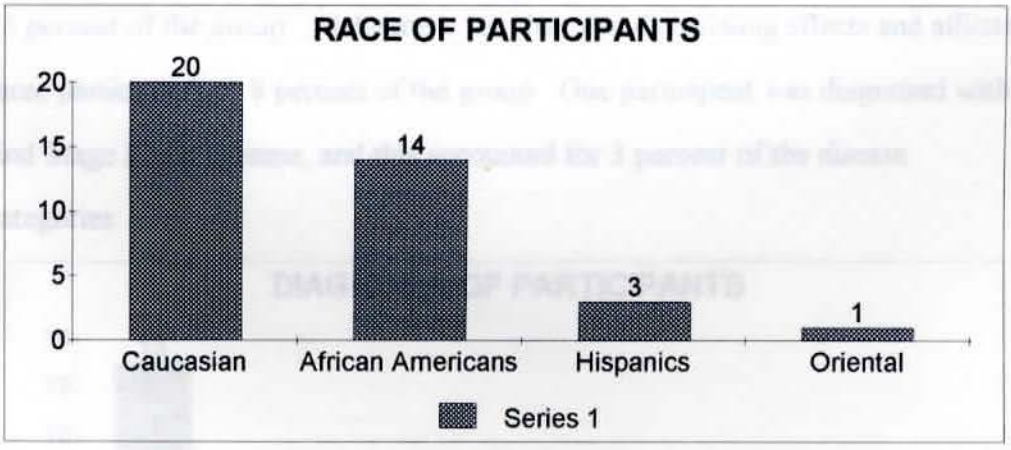


Table IV

Table IV depicts the various diseases suffered by the survey population. All participants indicated a primary diagnosis with many secondary diagnoses.

The most prevalent secondary diagnosis was Diabetes Mellitus. Vision and hearing impairments followed. Some of the vision impairments were directly related to diabetes.

Participants reported seven different categories of disease. The leading category for disease was cardiovascular disease. Heart disease affected thirteen participants or 34 percent of the survey group. Diabetes Mellitus was the next category of disease, which accounted for eight participants or 21 percent of the group. Arthritis and Osteoporosis affected seven participants, equaling 18 percent of the survey group. Joint disease or joint surgery was found in five participants or 13 percent of the group. Alzheimer's has the most devastating effects and afflicted three participants or 8 percent of the group. One participant was diagnosed with End Stage Renal Disease, and this accounted for 3 percent of the disease categories.

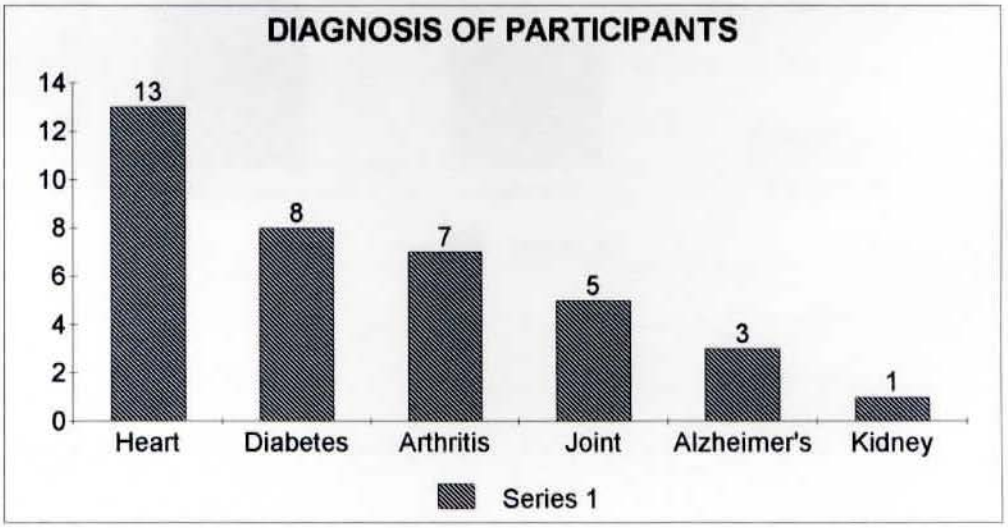


Table V

Table V indicates that the major portion of income ranges from $10,000 to $15,000 per year. African Americans and Caucasians fall mainly in the middle income bracket with African Americans being at the lower end of the scale and Caucasians being at the middle to higher end of the scale.

