

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MIAMI AREA HMOs:
MEDICARE ENROLLMENT PATTERNS**



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Department of Health and Human Services

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OEI-04-91-00640

EXECUTIVE SUMMARY

PURPOSE

Our purpose was to determine if and why enrollment and disenrollment patterns in the Miami area Health Maintenance Organizations differ from those nationally.

BACKGROUND

In the fall of 1990, newspapers in the Miami area published articles critical of local Health Maintenance Organizations' (HMO) practices. Concerned about the situations described in these articles, the Administrator of the Health Care Financing Administration (HCFA) requested the Inspector General to examine the marketing practices and enrollment patterns of South Florida HMOs. This report deals with enrollment patterns. Marketing practices are described in a separate report (OEI-04-91-00630).

Medicare is the Federal health insurance program available to most individuals age 65 and older and certain disabled people. Most Medicare beneficiaries receive services under the fee-for-service sector of the health care system. Under fee-for-service, beneficiaries may choose their own physicians, hospitals, and other medical care providers. The beneficiary is required to satisfy a deductible, then Medicare pays 80 percent of the allowable charges for covered physician and outpatient services.

Medicare beneficiaries also may choose to receive their health care from a prepaid health organization such as an HMO. These plans contract with HCFA to provide or arrange for all Medicare covered services. Beneficiaries enrolled in HMOs that contract on a risk basis are considered to be "locked in" to the services provided by that plan. Except for emergency care and urgently-needed care when out of the HMO's service area, beneficiaries agree to receive all their medical care through the providers affiliated with the HMO. Neither the Medicare program nor the HMO is liable for services, other than emergency or urgently-needed care received outside the risk-contracting plan.

The HMO market in the Miami area is unique in the number of elderly and the number of Medicare-contracted HMOs. In the three county metropolitan Miami area, approximately 18 percent of the population is over age 65. Five HMOs currently serve beneficiaries in the Miami area. Since the benefits HMOs offer are quite similar, marketing of the programs is highly competitive.

FINDINGS

This study of Medicare beneficiary enrollment practices in Miami area HMOs found that:

- ▶ The proportion of Medicare beneficiaries choosing HMOs over Medicare fee-for-service is higher than nationally.
- ▶ Medicare enrollees change plans more frequently than any other group in the nation.
- ▶ Most Medicare beneficiaries who leave one HMO choose another HMO over fee-for-service coverage.
- ▶ Excessive turnover of beneficiaries among HMOs may jeopardize patient care.
- ▶ Inappropriate enrollments result in unnecessary costs to HCFA and SSA.

RECOMMENDATIONS

The following recommendations target Medicare prepaid health care program vulnerabilities, as well as addressing troublesome situations encountered during this inspection of South Florida HMOs.

1. The HCFA should establish a policy limiting enrollment to one "open season" (opportunity to enroll) per year.
2. The HCFA should establish an on-line system to identify and review cases of frequent enrollment change.
3. In the three-county Miami service area, HCFA should test the efficacy of a third party handling HMO enrollment actions.
4. The HCFA should impose a "cooling off" period allowing beneficiaries to reconsider HMO enrollment decisions before enrollment applications are processed.

COMMENTS

Comments on the draft report were received from HCFA and the Assistant Secretary for Planning and Evaluation (ASPE). Both agencies agree that HCFA should identify and review frequent enrollment changes, and HCFA believes they now have that capability. While ASPE supported the concept of a "cooling off" period for Medicare enrollees, HCFA thinks a "cooling off" period is not needed.

Neither agency concurred with the other recommendations. We will defer our comments on their responses until the OIG completes its national study on HMO disenrollments (OEI-06-91-00730).

The comments of HCFA and ASPE can be found in appendix E. We have responded to each technical change suggested by HCFA and ASPE.

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INTRODUCTION

PURPOSE

Our purpose was to determine if and why enrollment and disenrollment patterns in the Miami area differ from those nationally.

This inspection was requested by the Administrator of the Health Care Financing Administration (HCFA).

BACKGROUND

In the fall of 1990, newspapers in South Florida published articles critical of local HMO sales and marketing practices. The articles also claimed that beneficiaries are not adequately informed of the "lock-in" feature of HMO enrollment.¹ Lock-in requires that with the exception of emergencies and urgently needed care when out of the area, all medical care must be received from HMO affiliated providers.

Concerned about these newspaper articles, the Administrator of HCFA requested the Inspector General to examine HMO enrollment and disenrollment patterns in South Florida. An inspection of Marketing Practices of South Florida HMOs Serving Medicare Beneficiaries (OEI-04-91-00630) was also requested.

The Medicare Program

Medicare is a Federal health insurance program for individuals age 65 and older and for certain categories of disabled people. Authorized in 1965 by Title XVIII of the Social Security Act, Medicare serves over 33 million beneficiaries nationwide. Within the Department of Health and Human Services, HCFA is responsible for administering the Medicare Program.

Method of Service

In most geographic areas, Medicare beneficiaries obtain medical care through the fee-for-service program. However, in some places, there are two ways in which beneficiaries may obtain medical care covered by Medicare.

¹Bergal, J., and Schult, F., "Patients Feel Betrayed by HMO," The Sun-Sentinel, Ft. Lauderdale, FL, October 23, 1990, pp 1A and 6A.

Regular Fee-for-Service Coverage - Beneficiaries choose each of their own physicians, hospitals, and other medical care providers. The beneficiary pays the Medicare premiums, deductibles for inpatient and outpatient care, and 20 percent of the allowable charge for covered physician and other outpatient services.

Prepaid Health Plans - Beneficiaries enroll in Medicare-contracted health organizations which manage their medical care. Beneficiaries continue to pay Medicare premiums. They may pay the plan a monthly premium and/or a copayment for each service received. However, they do not pay the deductibles or 20 percent of physician and outpatient charges required under the fee-for-service program. As a result, these beneficiaries do not need Medicare supplemental policies.

A beneficiary can be in only one program at a time. He/she cannot combine fee-for-service and prepaid health plans.

The most common types of Medicare prepaid health plans are risk-contracted HMOs. These HMOs are considered "at financial risk" because they agree to provide a beneficiary's total medical care for a set amount paid monthly by Medicare.

These HMOs serve beneficiaries who live within a defined geographic area. They are responsible for providing the full range of Medicare services. They may offer other benefits not covered by Medicare, such as prescription drugs.

After joining an HMO, the beneficiary selects a primary care physician (PCP) affiliated with the plan. All medical care is managed by that PCP. The PCP either provides the services needed or refers the beneficiary to appropriate specialists or other health care providers.

The HMO network of providers may be either HMO employees working in an HMO-owned facility or private physicians contracting with the HMO to provide services to the members. Some HMOs use a combination of providers.

Beneficiaries are required to obtain all their medical care through the providers affiliated with the HMO, except for emergency and urgently needed care.

In an emergency, beneficiaries can receive care anywhere. The HMO will pay for the care, even if the provider is not affiliated with the HMO. The HMOs also will pay for urgently-needed care a beneficiary receives when out of the HMO's service area. Neither the HMO nor Medicare will pay for non-emergency or non-urgent care obtained outside the HMO without prior approval of the HMO. The beneficiary is responsible for those charges.

Uniqueness of Miami HMO Market

The HMO market in the three-county Miami area is unique in the number of elderly and the number of risk-contract HMOs.

