Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MARKETING PRACTICES OF SOUTH FLORIDA HMOs SERVING MEDICARE BENEFICIARIES

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NOVEMBER 1991

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OEI-04-91-00630

EXECUTIVE SUMMARY

PURPOSE

This report describes marketing practices of risk-contracted health maintenance organizations (HMOs) serving Medicare beneficiaries in South Florida.

BACKGROUND

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

Regular Fee-for-Service Medicare Program - Beneficiaries choose each of their own health care providers. Medicare payments are based on each allowed service the beneficiary receives.

Prepaid Health Plans - Beneficiaries enroll in health organizations which manage their medical care. Under these plans, Medicare pays a predetermined amount per beneficiary enrollee.

The most common types of prepaid health plans are risk-contracted HMOs. Such HMOs are considered "at financial risk" because they agree to provide a beneficiary's total medical care for a set amount each month. Beneficiaries are required to obtain all their medical care through providers affiliated with an HMO, except during (1) an emergency, and (2) periods when care is urgently needed and the beneficiary is out of the HMO service area.

In the fall of 1990, newspapers in South Florida ran articles alleging marketing abuses by HMOs. The articles indicated Medicare beneficiaries are sometimes inappropriately enrolled and not adequately informed of the requirement that all medical care must be received from HMO-affiliated providers. 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 marketing practices. Enrollment patterns are described in a separate report (OEI-04-91-00640).

To analyze marketing practices, we relied on data collected from sampled beneficiaries who enrolled in one of the six South Florida HMOs in 1990, HMO marketing materials, and HMO officials.

FINDINGS

On the positive side, we found that:

- Almost three-fourths of the beneficiaries themselves initiate contact with the HMO and ask about joining. However, this number varies by HMO.

- Few beneficiaries feel pressured by sales staff.

- Most of the beneficiaries know they are enrolling in an HMO and can only use providers affiliated with the HMO. However, this number also varies by HMO.

On the other hand, some instances of inappropriate marketing practices do occur. Some HMOs fail to adequately monitor sales staff, leaving beneficiaries vulnerable to inappropriate marketing practices. We found that:

- Eight percent of the beneficiaries say salespersons made unannounced visits to their homes asking them to enroll in an HMO.

- Nine percent of the beneficiaries say they had not known they were enrolling in an HMO when they signed the application. Another 10 beneficiaries could not be interviewed because they maintained they had not been in an HMO.

- Ten percent of the beneficiaries were unaware they could only use HMO providers.

- Seventeen percent of the beneficiaries were unaware they could "back-out" if they changed their minds after signing the application.

- Some beneficiaries have been vulnerable to unethical sales practices.

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

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

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

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

5. 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. Where appropriate, we made the technical changes they suggested.

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INTRODUCTION

PURPOSE

This report describes marketing practices of risk-contracted health maintenance organizations (HMOs) serving Medicare beneficiaries in South Florida.

BACKGROUND

In the fall of 1990, newspapers in South Florida ran articles alleging marketing abuses by HMOs. The articles indicated Medicare beneficiaries are sometimes inappropriately enrolled and not adequately informed of the requirement that all medical care must be received from HMO-affiliated providers. Monitoring reports from HCFA also noted problems with marketing materials and practices of some South Florida HMOs.

Responding to these concerns, the Administrator of the Health Care Financing Administration (HCFA) requested that the Inspector General conduct an inspection of marketing practices of HMOs serving Medicare beneficiaries in South Florida. An inspection of beneficiaries who repeatedly change their enrollments among South Florida HMOs was conducted at the same time. (OEI-04-91-00640)

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 a fee-for-service program. However, in some places, there are two ways in which beneficiaries may obtain medical care covered by Medicare.

Regular Fee-for-Service Coverage - Beneficiaries choose 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 also have to 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.

Beneficiaries are required to obtain all their medical care through the providers affiliated with the HMO, except for emergency and out-of-area 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 HMO 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. Some live in

Florida full-time. Others live there only part of the year, and reside in other States the rest of the time.[1]

In most locations, only one or two HMOs are available to Medicare beneficiaries. 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.