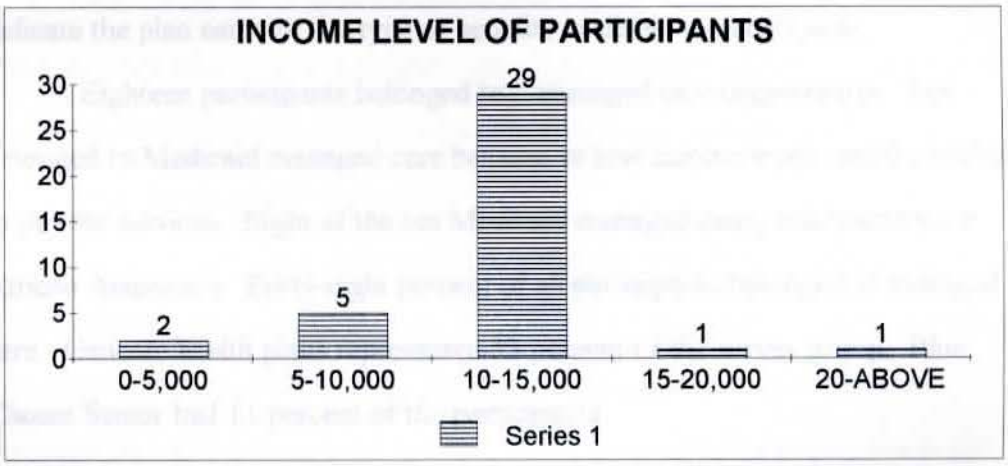
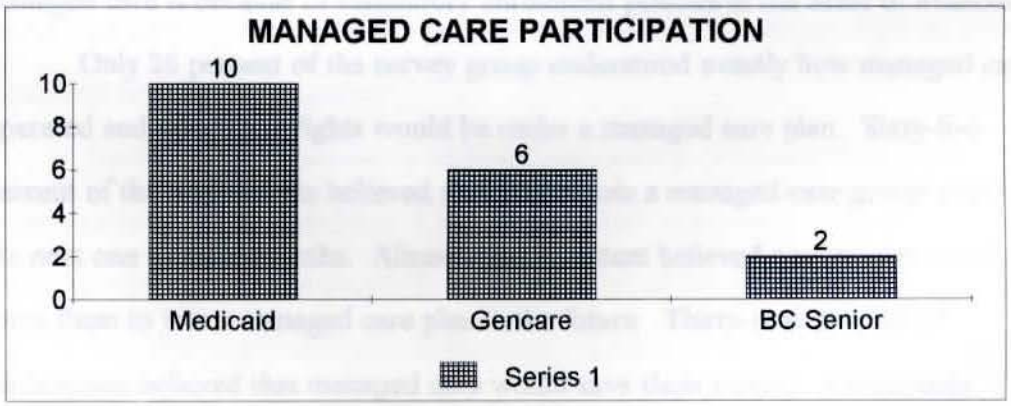


Table VI

The large number of participants in the Medicaid managed care plans is a reflection of the current efforts to enroll Medicaid patients in a new Missouri Medicaid managed care plan. Enrollment in the managed care plan does not indicate the plan name or the type of benefits available to participants.

Eighteen participants belonged to a managed care organization. Ten belonged to Medicaid managed care because of low income levels and the inability to pay for services. Eight of the ten Medicaid managed care participants were African Americans. Forty-eight percent of all participants belonged to managed care. Gencare health plans represented 33 percent of the survey group. Blue Choice Senior had 11 percent of the participants.



Survey Results

The managed care survey yielded interesting results. Respondents to the survey indicated they know a great deal about managed care. Provided in this section is a brief discussion about the survey. This is in no way a reflection of the entire elderly population since only a small sampling was obtained.

Americans know little about Medicare while 82 percent of the participants indicated they knew about managed care. The reasons cited for knowing a great deal about managed care was because of publicity and younger family members are participants in a managed care group.

Younger relatives participating in managed care plans are educating some seniors about similar managed care plans. Forty-seven percent of those surveyed belonged to a managed care plan. Medicaid managed care was the largest managed care group among the elderly. The reason for belonging to Medicaid managed care is because of mandatory enrollment policies in the State of Missouri.