Nationally, persons over age 65 comprise 13 percent of the population. In the three-county Miami area, approximately 18 percent of the population is over the age of 65. In 2 of the 3 counties, over 20 percent of the population is over 65.² Some live in Florida full-time. Others live there only part of the year, and reside in other States the rest of the time.

In most locations where HMOs are accessible to Medicare beneficiaries, only one or two are available from which to choose. In the Miami area, five risk-contract HMOs currently serve beneficiaries. Approximately 33 percent of the elderly are enrolled in one of those HMOs. Two additional HMOs have applied to serve beneficiaries in the Miami area and will be granted contracts if they meet HCFA requirements. Since the benefits HMOs offer are quite similar, marketing of the programs is highly competitive.

SCOPE

This inspection examined the enrollment and disenrollment practices of Medicare beneficiaries served by the five Medicare contracted HMOs operating in the metropolitan Miami area during Federal fiscal years 1988 through 1990 (October 1, 1987 through September 30, 1990). The five HMOs, and counties included in their service areas, are shown below.

NAME OF HMO	COUNTIES INCLUDED IN SERVICE AREA
Humana Medical Plan	Broward, Dade and Palm Beach
CAC-RAMSAY	Broward and Dade
Av-Med Health Plan	Broward, Dade and Palm Beach
Health Options of South Florida	Broward and Dade
CareFlorida	Broward, Dade and Palm Beach

Although these HMOs may also have operations outside the Miami area, only the service areas listed were included in this inspection.

METHODS

Information for this inspection was obtained from a variety of sources. We:

- ▶ reviewed State and Federal regulations governing HMOs;
- ▶ interviewed HCFA and Florida Department of Insurance officials;
- ▶ reviewed prior studies of contracted HMO operations;

²Demographic data from county planning departments in Dade, Broward, and Palm Beach Counties and the U.S. Department of Commerce; Bureau of the Census.

- ▶ reviewed a General Accounting Office audit report;
- ▶ reviewed various newspaper articles relating to South Florida HMOs;
- ▶ reviewed financial and enrollment data for Medicare beneficiaries enrolled in contract HMOs; and
- ▶ conducted telephone and mail surveys of Medicare beneficiaries and physicians.

To determine reasons beneficiaries changed HMO plans, we asked beneficiaries themselves. We randomly selected 237 Medicare beneficiaries from all beneficiaries who:

- ▶ enrolled in a Miami area HMO between October 1, 1987 and September 30, 1990; and
- ▶ changed enrollment at least four times during that period.

We interviewed these beneficiaries by phone in January 1991. The response rate was 60 percent. Appendix B contains the survey instrument and response frequencies.

To get physicians' opinions on reasons for and effects of rapid changes in HMO enrollment, we queried 217 South Florida physicians by mail in January 1991. Nearly half responded. Appendix C contains the survey instrument and responses.

The Florida Humana HMO is the largest in the country. Humana operates in several geographic areas of the State. In most of those areas, unlike Miami, Humana has no competition. We were not able to segregate information about Humana into its several Florida service areas. Therefore when Humana is included, the data is for the entire State. For this reason, we have removed Humana from a number of the calculations reported in this document. A more detailed explanation of Humana's effect on the data is provided in appendix D.

FINDINGS

In the Miami area, the proportion of Medicare beneficiaries choosing HMOs over Medicare fee-for-service is higher than nationally.

Nationally, at the time of this study, over 1.3 million Medicare beneficiaries were enrolled in risk contract HMOs. Seventeen percent of them presently live in the Miami area. In fact, in the Miami area, one out of three Medicare beneficiaries is enrolled in an HMO, compared to one in 20 nationally.

The out-of-pocket cost for an HMO member in Miami is considerably less than for the fee-for-service beneficiary. Although beneficiaries who enroll in HMOs are still required to pay the standard Medicare Part B premium, they do not need to fulfill any deductibles for their care to be fully covered. Although HCFA regulations allow HMOs to charge an additional monthly premium, none of the Miami area HMOs do so. Only two of the HMOs charge nominal copayments for physician services.

Ninety-two percent of the physicians responding to our survey believe Miami area beneficiaries choose HMOs over fee-for-service because the costs to beneficiaries are lower than fee-for-service.

Medicare enrollees in Miami area HMOs disenroll more frequently than any other group in the nation.

Whereas nationally about 12 percent of Medicare HMO enrollees disenroll within one year of joining, in the Miami area, 28 percent do so.

Some beneficiaries have made a very high number of changes. In the three years we studied, 2,276 beneficiaries had enrolled four or more times. Of these, 82 percent live in the Miami area. As the numbers of enrollments increase, the proportion of multiple enrollees living in the Miami area also increases. For example, of all Medicare enrollees who have enrolled 6 or more times, 98 percent live in the Miami area.

This phenomenon is illustrated in the following table.

MEDICARE BENEFICIARY ENROLLMENTS IN HMOs: NATION AND SOUTH FLORIDA			
	All HMOs Nationally	South Florida HMOs	Percent of National HMO Total
Number of Beneficiary Enrollments	881,861	182,405	21%
Beneficiaries Enrolled 4 or More Times	2,276	1,866	82%
Beneficiaries Enrolled 6 or More Times	364	356	98%

South Florida HMOs experience beneficiary disenrollment rates that dramatically exceed the national quarterly disenrollment averages. Even AV-MED's disenrollment rate, which is closest to the national average at six months, is one-third higher at 12 months.

RAPID TURNOVER AMONG SOUTH FLORIDA HMOs		
	Cumulative Disenrollment	
	Within 6 Months	Within 12 Months
All HMOs, excluding South Florida HMOs	7%	12%
South Florida HMOs	17%	28%
Humana	16%	25%
CAC	21%	35%
Av-Med	8%	16%
Health Options	22%	37%
CareFlorida	29%	46%

In efforts unrelated to this inspection, HCFA and the U.S. Public Health Service previously determined that about 10 percent of the elderly population report having no continuous source of health care. The national HMO disenrollment figures above are not inconsistent with this. However, South Florida HMO disenrollment, averaging 28 percent over 12 months, far exceeds this general experience of the elderly.

We examined the records of a sample of 237 Miami area Medicare beneficiaries who had 4 or more HMO enrollments within three years.

We found that:

- ▶ 140 changed HMOs four times;
- ▶ 45 changed five times; and
- ▶ 52 (22 percent) changed 6 or more times.

When we asked these beneficiaries if they planned to change again, 13 percent of the respondents said they do.

The HCFA guidelines allow beneficiaries to change the form of their Medicare coverage as often as every 30 days. By contrast, most employers who offer several private health insurance plans to their employees, allow just one opportunity a year to change plans. The HCFA policy has set up a potential for as many as 12 changes a year. Nationally this license seems no cause for concern, however in the Miami area it sets the stage for high enrollment turnovers.

The many choices of HMOs available to the Miami area Medicare beneficiaries may be an incentive to switch plans frequently. There are five HMOs for Medicare beneficiaries to choose from, as well as the regular fee-for-service Medicare system. Four of the 5 Miami area HMOs - CareFlorida, Av-Med, Health Options and CAC - operate only in the 3-county Miami service area. The fifth, Humana, the HMO with the nation's largest number of enrollments during this period, operates in Tampa/St. Petersburg, Orlando, and Daytona, as well as Miami. (See appendix D for a description of the effect of Humana's disproportionate size and lack of competition in three of its four Florida markets, on the analysis of HMOs in this report).