The HMOs Serving Beneficiaries in South Florida

Six HMOs currently serve beneficiaries in South Florida. For the purpose of this study, the Humana Medical Plan serving the Miami area and the plan serving the Tampa area were treated as two separate HMOs. Although the Humana corporate policies are the same for both areas, the marketing practices may differ. In Tampa, Humana is the only risk-contracted HMO available. In Miami, Humana has competition from four other such plans serving Medicare beneficiaries.

The six HMOs serving beneficiaries in South Florida are:

- Humana Medical Plan (Tampa);
- Humana Medical Plan (Miami);
- CAC-RAMSAY;
- Av-Med Health Plan;
- Health Options of South Florida; and
- CareFlorida.

None of these HMOs charge an HMO monthly premium. They all charge copayments for some services not covered by the regular Medicare program, such as dental care. Only two, Health Options and Av-Med, charge copayments for physician services.

The HMOs vary in their methods of operation:

- Health Options and Av-Med provide services solely through contracted physicians and providers.

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

- CAC has a combination of HMO-owned medical centers and contracted private physicians. The CAC regional offices coordinate patients' care and referrals made by PCPs. The corporate office pays the specialists for the services they render.

- Humana also has a combination of HMO-owned medical centers and contracted private physicians and physician groups. Humana has risk contracts with all its contracted PCPs. The HMO provides each PCP (or PCP group) a set amount each month per HMO patient. The PCP controls and pays for all care the beneficiary receives, whether through the PCP or specialists.

- CareFlorida uses only contracted private physicians to provide care. Thirteen PCP groups are under a risk contract and 240 PCPs are not at risk. Some of those under a risk contract do their own advertising and have their own salespersons. Some industry people refer to this type arrangement as a "mini-HMO."

SCOPE

We examined the marketing practices of the six risk-contracted HMOs serving Medicare beneficiaries in the counties of Dade, Broward, Palm Beach, Hillsborough, Pinellas, and Pasco.

Although these HMOs may serve beneficiaries in other areas, we included only the South Florida operations in this inspection.

Medicare enrollment and service areas for the six HMOs currently serving beneficiaries in South Florida are:

NAME	MEDICARE ENROLLEES*	COUNTIES SERVED
Humana Medical Plan	62,722	Pinellas, Hillsborough, Pasco (Tampa area)
Humana Medical Plan	100,503	Dade, Broward, Palm Beach (Miami area)
CAC-RAMSAY	19,090	Dade, Broward
Av-Med Health Plan	17,138	Dade, Broward, Palm Beach
Health Options of South Florida	11,300	Dade, Broward
CareFlorida	10,484	Dade, Broward, Palm Beach

* *Number of Medicare members as of February 1991, according to the HMOs.*

METHODS

We obtained information for this study from various sources, including:

- a review of HCFA regulations to determine Federal requirements for HMOs;
- a review of the marketing materials used by each HMO to determine if they meet HCFA requirements;
- discussions with officials representing each HMO to learn each company's policies and practices;
- a telephone survey of 601 randomly selected Medicare beneficiaries to ascertain their experiences in joining an HMO; and
- face-to-face interviews with 22 beneficiaries who had 15 or more multiple enrollments in HMOs to determine their reasons for changing HMOs.

Telephone Survey

We drew a sample of 833 beneficiaries from a universe of 37,423 beneficiaries who enrolled in one of the South Florida HMOs between January and October 1990. This was their first, and only, enrollment in an HMO.

The survey was conducted January 7-25, 1991. A total of 601 of the 833 beneficiaries were interviewed, yielding an overall response rate of 72 percent.

Another 10 beneficiaries were contacted, but could not be interviewed. They maintained they had not been in an HMO and could not answer questions about enrollment.