Only 26 percent of the survey group understood exactly how managed care operated and what their rights would be under a managed care plan. Sixty-five percent of the respondents believed they would join a managed care group within the next one to three months. Almost ninety percent believed government would force them to join a managed care plan in the future. Thirty-nine percent of participants believed that managed care would save them money. Participants believe that managed care groups would begin limiting care after they realized the cost associated with care. An amazing seventy-six percent believed that HMO and PPO organizations withheld critical care.

Choice, quality and the option for specialized care were significant areas of concern for the elderly. Sixty-seven percent of the respondents had a negative reaction to questions about quality, choice and specialty care. The participants indicated that their current physicians were not part of a managed care plan.

Most respondents believed that managed care groups would provide emergency care, but most of the elderly surveyed did not realize emergency care must be provided in the local service area unless it was a life or death situation. They were also unaware that the primary care physician must approve an emergency room visit.

The majority of elderly surveyed did not support the idea of managed care. The survey group did support the idea of minimal claims, because most felt it was difficult to fill out and submit medical claims. Participants also indicated that when denials of coverage were sent to them, they are difficult to understand. Most denials are paid by the older adult because they are not sure of their right to appeal a medical decision for payment.

The response to questions eighteen and nineteen followed most of the responses to previous questions. Choice and quality were the greatest fears, and small co-payments and pharmacy benefits would be of the greatest help to seniors. The next several pages will indicate the response to each individual question with the response being reported in actual numbers and then converted to percentages.

SURVEY RESULTS

Question 1

Do you know what managed care is (HMO or PPO)?

Result	Yes	No	Yes %	No %
	31	7	82	18

Question 2

Do you currently participate in a managed care plan (HMO or PPO) organization?

Result	Yes	No	Yes %	No %
	18	20	47	53

Question 3

Do you know what services are offered by an HMO or PPO organization?

Result	Yes	No	Yes %	No %
	12	26	32	68

Question 4

Do you understand the services offered by an HMO or PPO organization?

Result	Yes	No	Yes %	No %
	10	28	26	74

Question 5

Do you believe that an HMO or PPO will save you money?

Result	Yes	No	Yes %	No %
	15	23	39	61

Question 6

Do you believe that an HMO and PPO offer a variety of specialists?

Result	Yes	No	Yes %	No %
	8	30	29	71

Question 7

Do you believe that HMO and PPO organizations provide quality service?

Result	Yes	No	Yes %	No %
	12	26	32	68

Question 8

Do you believe that physician choice is limited with an HMO or PPO?

Result	Yes	No	Yes %	No %
	30	8	79	21

Question 9

Do you believe that critical care is withheld from a patient when they participate in and HMO or PPO?

Result	Yes	No	Yes %	No %
	29	9	76	24

Question 10

Do you believe or know that an HMO or PPO will provide emergency care?

Result	Yes	No	Yes %	No %
	31	7	82	18

Question 11

Do you know if an HMO or PPO will provide emergency care when you are not in your designated service area?

Result	Yes	No	Yes %	No %
	5	33	13	87

Question 12

Do you support the idea of managed care for senior adults?

Result	Yes	No	Yes %	No %
	12	26	32	68

Question 13

Do you believe that senior adults enrolled in a managed care plan should pay small co-payments at each office visit?

Result	Yes	No	Yes %	No %
	37	1	97	3

Question 14

Do you believe or know that managed care (HMO or PPO) organizations take the hassle out of filing medical claims?

Result	Yes	No	Yes %	No %
	38	0	100	0

Question 15

Do you currently have friends or relatives that are enrolled in an HMO or PPO?

Result	Yes	No	Yes %	No %
	33	5	87	23

Question 16

Do you believe that you will join a managed care company with the next several months? Please pick the appropriate response.

4	Never
25	0-3 Months
5	3-6 Months
4	6-12 Months

Question 17

Do you believe that government will force senior citizens to join an HMO or PPO for the delivery of their health care?

Result	Yes	No	Yes %	No %
	34	4	89	11

Question 18

What is your greatest fear about joining an HMO or PPO?

Quality and choice accounted for	93%
Cost of plan	3%
Emergency care	2%
Service Area	1%
Dropping of Medicare Part B	1%

Question 19

What is the greatest benefit of joining an HMO or PPO?