Fifty-six percent of the beneficiaries responding to our survey say they changed enrollment in the past because, simply, they didn't like the plans they were in. When asked about the most recent change:

- ▶ 59 percent said they were dissatisfied with the HMOs doctors or services;
- ▶ 17 percent said they changed because the HMO had financial problems or the ownership changed; and
- ▶ 16 percent cited HMO location, or lack of transportation.

When asked to think back and give reasons why they had ever changed plans, 33 percent of these respondents cited at least one reason related to the "lock-in" feature of HMO enrollment:

- ▶ 16 percent said they wanted to use a particular doctor who was not affiliated with their plan;

- ▶ 14 percent said their doctor left the plan, or advised them to change plans;
- ▶ 11 percent said they could not get the specialty care they needed within the HMO; and
- ▶ 10 percent said they needed to see a doctor more often than their HMO would allow.

Twenty-seven respondents (20 percent) said they had changed coverage on advice of an HMO sales representative, but only four beneficiaries said they had been offered a free gift or other incentive to change.

Friends and relatives are as likely as sales representatives to influence beneficiaries to change HMOs. Nineteen percent of the respondents said they had changed plans on the advice of a friend or relative.

Physicians we surveyed generally confirmed these findings. They suggested that Medicare beneficiaries change HMOs because of:

- ▶ quality of care;
- ▶ restrictions and limitations on services;
- ▶ limitations in number of HMO physicians, especially consultants,
- ▶ enrollee misunderstanding of the HMO system; and
- ▶ manipulation by HMO sales representatives.

In-person interviews during the HMO marketing practices inspection showed some beneficiaries who changed HMOs frequently were exposed to unethical HMO marketing practices. Others were not fully aware of their enrollment actions. These findings are described in detail in the inspection entitled Marketing Practices of South Florida HMOs Serving Medicare Beneficiaries (OEI-04-91-00630).

When Medicare beneficiaries in Miami leave one HMO, most choose another HMO over fee-for-service coverage.

This inspection shows Medicare HMO enrollees in the Miami area disenroll from their HMOs with much greater frequency than their peers nationwide. In the Miami area, 28 percent disenroll within one year vs. 12 percent nationwide. Although the reasons most often given for leaving an HMO relate to dissatisfaction with one or more features of the HMO, preference for the HMO form of coverage is remarkably high.

Figures from this study show that nearly three of four Miami area beneficiaries who leave HMOs join another HMO immediately or within the next 12 months. The following table (which excludes Humana for reasons explained in appendix D) illustrates this pattern.

ACTIONS OF MEDICARE BENEFICIARIES WHO DISENROLLED			
	Went to Fee-For-Svc. For at Least 12 Months	Went to Competing HMO	Went to Fee-For-Svc. But Joined HMO Within 12 Months
CareFlorida	20%	67%	13%
Av-Med	38%	49%	13%
Health Options	31%	55%	15%
CAC	28%	57%	15%
Combined	26%	60%	14%
National	68%	13%	19%

Excessive turnover may jeopardize patient care.

Nearly all physicians who responded to our survey are affiliated with one or more HMOs. All serve Medicare patients. Sixty percent of them say they believe frequent HMO changes disrupt the continuity of care. Fifteen percent say frequent changes degrade the quality of care.

Inappropriate enrollments lead to unnecessary costs.

The HCFA Region IV office estimates that over the past three years it has received 16,000 inquiries from beneficiaries regarding HMOs. The office investigated 1,500 potentially fraudulent HMO enrollments and 1,800 failures to disenroll beneficiaries in a timely manner.

Reviewing and resolving HMO enrollment problems now requires three HCFA Regional office staff. Further, many of the inquiries received by HCFA originate in an SSA District Office, or are ultimately referred to SSA for resolution.

There are approximately 3,000 enrollments and 2,000 disenrollments in the Miami area per month. The HCFA estimates that 20 percent of these, or 12,000 enrollment/disenrollment actions per year, may be inappropriate. Better informed beneficiaries and more effective enrollment verification procedures by HMOs would reduce significantly the number of inappropriate actions, resulting in savings to both HCFA and SSA.

CONCLUSION

Beneficiaries enrolled in Miami area HMOs change plans more frequently than any other group in the nation. They disenroll because of dissatisfaction with their HMOs' care and services. When they leave an HMO, however, most beneficiaries enroll in another HMO. Despite problems they encounter with HMOs, beneficiaries in the Miami area who have once joined an HMO prefer HMO coverage to fee-for-service.

Because some of the beneficiaries who change most often are particularly vulnerable, HCFA should be vigilant to assure that these people are not abused. The quality and continuity of care for these multiple enrollees may unduly suffer. Excessive and inappropriate enrollment actions result in avoidable costs to HCFA and SSA. These conditions warrant that steps must be taken to protect both beneficiaries and the integrity of the health care delivery system.

RECOMMENDATIONS

A number of HCFA policies and HMO practices leave the Medicare prepaid health care program vulnerable to abuse. The following recommendations target those vulnerabilities, as well as address troublesome situations encountered during this inspection of South Florida HMOs.

1. ***The HCFA should establish a policy limiting enrollment to one "open season" (opportunity to enroll) per year.***

Presently, HCFA rules allow Medicare beneficiaries to change their health insurance coverage as frequently as every month. Disenrollment from prior coverage is automatic when the new enrollment occurs. This policy allows beneficiaries to change plans without thoughtful consideration of the pros and cons of their actions. The policy also encourages an aggressive approach to sales, since it allows a new sale to each enrollee every thirty days.

This policy clearly undermines HCFA's commitment to managed health care. It also increases the likelihood of confusion among beneficiaries over coverage issues, and may jeopardize the well-being of those who have not made thoughtful decisions. Physicians queried in this inspection indicate that frequent change of health care coverage disrupts continuity of care and may affect the quality of care.

Based on health insurance industry norms, HCFA should establish an annual "open season," so that changes in coverage may be made only once a year. The effective date of change should be no sooner than 30 days after a new plan/form of coverage is selected by the beneficiary.

To safeguard that beneficiaries are not disadvantaged by enrollment decisions contrary to their best interests, HCFA should allow disenrollment "for cause" between open season periods. The HCFA should develop criteria for determining whether sufficient "cause" is established.

2. ***The HCFA should establish an on-line system to identify and review cases of frequent enrollment change.***

The HCFA's automated systems are capable of identifying individual Medicare beneficiaries who have applied for HMO enrollment at the point each new enrollment begins. The agency should capitalize on this capability by:

- ▶ determining an appropriate threshold for number of changes acceptable over a specified period of time (e.g., two per year) or minimum time between new enrollments (e.g., six months);

- ▶ automatically scanning new enrollments for beneficiaries who exceed those thresholds;
- ▶ alerting the new HMO-of-enrollment to these cases, with adequate beneficiary identification information;
- ▶ requiring the HMO to explain and document the circumstances surrounding the sale and application for enrollment; and
- ▶ developing corrective actions and penalties for HMOs found to have inappropriately enrolled Medicare beneficiaries.

We note that HCFA has already taken preliminary steps to develop such a system. We endorse the agency's early efforts in this regard. The refinements outlined above are recommended to strengthen and standardize HCFA's monitoring of excessively frequent HMO enrollment change.

The system recommended here would be obviated by implementation of Recommendation #3 to follow.

3. *In the three-county Miami service area, HCFA should test the efficacy of a third party handling HMO enrollment actions.*

A major vulnerability of the present system is that an HMO sales agent can sign up a Medicare beneficiary in his/her home at the time of the sales presentation. Beneficiaries may not object to this practice in many instances, since it is convenient. However, in cases where the beneficiary is intimidated by the sales agent, he/she may sign-up just to get the salesperson to leave.

Although the HMOs included in this review do have procedures for verifying that beneficiaries understand certain provisions of HMO coverage, this may not be adequate protection against inappropriate sales practices. We note in this report that one HMO allows the verification call to be made while the salesperson is still present in the beneficiary's home.

The best safeguard for an informed choice by the beneficiary is to ensure that the decision to enroll in a new HMO is made independent of the salesperson and even of the HMO.

We recommend that HCFA contract, on a two to three year pilot basis, with a third party to provide HMO enrollment services. One possible enrollment agent is the Social Security Administration (SSA) District Offices (DO). In each DO in the Miami area, HCFA could fund a position or part of a position for a service representative to advise new enrollees on their decisions, and process the enrollments. An SSA service representative would be able to provide objective, balanced information on health

coverage to the beneficiary, and answer applicants' questions stemming from the sales presentation.

This proposal is consistent with Secretary Sullivan's Program Direction which calls for a more expansive role for SSA district offices in integrating SSA and other health and human services.

If an arrangement cannot be made with SSA, HCFA might contract for this service with a private contractor in the Miami area. Such services could possibly be provided under the auspices of senior citizen or other neighborhood service centers. Assuming proper guidelines to the contractor, this recommendation would obviate Recommendations #1 and #2 above.

4. *The HCFA should impose a "cooling off" period allowing beneficiaries to reconsider HMO enrollment decisions before enrollment applications are processed.*

Florida law now requires that, after an individual has applied to enroll in an HMO, a verification phone call must be made by the HMO to ascertain the applicant's understanding of the "lock-in" feature of HMO enrollment, and assure that he/she affirms his enrollment decision. This consumer protection step would seem a good model for HCFA to adopt, with application nationally, to cover Medicare beneficiary enrollments in prepaid health plans.

To further refine Florida's model, HCFA should require that enrollment verification take place no sooner than 72 hours after the beneficiary has signed his/her application to enroll. This "cooling-off" period is consistent with consumer contract protection in many states.

APPENDIX A

METHODS AND SAMPLE SELECTIONS

Information for this inspection was obtained from a variety of sources. We:

- ▶ reviewed State and Federal regulations governing HMOs;
- ▶ interviewed HCFA and Florida Department of Insurance officials;
- ▶ reviewed prior studies of risk-contracted HMO operations, U.S. GAO Audit Reports, and various newspaper articles relating to the South Florida HMOs;
- ▶ reviewed enrollment data for Medicare beneficiaries enrolled in risk contract HMOs;
- ▶ conducted telephone interviews with Medicare beneficiaries served by Miami area HMOs; and
- ▶ conducted a mail survey of physicians practicing in South Florida.

Review of State and Federal Regulations

We examined State and Federal regulations governing HMO enrollment practices. This information was compared to data obtained from beneficiaries who were served by the HMOs and from beneficiary enrollment data maintained by HCFA.

Discussions with officials of HCFA and Florida Department of Insurance

We met with officials from HCFA and discussed beneficiary enrollment characteristics identified during their monitoring of HMO activities. We also met with officials of the State of Florida's Department of Insurance and discussed the results of their financial and performance audits for South Florida HMOs.

Prior studies of risk contracted HMO operations, U.S. GAO Audit Reports, and various newspaper articles relating to the South Florida HMOs

We reviewed the results of prior studies and investigative reports of risk contract HMOs.

We also reviewed relevant newspaper articles regarding South Florida HMO business practices. These articles indicated Medicare beneficiaries are sometimes

inappropriately enrolled and not adequately informed of the requirements related to membership in an HMO.

Enrollment data for Medicare beneficiaries enrolled in risk contract HMOs

Episodes of HMO disenrollments may be measured using one of two basic methods. One approach uses a time-related disenrollment rate (or ratio) while a second approach uses a cohort-based disenrollment rate. We used a cohort-based methodology in this inspection.

The ratio method expresses disenrollments in a given time period as a percentage of total enrollment in the same period, where total enrollment is defined as the sum of enrollment at the start of the period plus new enrollees during the period.

The cohort-based methodology tracks a cohort of enrollees over time and determines what percentage of them disenroll within a certain length of time after joining the HMO.³

We obtained information on each episode of beneficiary disenrollment from HCFA's Group Health Plan Operations (GHPO) master file and computed enrollment patterns for all beneficiaries enrolled in South Florida HMOs during Federal fiscal years 1988 and 1989 (October 1, 1987 through September 30, 1989). Cumulative disenrollment rates by duration of enrollment were computed for each HMO on a three, six, nine and twelve month basis.

Enrollment data were examined for beneficiaries enrolled in South Florida HMOs. The data was obtained from the Group Health Plan Operations (GHPO) master file and the Medicare Automated Data Retrieval System (MADRS).

Telephone interviews with Medicare beneficiaries served by Miami area HMOs

We developed a survey instrument and asked beneficiaries why they changed HMO plans. A random sample of 237 Medicare beneficiary names were selected from the GHPO file for use in the telephone survey.

This sample was selected from the universe of Medicare beneficiaries who: (1) had enrolled in Miami area HMOs during the period October 1, 1987 through September 30, 1990 and (2) had changed HMO plans at least four times during that period. Fifteen of the beneficiaries had expired, reducing the sample size to 225 beneficiaries.

Telephone interviews were performed during January 14-25, 1991. One hundred thirty six beneficiaries (60 percent) were interviewed.

³Mathmatica Research Policy, Inc., **"DISENROLLMENT EXPERIENCES IN THE MEDICARE HMO AND CMP RISK PROGRAM: 1985 TO 1988"**, HCFA Contract No. 500-88-0006, 1990, p.20.

Questionnaires mailed to physicians practicing in South Florida

For information on why physicians thought beneficiaries changed HMO plans so frequently, we developed a survey instrument and mailed questionnaires to 217 physicians practicing in the South Florida area. The survey instruments were mailed January 25, 1991. One hundred and two physicians responded, a response rate was 47 percent. Appendix D contains the survey instrument and total responses.

APPENDIX B

RESPONDENT ANSWERS: BENEFICIARY SURVEY ENROLLMENT PRACTICES OF MEDICARE BENEFICIARIES SERVED BY SOUTH FLORIDA HMOs

We collected proxy responses when the beneficiary was not available for this interview. An analysis of the answers provided by the different types of respondents (beneficiary, spouse, and other) revealed there was no difference in the outcome.