Pharmacy	97%
Small co-payments	3%

CHAPTER 5
CONCLUSION

According to Annis, elderly Americans will number over 50 million by the year 2030. The population growth will force the growth in health care needs. Acute episodes have decreased, and chronic conditions have increased. The need for hospitalization will drop and the average length of stay will be decreased. Managed care organizations will play a key role in the success of seniors securing adequate health care. The health care industry will focus on the lifestyle and choices of the elderly.

Seniors across America will be forced to find health care services to meet their changing needs. The elderly will also have a responsibility to protect themselves from chronic illnesses by making lifestyle changes. Lifestyle changes that occur in the early years can prevent problems in the senior years.

The survey conducted for this thesis was limited in several areas. Geographic limitations were a problem, because all participants lived in the St. Louis or St. Louis county area. Rural areas were excluded from the survey. Most information compiled during the literature review did not adequately discuss rural health care and the problems experienced by seniors living in rural areas.

Rural health care is a concern for seniors and should be a concern for managed care companies, physicians, and providers. Many residents in the rural setting have limited transportation to larger facilities.

Further research in managed care will be necessary to properly provide rural health care. Current managed care plans do not offer services to those seniors that are not able to travel to larger facilities or physicians.

Research should be conducted to determine the feasibility of providing health care for seniors in their area on a limited basis, and the managed care company must be able to contract with local inpatient facilities to ensure delivery of health care services.

Managed care restricts participation for many seniors because they travel or have summer residences outside of their service area. The managed care organizations should research the feasibility of providing regional health care. Regional health care would allow seniors to exercise managed care benefits while traveling. The survey did not have any participants that traveled outside their service area for more than two or three days.

Pharmacy benefits are a significant change from traditional health care. It would be helpful to have seniors list their current pharmacy needs and plan how to use their pharmacy dollars appropriately. Seniors who choose to use generic drugs will find pharmacy benefits helpful.

Health conditions were limiting in the survey. All participants selected for the survey represented people needing some type of health care or assistance in their home. The survey may have yielded different results if a healthy group of seniors had been selected to participate in the survey. Further research of a group of well seniors would be appropriate. It would be interesting to compare the results of both survey groups.

The survey limited the amount of input from seniors regarding concerns about quality. Managed care companies should conduct further research to

identify if their concerns about quality are real or a perception of a problem. All aspects of health care delivery systems experience problems with quality. Medicare and Medicaid have problems regarding quality, but it is not highly publicized to the American public, and seniors believe that they must live with the poor quality because it is the only option available to them.

Education of the elderly consumer is lacking. It appeared in the literature review that most of the elderly did not understand Medicare. Managed care companies and providers must assume responsibility for educating seniors on managed care and their rights in a managed care plan. Education should include who the plan works, how to access their health care, and the plans limitations.

Elderly concerns about limited physician access can be studied further to determine what their needs will be. Most elderly fear the loss of their physician and will not listen to the benefits of managed care. The bond that is created between a physician and patient is only possible by delivering quality service and access to care. Managed care companies must be willing to recruit, select, and retain quality physicians and specialists.

Many aspects of senior managed care plans are not understood or known. Missouri managed care companies have the opportunity to collaborate with seniors, providers, physicians and other successful senior plans to develop a plan that meets the seniors needs but will exceed their needs. Managed care is not to be feared if it understood and the limitations are known. Providing quality care at a reasonable cost is what seniors need, and it appears that managed care is able to provide quality health care at a reasonable cost.

APPENDICES

APPENDIX A

HEALTH CARE TERMS

AMA- American Medical Association

Account Number- The policy number assigned to you which shows the plan that covers you and your family.

Alternative Delivery Systems- An umbrella term referring to nay health care provider group which monitors both cost and quality of care. This includes preferred provider organizations or arrangements and health maintenance organizations.

Assignment of Benefits- Giving the insurance company consent to send claim payments directly to the health care provider. Most claim forms allow you to choose the provider or yourself as the primary source of who gets the payment.

Average Length of Stay- Average number of days patients stay in the hospital.

Benefit- The amount your plans pays towards the cost of treatment or service.

Benefit Periods- A term used in the Medicare plan that identifies a certain allotted time or an illness or injury.