NUMBER OF RESPONDENTS, BY HMO

<u>Respondents</u>	<u>HMO Plan</u>
65	Humana Gold Plus Plan (Dade, Broward, & Palm Beach)
26	CAC-RAMSAY
11	Av-Med Health Plan
5	Health Options of South Florida
29	CareFlorida (Formerly Heritage)
<hr/>	
136	Total Respondents

100. Are you a year-round Florida resident or do you live in Florida only part of the year?

Percent	Response	
96.3	131	Live in Florida year-round
2.2	3	Live in Florida only part of the year
1.5	2	Respondents were unable to answer question
<hr/>	<hr/>	
100.0	136	Total

200. Primary reasons beneficiaries changed plans.

SEQUENCE OF RESPONSE	BENEFICIARY RESPONSES								TOTAL
	1	2	3	4	5	6	7	8	
FIRST	43	21	18	10	7	6	5	25	135
SECOND	25	3	5	3	2	1	1	9	49
THIRD	10	0	0	1	2	2	0	2	17
FOURTH	0	0	0	1	0	1	0	2	4
Total	78	24	23	15	11	10	6	38	205
RESPN %	38	12	11	7	5	5	3	19	100%

REASONS WHY BENEFICIARIES CHANGED PLANS (CODES 1 THROUGH 8)

1. Dissatisfied with doctors and/or services.
2. HMO had financial problems or plan changed ownership.
3. Beneficiary experienced transportation problems or desired a plan closer to his/her home.
4. Restrictions or limitations on services, including specialists referrals.
5. Quality of care issues.
6. Marketing tactics by HMO sales persons.
7. Followed physician when HMO went out of business.
8. Other

300. Did (CURRENT HMO) offer a free gift to enroll in their plan?

Percent	Response	
2.9	4	Beneficiaries didn't remember
94.2	128	No
2.9	4*	Yes
<hr/> 100.0	<hr/> 136	Total

*** Type of free gift provided to the Beneficiary:**

1. Beneficiary never picked up gift.
2. Pocket book
3. Transportation from home to doctor's office.
4. Cloth bag & \$25 coupons for use at the grocery store.

400. When you signed the application form for (CURRENT HMO), was it clear that you were enrolling in an HMO?

Percent	Response	
3.7	5	Beneficiaries didn't remember
7.4	10	No
88.9	121	Yes
<u>100.0</u>	<u>136</u>	Total

500. When you joined (CURRENT HMO) was it clear that you could only use the services of the HMO's doctors and hospitals (EXCEPT IN EMERGENCIES)?

Percent	Response	
3.7	5	Beneficiaries didn't remember
7.4	10	No
88.9	121	Yes
<u>100.0</u>	<u>136</u>	Total

Some people give the following reasons for changing health care plans. Have you ever changed plans because of any of these reasons?

600. You needed the services of a specialist and those services were not available in your plan?

Percent	Response	
1.5	2	Beneficiaries didn't remember
87.5	119	No
11.0	15*	Yes
<u>100.0</u>	<u>136</u>	Total

* Type of specialist not available in plan:

1. Chiropractor
2. Cardiologist
3. Dentist
4. Podiatrist - 2
5. Gastroenterologist - 2
6. Urologist - 3
7. Neurologist - 3
8. Ophthalmologist
9. Diabetes shots required

601. You needed to see a doctor more often than your plan would allow?

Percent	Response	
3.7	5	Beneficiaries didn't remember
86.8	118	No
9.5	13	Yes
<u>100.0</u>	<u>136</u>	Total

602. You wanted to use a specific doctor and he/she was not in your plan?

Percent	Response	
2.9	4	Beneficiaries didn't remember
81.6	111	No
15.5	21	Yes
<u>100.0</u>	<u>136</u>	Total

603. Your doctor advised you to change to another plan?

Percent	Response	
2.9	4	Beneficiaries didn't remember
92.6	126	No
4.5	6	Yes
<u>100.0</u>	<u>136</u>	Total

Reasons doctor advised beneficiary to change plan:

1. Follow doctor - Last HMO went out of business.
2. Transportation - Closer to home.
3. Dentist advised beneficiary that only minimal dental care was required.
4. Followed doctor from one HMO to another - 2
5. Reason not provided.

604. Your doctor left the plan and you wanted to continue with that doctor?

Percent	Response	
2.2	3	Beneficiaries didn't remember
85.3	116	No
12.5	17	Yes
<u>100.0</u>	<u>136</u>	Total

605. An HMO sales representative advised you to join a new plan?

Percent	Response	
2.9	4	Beneficiaries didn't remember
77.2	105	No
19.9	27	Yes
<u>100.0</u>	<u>136</u>	Total

606. A free gift or a special offer was made to you?

Percent	Response	
1.5	2	Beneficiaries didn't remember
97.8	133	No
.7	1	Yes
<u>100.0</u>	<u>136</u>	Total

607. A friend or relative suggested that you join a different plan?

Percent	Response	
2.2	3	Beneficiaries didn't remember
78.7	107	No
19.1	26	Yes
<u>100.0</u>	<u>136</u>	Total

608. You didn't like the plan you were in?

Percent	Response	
3.7	5	Beneficiaries didn't remember
40.4	55	No
55.9	76	Yes
<u>100.0</u>	<u>136</u>	Total

Primary reasons why beneficiaries disliked their HMOs:

1. Didn't like the medical treatment.
2. Didn't like the doctors/staff.
3. Didn't like the services.
3. Needed the services of a specialist.
4. Office waiting time was too long.
5. Transportation problems
6. Other - various reasons.

609. Have you changed health care plans for any other reason we did not mention?

Percent	Response	
81.6	111	No
18.4	25	Yes
<u>100.0</u>	<u>136</u>	Total

700. Do you plan to change from (CURRENT HMO PLAN) to another plan? If so, why?

Percent	Response	
86.8	118	No
13.2	18	Yes
<u>100.0</u>	<u>136</u>	Total

Primary reasons for the forthcoming change in HMOs:

1. Moving - 3
2. Desires plan that allows beneficiary to select Doctor - 2
3. Need plan closer to home - 2
4. HMO too expensive - 2

5. Other or No reason provided - 4
6. Plan went out of business
7. Beneficiary disliked the treatment or services provided by the HMO.
8. Shopping for maximum services
9. HMO changed beneficiary's primary doctor 4 times in three years.
10. Beneficiary couldn't get an appointment with the doctor.

800. Is there anything else you would like to tell us about why you have changed HMO plans in the past?

Percent	Response	
71.3	97	No
28.7	39	Yes
<u>100.0</u>	<u>136</u>	Total

APPENDIX C

HMO ENROLLMENT SURVEY OF SOUTH FLORIDA PHYSICIANS

For information on why physicians thought beneficiaries changed HMO plans so frequently, we developed a survey instrument and mailed questionnaires to 217 physicians practicing in the South Florida area. One hundred and two responded. The responses are shown below.

Primary County of Practice?

PHYSICIANS RESPONSES	RESPONSE PERCENTAGE	COUNTY
44	43.2	Dade
32	31.4	Broward
8	7.8	Palm Beach
6	5.9	Pinellas
6	5.9	Hillsborough
2	1.9	Pasco
4	3.9	No Response
102	100.0	TOTAL

PLEASE PROVIDE ANSWERS TO THE FOLLOWING QUESTIONS.