Carrier- The insurance company which underwrites the medical benefit plan an employer sponsors.

-Claim- Your demand for payment of medical services.

Coinsurance/CoPay- The percentage of covered charges you pay toward your health care bill after you satisfy your deductible.

Coordination of Benefits- The amount of payment each carrier pays for a single provider charge.

Cost Containment- An approach to affordable health care. It can be coverage that promotes health and wellness thereby reducing the cost.

Covered Charges- The amount of charges covered for services provided. Each plan clearly spells out what is a covered expense.

Deductible- The amount you pay before the plan begins paying for services. Deductible amounts can and do vary according to the particular plan.

Diagnosis- Identification of a disease or illness. A diagnosis is made after diagnostic test are done.

Discharge Planning- Hospital or agency program that helps prepare patients for going home after a hospital or nursing home stay.

DRG- Diagnosis related group that pays for services based on the diagnosis. The DRG indicates the average length of stay, the charges and the chances of reoccurrence.

Fee-for Service- A billing method used by health care providers to charge separately for each service and visit.

Gatekeeper- A system used by HMO and PPO providers to control access to specialized medicine. A patient must visit their primary physician before using a specialist and the referral must accompany the patient when make a visit to the specialist.

Health Maintenance Organizations- A system offering a wide range of health services to persons in a specific area through a select group of doctors, hospitals, clinics, and pharmacies. HMOs usually cover expenses in full, but you must use providers which belong to the HMO to receive coverage. If you use someone outside of the HMO, you are responsible for all of the charges.

Home Health Care- A program developed to care for the chronically ill in the comfort of their home.

Hospice Care- A program for patients that meets the physical, psychological, spiritual and social needs of dying patients and their families. Enrollment in a hospice indicates that a person usually has 6 months or less to live.

Hospital Preadmission Authorization- A process requiring your physician or their assistant to get insurance approval prior to entering a health care facility for treatment or surgery.

Inpatient- A person that enters the hospital or facility for more than an overnight stay.

Insurance Poor- a person that has too much insurance.

Medicare- A federally funded program for persons over the age of 65 or certain other individuals that meet eligibility criteria.

Medicaid- A state administered program for persons with low incomes.

Medigap Insurance- A policy that helps fill in the gaps not covered by Medicare.

Out-of-Pocket Limit/Maximums- The total amount paid in a year before the insurance plan will pay 100%.

Preexisting Condition- A sickness or injury diagnosed and/or treated prior to you joining a new insurance group. You must go treatment free for 90 days and if you do not go treatment free, the insurance carrier will not cover any treatments associated with the diagnosis for a period of 12 months.

Preferred Provider Organization- An organization of physicians, clinics, and/or hospitals that offer services at discounted fees. This type of plan offers you the freedom of choice.

Prevailing Fee- The usual dollar amount charged for a particular treatment or service. This is based on geographic areas.

Primary Care Physician- The physician that is selected by the subscriber to deliver health care services.

Providers- Physicians, hospital, home health agencies, pharmacies, and others that provide health care services.

Referral- A referral is an agreement with the primary physician to seek the help of a specialist or diagnostic testing to properly diagnosis a disease or illness.

Reimbursement- Amount paid to subscriber or insurance company for services rendered/delivered.

Ryan White- A federal program designed to help the victims of AIDS.

Subscriber- A person that enrolls in a specific insurance plan.

Supplemental Insurance- see Medigap.

Third Party Payer- Any organization, public or private, that pays and individual's health care expenses.

Usual and Customary Charge- See Prevailing Fee.

Source: Enteen, Robert. Health Insurance New York: Paragon House, 1992.

APPENDIX B

TIMELINE OF HEALTH INSURANCE

1847 First health insurance

1850 Accident insurance

1864 Coverage for every accident available

1887 Forty seven (47) companies issuing accident insurance

1875 Mutual benefit associations

1900 Accident and Life Insurance companies began offering health insurance

1912 Single hospital benefit becomes available in Rockford, IL.

1916 Attempt to establish compulsory health insurance

1919 Both efforts rejected because of lack of political support, AMA support, pharmaceutical support, business and industry support. None wanted payroll tax to fund health insurance

1929 Marked the birth of modern health care insurance. Justin Kimball established a fund for school teachers at Baylor University
*50 cents per month per teacher guaranteed 21 days of hospitalization in a semi-private room