1. In your clinical practice, are you:

RESPONSE

96 Currently affiliated with a Health Maintenance Organization (HMO) or other prepaid health care plan?

Nature of your affiliation:

83	Contractual
0	Salaried
8	Other:
3	- Fee-For-Service
5	- Capitation

5 No Response

3 Not currently affiliated with an HMO but have been in the past 3 years?

3 Not affiliated with an HMO and have not been in the past 3 years?

2. Name of plans with which you are/were affiliated?

RESPONSE

- 45 HUMANA GOLD PLUS PLAN in Dade, Broward, & Palm Beach counties service area
- 10 HUMANA GOLD PLUS PLAN in Pinellas, Hillsborough, & Pasco counties service area
- 28 CAC-RAMSAY
- 64 AV-MED HEALTH PLAN
- 58 HEALTH OPTIONS OF SOUTH FLORIDA
- 52 CAREFLORIDA (formerly Heritage)
- 23 OTHER(S):
 - 16 - METLIFE
 - 7 - PRU-CARE

3. Do you serve Medicare patients?

RESPONSE

- 102 YES
- 0 NO

4. What are the reasons you believe Medicare beneficiaries ENROLL in HMO plans?

RESPONSE

- 75 - Reduced costs of services.
- 19 - Unlimited free care.
- 3 - Improved advertising campaigns.
- 2 - Avoidance of paperwork.
- 1 - False advertising.
- 1 - Other answers not listed/no answer.
- 1 - All medical services in one place.

5. **What are the reasons you believe Medicare beneficiaries DISENROLL from HMO plans?**

RESPONSE

- 31 - Quality of care issues.
- 19 - Restrictions and limitations on services.
- 17 - Limited doctors available, especially consultants.
- 11 - Disenchantment with plan.
- 7 - No answer
- 6 - Misunderstanding of plan and/or benefits.
- 6 - Unrealistic expectations of plan.
- 5 - "Snowbirds" (moving in and out of area)

6. **Data maintained by the Health Care Financing Administration show a small percentage of Medicare beneficiaries ENROLL AND DISENROLL in HMOs numerous times. Why do you think they do this?**

RESPONSE

- 25 - Looking for better plan.
- 19 - No other answer.
- 17 - Manipulated by salesman.
- 13 - Quality of care issues.
- 10 - Misunderstanding of system/plan.
- 9 - "Snowbirds" (moving in and out of area)
- 5 - Unrealistic expectations of plan.
- 3 - Dementia
- 1 - Propaganda through media.

7. **What are the effects on health care quality for patients who move in and out of HMOs, or between HMOs, frequently?**

RESPONSE

- 85 - The effects of frequent movement on medical care would be:
 - 61 - Lack of continuity of care.
 - 15 - Degrading quality of care.
 - 6 - Duplication of test and/or procedures.
 - 3 - Uncontrolled medical records.
- 10 - Quality of medical care is not necessarily affected.
- 7 - No other answer or other.
- 19 - Doctor provided additional comments.

APPENDIX D

EFFECT OF HUMANA ON DATA ANALYSIS

Beneficiaries in the Miami area have five HMO plans to choose from. The unusually high rate at which they change plans reflects the availability of several competing plans.

Humana's Florida enrollment is five to 14 times larger than the Miami area HMOs included in this study. Because no data was available on Humana's enrollee population in the Miami area only, the Humana figures can skew the analysis of HMO-to-HMO turnover in the Miami area.

The following analysis, therefore, treats Humana separately, and demonstrates the effect of its Florida-wide experience on the turnover analysis. Excluding the Humana population, of all Medicare beneficiaries who disenrolled from their HMOs within 12 months of enrolling, 26% went to Medicare's fee-for-service coverage and remained there for at least one year. Sixty percent immediately enrolled in another HMO; and the remaining 14% moved to fee-for-service coverage, but once again joined an HMO within 12 months. Figures for the Humana Florida-wide HMO, its Miami area HMO competitors and all five HMOs combined are shown below.

The figures for Humana, which include its Tampa/St.Petersburg, Orlando and Daytona markets where there are no HMO competitors, are quite different. Due to Humana's much greater size, including its figures in the overall analysis substantially changes the conclusion regarding beneficiary enrollment patterns.

HUMANA FLORIDA - WIDE COMPARED TO ITS MIAMI AREA COMPETITORS ACTIONS OF MEDICARE BENEFICIARIES WHO DISENROLLED			
	Went To Fee-For-Svc. For At Least 12 Months	Went To Competing HMO	Went To Fee-For-Svc. But Joined HMO Within 12 Months
Humana (FL Wide)	56%	19%	25%
Miami Area HMO Competitors	26%	60%	14%
All 5 HMOs Combined	44%	35%	21%

Even though Medicare HMO enrollees in South Florida disenroll from their HMOs with much greater frequency than their peers nationwide (28% disenrollment within one year in South Florida vs. 16% nationwide) their loyalty to the HMO form of coverage is remarkably high. Figures from this inspection show that nearly 3/4 of all Miami area beneficiaries who leave HMOs and have other HMOs available join another HMO immediately or within the next 12 months.

APPENDIX E

COMMENTS TO DRAFT REPORT

Comments on the draft report were received from HCFA and the Assistant Secretary for Planning and Evaluation (ASPE). Both agencies agree that HCFA should identify and review frequent enrollment changes, and HCFA believes they now have that capability. While ASPE supported the concept of a "cooling off" period for Medicare enrollees, HCFA thinks a "cooling off" period is not needed.

Neither agency concurred with the other recommendations. We will defer our comments on their responses until the OIG completes its national study on HMO disenrollments (OEI-06-91-00730).

We have responded to each of the technical changes suggested by HCFA and ASPE.



Carson
Brown
Reg. 4 Office of the Secretary

Washington, D.C. 20201

MAY 29 1991

KS	_____
FDHG	_____
DIG-AS	_____
DIG-EE	_____
DIG-OI	_____
AIG-MP	_____
OGC/IG	_____
EX SEC	_____
DATE SENT	<u>5/31</u>

RECEIVED
OFFICE OF INSPECTOR
GENERAL
MAY 31 11:11 AM '91

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Reports: Marketing Practices and Enrollment
Patterns for South Florida HMOs, OEI-04-91-00630 and
OEI-04-91-00640 -- COMMENTS

I appreciate the opportunity to comment on the reports. In general, they appear to point more to the need for improved data collection, closer monitoring and follow-up, particularly on disenrollment patterns, than for implementation of new procedures. Consequently, I am inclined to disagree with certain of your recommendations, as noted below.

o OEI-04-91-00630: Marketing Practices

- HCFA to establish standards for sales force training and monitoring: I understand that HCFA has worked informally with the Group Health Association of America to improve marketing practices of HMO sales representatives nationally. Responsibility for oversight of marketing staff rests with state licensing agencies.
- Limit enrollment to one "open season" per year. This recommendation would require legislation and has the appearance of a year-long lock-in which Congress has constantly rejected. Moreover, section 6206 of OBRA-89 eliminated a coordinated open enrollment requirement, which had never been implemented, except under certain circumstances. Continuous open enrollment in competitive markets allows beneficiaries to select the benefit package that best fits their needs, regardless of when that decision is reached (and, given the data on page 8 of the Miami Area HMO's report, at most, sales representatives appear responsible for only 20 percent of changes compared with nearly three times more who expressed dissatisfaction regarding HMO physicians or services). Admittedly, this practice requires closer monitoring against abusive marketing practices.

- Based on the preceding comment, I agree that HCFA should establish systems to identify and review cases of frequent enrollment change. Cases in which marketing abuses are suspected should be reported to state licensing agencies.
- Third party handling of HMO enrollment actions: Except for existing authority to disenroll at Social Security District Offices, closer monitoring and follow-up would be preferable. Otherwise, responsibility for training salespersons and the question of payment for these services arise.
- I support the concept of a "cooling off" period for Medicare risk enrollees.

o OEI-04-91-00640: Enrollment Patterns

- This analysis indicates the need for more data collection, closer monitoring and follow-up. The inability to segregate the Miami Area enrollment for Humana makes it difficult to interpret the results.

o Editorial Comments

Regarding both reports, I suggest that OIG staff solicit technical assistance from HCFA/Office of Prepaid Health Care Operations and Oversight on the "Background" sections which distinguish fee-for-service from prepaid health plans. See, for example, the attached pages.



Martin H. Gerry

Attachments



Memorandum

AUG 15 1991

1501 10 19 AM 10:28

Date
From Gail R. Wilensky, Ph.D. *grw*
Administrator

Subject
OIG Draft Reports: "Marketing Practices and Enrollment Patterns for South Florida HMOs" (OEI-04-91-00630 and OEI-04-91-00640)

To
Inspector General
Office of the Secretary

We have reviewed the above referenced draft reports evaluating Health Maintenance Organization (HMO) marketing practices for South Florida and HMO enrollment patterns in the Miami area. As an overall comment on each of the above reports, we view the findings as generally positive in that they dispel many of the erroneous preconceptions about the marketing and enrollment practices of Medicare-contracting HMOs in the South Florida area.

Given the positive nature of the reports, we do not believe that the findings as reported in the two reports warrant all of the changes in the Medicare HMO program suggested by OIG. However, we agree with one of your recommendations. Our specific comments on the reports' recommendations are attached for your consideration.

Thank you for the opportunity to comment on these reports. Please advise us of whether you agree with our position on the reports' recommendations at your earliest convenience.

Attachment

IG	<input checked="" type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input checked="" type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
AIG-MP	<input checked="" type="checkbox"/>
OGC/IG	<input checked="" type="checkbox"/>
EX SEC	<input checked="" type="checkbox"/>
DATE SENT	8/20

Comments of the Health Care Financing Administration
on OIG Draft Reports:
"Marketing Practices and
Enrollment Patterns for South Florida HMOs"
(OEI-04-91-00630 and OEI-04-91-00640)

Recommendation 1 is contained only in OEI-04-91-00630. Recommendations 2 through 5 are contained in both OIG reports.

Recommendation

HCFA should establish standards for sales force training and monitoring, and hold HMOs accountable for maintaining those standards.

HCFA Response

We do not believe it is appropriate or necessary to prescribe more than the general standards for sales activities of organizations that are already required for HCFA contracts. HMOs are currently held accountable for marketing practices that lead to erroneous and uninformed enrollments. Without effective sales force training and monitoring, an HMO will be subject to contract termination, intermediate sanctions, and/or civil monetary penalties for marketing and enrollment failures. Under the authority of 42 CFR §417.428(a), which requires an HMO to provide a written statement of rules "and other information for beneficiaries to make an informed decision about enrollment," HCFA has taken a number of actions to correct problems found at individual HMOs.

In Southern California, for example, where there have been problems with beneficiaries not understanding lock-in, an after-the-fact (i.e., "after-sale") enrollment verification process is the norm among all HMOs in the area, and the situation has improved as a result of the efforts of the HCFA regional office. Similarly, for Humana Medical Plan of Florida, we believe that marketing practices have significantly improved since October, 1990 (after the OIG survey of beneficiaries) as a result of Humana's working with the HCFA regional and central office staff, in conjunction with intensified monitoring of the Plan. HCFA was successful in its efforts to encourage Humana to set up its own internal monitoring of certain operations, and we can monitor Humana through its internal reports.

We believe the regulation of insurance and HMO sales agents is more properly a State function and we wish to note that many States impose requirements on HMO marketing personnel and brokers. Florida has taken a number of steps to prevent marketing abuses, including a requirement that there be certification of enrollment in a Medicare HMO by someone other than a sales agent.

Finally, we do believe our civil monetary penalties (CMP) and intermediate sanctions authority in this area could be expanded. Currently, although CMPs and intermediate sanctions can be applied against entities that provide false information, we do not have that authority in regard to entities that engage in door-to-door marketing or that offer gifts or payment of more than a nominal value to induce enrollment. In addition, we currently only have the authority to impose a CMP against an entity; we do not have the option of imposing a CMP against an individual, such as a sales agent. We are submitting an A-19 to the Department which addresses these issues. We would hope that you will support our proposal.

Recommendation

HCFA should establish a policy limiting enrollment to one "open season" (opportunity to enroll) per year.

HCFA Response

We do not believe that OIG findings, which show that a minority of HMO enrollees have had multiple HMO enrollments, are sufficient cause to make a major policy change in HCFA's approach to beneficiaries' ability to choose HMO enrollment as a Medicare option. The OIG found that switching from one plan to another, even on a frequent basis, is not necessarily indicative of marketing or enrollment abuses, but rather beneficiary choice, as noted above. Where "ping-ponging" does in fact result from marketing or enrollment abuses, HCFA has the means to require an HMO to cease such practices.

A hallmark of the Medicare fee-for-service program is the beneficiaries' freedom of choice of providers. Beneficiaries who choose to enroll in a Medicare risk-based HMO consciously choose to receive care from only the HMO providers, in order to minimize their administrative burden and to benefit from lower out-of-pocket costs. Under current law, it should be noted that they are able to exercise the choice between HMOs and fee-for-service at any time, if they choose to disenroll from an HMO. However, there are limitations under current law, if an HMO conducts only the minimum 30-day required annual enrollment period.

HCFA has traditionally viewed the HMO option as a choice that is available on a voluntary basis to beneficiaries residing in areas where Medicare HMOs are available, and we have left it up to the HMOs to decide whether they preferred a policy of enrollment other than on a year-round, continuous basis. Currently, only 3 percent of Medicare beneficiaries are enrolled in Medicare risk-based HMOs. HMOs that have a capacity to conduct continuous open enrollment should be allowed the option of flexible enrollment periods, since it expands beneficiaries' choices.

A legislative change would be necessary to impose a single open enrollment period. Since 1985 (the first year of "TEFRA" Medicare risk contracting), Congress has changed the original provisions of the Social Security Act relating to Medicare HMO enrollment and disenrollment. Congress mandated that Medicare risk-based HMO enrollees have the right of immediate disenrollment from the HMO (to replace the previous provision that could delay a disenrollment for up to 60 days). Congress also did away with a coordinated open enrollment period requirement (introduced in the Deficit Reduction Act of 1984). The intent of Congress has been consistently to give beneficiaries maximum flexibility in choosing the HMO option while giving HMOs the leeway to determine the appropriate enrollment periods.

Recommendation

HCFA should establish an on-line system to identify and review cases of frequent enrollment change.

HCFA Response

HCFA has developed such a capability. The Managed Care Option Information (MCCOY) Group Health Plan (GHP) System provides online management information reports and the capability to update beneficiary enrollments, disenrollments, health status indicators and residence codes. We believe this system satisfies the intent and spirit of OIG's recommendation.

Recommendation

In the three-county Miami service area, HCFA should test the efficacy of a third party handling HMO enrollment actions.