1931 AMA requested Kimball to present the plan for Baylor at their annual meeting

1932 Blue Cross was formed

1935 Fifteen (15) hospital insurance plans in eleven (11) states

1936 Six (6) new plans established

1939 Blue Shield was formed

1940 Six million subscribers to health insurance

1945 Nineteen million subscribers in eighty (80) plans

1950 Forty million subscribers to health insurance

1973 Health Maintenance Organization Act signed by President Nixon

1976 One hundred seventy seven million subscribers in traditional health care plans

1980 Health Maintenance Organizations growing

1982 PPO organizations begin with (25) plans

1986 PPO organizations number 506 plans with 5 to 8 million subscribers

1990 Approximately 356 million HMO and PPO subscribers

Source: Atchley, Robert. Social Forces and Aging California: Wadsworth Publishing Company, 1994.

APPENDIX C

Managed Care
HMO and PPO Organizations

Please circle yes or no for questions 1-18 and 20
Please rank questions 19, 21 and 22

1. Do you know what managed care is (HMO or PPO)?

Yes No

2. Do you currently participate in a managed care plan (HMO or PPO)?

Yes No

3. Do you know what services are offered by an HMO or PPO organization?

Yes No

4. Do you understand the services offered by and HMO or PPO organization?

Yes No

5. Do you believe that an HMO or PPO will save you money?

Yes No

6. Do you believe that an HMO or PPO offers a variety of specialists?

Yes No

7. Do you believe that HMO and PPO organizations provide quality services?

Yes No

8. Do you believe that physician choice is limited with an HMO or PPO?

Yes No

9. Do you believe that critical care is withheld from a patient when they participate in an HMO or PPO?

Yes No

10. Do you believe or know that an HMO or PPO will provide emergency care?

Yes No

11. Do you know if an HMO or PPO will provide emergency care when you are not in your designated service area?

Yes No

12. Do you support the idea of managed care for senior adults?

Yes No

13. Do you believe that senior adults enrolled in a managed care plan should pay small co-payments at each office visit?

Yes No

14. Do you believe that managed care organizations take the hassle out of filing medical claims?

Yes No

15. Do you currently have friends or relatives enrolled in an HMO or PPO?

Yes No

16. Do you believe that you will join a managed care company within the next several months? Please place a check next to the appropriate response.

____ Never
____ 0-3 Months
____ 3-6 Months
____ 6-12 Months

17. Do you believe the government will force senior citizens to join an HMO or PPO for delivery of health care services?

Yes No

18. What is your greatest fear about joining an HMO or PPO? (please rank in order of importance with 1 being your first concern and 8 being your least concern)

____ Cost of plan
____ Choice of primary physician
____ Quality of service
____ Choice of specialist
____ Pharmacy, Dental, and Vision benefits
____ Emergency care
____ Service area
____ Dropping Medicare Part B coverage

19. What do you believe to be the greatest benefit of joining an HMO or PPO? (Please rank in order of importance with 1 being your greatest benefit and 8 being your least benefit)

____ Cost savings
____ Choice of physicians
____ Quality services
____ Variety of specialists
____ Pharmacy, Dental and Vision benefits
____ Emergency care
____ Service area
____ Small co-payments

Thank You for your participation in the survey.

APPENDIX D

HMO Checklist

1. How and under what conditions and limitations are referrals obtained to participating and non-participating providers?

2. What is the appeals process?

3. Can you supply a list of providers participating in the plan?

Yes No

4. What specialist can be used in the plan?

5. What restrictions apply to physical, speech, occupational and social work therapies?

6. Is there access to medical equipment companies?

Yes No

7. What is the referral process, and how long does it take?

_____

_____

_____

8. How do you access additional benefits such as dental and vision care?

_____

_____

_____

_____

9. Is there a grievance procedure, and what is the procedure?

_____

_____

_____

_____

10. What is the average time a patient must wait for an appointment with a physician?

_____

11. What is the policy for emergency care outside an enrollees service area?

_____

_____

_____

_____

12. Can the HMO or PPO provide a financial report?

Yes No

13. Can the HMO or PPO provide a list of references?

Yes No

Source: Enteen, Robert. Health Insurance New York: Paragon House, 1992.

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