HCFA Response

The efficacy of a third party enrollment process has been tested and many problems were found. We do not believe that the OIG's findings warrant another test because this problem affects a small number of beneficiaries. In the vast majority of cases (72 percent), the beneficiary initiated the first contact with an HMO. A third party enrollment process would be more appropriate in a situation where the HMO contacts the beneficiaries first, in the majority of cases.

If enrollments were the responsibility of a third party, such as the Social Security Administration (SSA) (as OIG suggests), the level of enrollment activity in the Miami area would make the function a massive undertaking in terms of personnel and costs (costs currently financed through the HCFA capitation payments made to the HMOs). Unless the third party could fairly present each HMO's advantages, competition in the marketplace could be stifled. HCFA would also have a new monitoring responsibility of assuring that the third party was properly enrolling individuals in the appropriate HMO, etc.

The OIG may wish to consider the findings of the General Accounting Office (GAO) in its evaluation of the HealthChoice demonstration project in Oregon and California--a demonstration of the use of a third-party broker for Medicare HMO enrollment. Problems that the GAO pointed out included the questionable authority for HCFA's financing the project, unfair treatment of HMOs (those paying the broker for its services versus those that did not), inadequate Privacy Act safeguards, and the erroneous impression given by the broker that it was an agent of the Government. Many of the GAO objections would be obviated if SSA were the third party, but having SSA function as an HMO broker is itself problematic, beginning with the difficulty of getting SSA to agree to undertake such a function. (Please note that the SSA HMO disenrollment function was a legislative mandate.)

Recommendation

HCFA should impose a "cooling off" period allowing beneficiaries to reconsider HMO enrollment decisions before enrollment applications are processed.

HCFA Response

An official "cooling off" period is not needed. If a beneficiary does change his or her mind, there is usually a certain time lag between the marketing presentation and the time the enrollment is actually transmitted to HCFA; a timely cancellation is therefore possible. HCFA also permits retroactive disenrollment of beneficiaries for good cause (for example, failure to fully understand lock-in) if there has not been a fully informed decision to enroll in an HMO.

COMMENTS

General

1. The beneficiary sample of 237 Medicare beneficiaries was taken over a 36-month period ranging from October 1, 1987 to September 30, 1990. During this period, 1 percent of enrollees (1,866 enrollees out of 182,405) were enrolled 4 or more times in South Florida HMOs. Nationally during this same period .3 percent (2,276 out of 881,861) were enrolled 4 or more times in an HMO. Non-South Florida HMOs during the same period had .1 percent of their enrollees enrolled 4 or more times in HMOs. South Florida enrollees thus have enrolled in 4 or more HMOs over the above noted 3-year period at a rate 10 times the national average.

It should always be kept in mind when looking at Medicare enrollment patterns in South Florida that:

- o Medicare enrollees in South Florida are able to change physicians (and HMOs almost as freely as a Medicare fee-for-service enrollee. Most HMOs in South Florida charge no premium to the Medicare beneficiary nor is an individual "locked-in" to any HMO longer than 30 days before a change can be made to another HMO.
- o As we emphasized above, evidence of frequent change of enrollees is not necessarily evidence of illegal or unethical marketing practices.

The report often refers to activity in South Florida as being higher than the national average. It is important to recognize, as noted above, these higher activity levels may be unique to the South Florida market where five "zero premium" plans compete intensely for enrollees, or they may be indicative of "normal" conditions in a highly competitive market. The Southern California market most closely resembles the market studied. Perhaps a comparison of these two areas would be useful.

OIG Response: We added a section that describes the uniqueness of the Miami market to the Background of the report.

2. Page 4 states that Humana data are not included in parts of the analysis since there was no way to distinguish South Florida from other parts of the service area. We believe that analysis of South Florida data without Humana figures presents less than a complete and accurate picture of the situation.

OIG Response: Humana has four separate service areas in Florida: Miami, Tampa, Orlando, and Daytona. The HCFA data base combines enrollment data for all four service areas. It does not distinguish the separate service areas. Therefore, it was not possible to identify Humana enrollment data for Miami alone. Appendix D shows the effect of including the Humana data that represents all of Florida.

Specific

3. Page i

Although five TEFRA risk contractors serve the area, it should be noted that Medicare beneficiaries may also be members of HMOs or other entities which are not Federally qualified. In paragraph three of the BACKGROUND section, sentence three should read "Beneficiaries enrolled in risk-based HMOs are considered to be "locked in..."

OIG Response: We have revised the sentence.

4. Page 3

Comprehensive American Care is now CAC-RAMSAY, Inc.

OIG Response: We have made that change throughout the report.

5. Page 5

TEFRA risk-based contract enrollment is now approximately 1.3 million, and was about the same level during the period of the OIG study.

OIG Response: We revised the figure, and adjusted the percent enrolled in Miami HMOs.

6. Page 8

"only four of the 237..." Since only 136 responses were received, should this be 136?

OIG Response: We have made the correction.

7. Page 9

How many of the 16,000 beneficiary inquiries were complaints? Of those, how many were legitimate complaints about enrollment and disenrollment? Of the 1,500 "potentially fraudulent" HMO enrollments and 1,800 failures to disenroll, how many provided, upon investigation, to be the fault of the HMO?

It is not clear what is meant by the potentially inflammatory term "inappropriate" in sentence two of the final paragraph. What is the basis on which HCFA (and which HCFA component) has estimated that 20 percent of enrollments or disenrollments are inappropriate?

OIG Response: We revised the report to show that Region IV HCFA provided the estimates cited.

8. APPENDIX A

Page A-2, last paragraph. The data reflecting at least four enrollments actually means at least three changes, since the individual would have been in an HMO on the starting date of the study period. Another data run with a threshold of 4 changes would likely show significantly fewer beneficiaries involved.

OIG Response: We acknowledge that a data run with a threshold higher than four would likely show fewer beneficiaries. A threshold of four was chosen for this study.

9. APPENDIX B

The small number of responses (136) and the use of proxy information raises questions of overall value of the information gained.

It is important to distinguish which of the various operational elements of the Plan influence the enrollment and disenrollment process (e.g., marketing agency activity, member services, as well as the health care providers). In this way, specific problems or perceptions can be more accurately attributed.

OIG Response: Our survey of beneficiaries did not identify the specific operational element that influenced the enrollment and disenrollment activity. Appendix B reports each reason they gave us for changing HMOs.

10. Page B-7

The chart is incomplete. There are 8 responses identified, but only seven are reflected in the chart.

OIG Response: We have deleted the chart as it duplicated information found elsewhere in Appendix B.

11. APPENDIX C

Appendix C should be deleted from the report as well as references to Appendix C in the body of the report. Appendix C: HMO Enrollment Survey of South Florida Physicians sought to ascertain "why physicians thought beneficiaries changed HMO plans so frequently." Physicians have no reason to determine, and perhaps no way of ascertaining, why a patient left them if the first they learn of the patients' departure is from the physicians panel, through a deletion from an eligibility listing, or a request for records transferral from another physician.

Therefore, the evaluation of a physician's assessment of why a Medicare enrollee left one HMO to join another is anecdotal at best and certainly not informed or statistically valid. It would have been more effective to ask the HMOs themselves the reasons for enrollee disenrollment, rather than asking the physicians.

OIG Response: We surveyed physicians to obtain their opinions on not only the reasons beneficiaries change HMOs, but also on the effects of rapid turnover.