Face-to-Face Interviews

Through their data base, the HCFA Region IV office identified 26 beneficiaries who had each enrolled in different HMOs 15 or more times since becoming eligible for Medicare. Because of HCFA's concern about multiple enrollments, we included these beneficiaries in our study. Staff conducted face-to-face interviews with 22 of the 26 during January 28-31, 1991 to determine their reasons for multiple enrollments.

Appendix A describes in greater detail the data collection methods used in this inspection. Appendix B contains the telephone survey instrument and response frequencies, by HMO. Appendix C contains the survey instrument and response frequencies to the face-to-face interviews with beneficiaries. The analysis of nonrespondents is found in appendix D.

FINDINGS

MOST BENEFICIARIES INITIATE CONTACT WITH THE HMO TO ENROLL. HOWEVER, THE PERCENT VARIES BY HMO.

Our interviews with 601 HMO enrollees showed that almost three-fourths (72 percent) of the beneficiaries say they themselves had contacted the HMO about joining.

Although 25 percent of the beneficiaries say the HMO approached them about joining, the number varies widely by HMO. For example, 10 percent of the beneficiaries in Av-Med say the HMO contacted them, whereas 41 percent in CareFlorida say they were contacted by the HMO.

Three percent of the beneficiaries do not remember who initiated the contact.

How do the beneficiaries hear about the HMO?

About half of the beneficiaries in the survey indicate they first heard about their HMOs through friends or relatives. Others learned of the HMOs through advertisements on television, in newspapers, and in the mail. Only a few first heard about their HMOs from senior citizen groups, the Social Security office, or other sources. Approximately 2 percent had previously been in the HMO and simply converted to the Medicare component when they turned 65.

Advertising methods vary by HMO and are determined usually by the HMO's size and marketing budget. All have used television, radio, and newspaper advertising at one time or another.

Some HMOs also conduct mass mail-outs of brochures. They purchase lists of elderly persons within a given zip code and send them information about the HMO.

Presentations to groups of senior citizens and participation in "health fairs" are other marketing methods frequently used. Humana and CAC, which have HMO-owned centers, often have "open houses," offering free health screening tests, refreshments, and tours of the facilities.

Humana relies most heavily on television ads. The smaller HMOs use less expensive methods, such as mail-outs and presentations. Advertising by CAC is almost exclusively in Spanish, while the other HMOs primarily advertise to English-speaking audiences.

HMOs USE SEVERAL METHODS TO ADVERTISE						
	Humana Miami	Humana Tampa	CAC	Health Options	Av-Med	Care Florida
Television	Yes	Yes	Yes	Yes		Yes
Radio			Yes			
Newspapers			Yes	Yes		Yes
Mass Mailings	Yes	Yes			Yes	
"Open Houses"	Yes	Yes	Yes			
Phone Solicitation						Yes

What happens after the beneficiary contacts the HMO?

When beneficiaries call the HMO to inquire about joining, they are encouraged to let a salesperson come to their home and explain the program requirements. In most instances, that is what occurs, and the salesperson completes an application if the beneficiary requests to join. However, some beneficiaries prefer that the HMO mail them the additional information and the application, and not send a salesperson.

Where HMOs initiate contact, how do they identify prospective enrollees?

Each of the six HMOs we reviewed solicited Medicare beneficiaries through a door-to-door process--although such solicitation violates HCFA regulation. Of the 601 beneficiaries we interviewed, 150 told us an HMO salesperson had initially contacted them for enrollment. Thirty-four percent of the 150 said the HMO salesperson came to their homes, soliciting their enrollment in an HMO. Thus, about eight percent of the 601 we interviewed received unannounced visits from HMO salespersons asking them to enroll.

Salespersons used various sources to identify potential beneficiaries for HMO enrollment. The sources included relatives, friends, and doctors. About 64 percent of the 150 beneficiaries solicited by the HMOs we reviewed said they did not know how the HMO salesperson obtained their names. All of the HMOs included in our analysis reported that their salespersons obtain leads for potential enrollees from current members and functions such as open houses or presentations on the HMO.

FEW BENEFICIARIES FEEL PRESSURED BY SALES STAFF.

Only four percent of the beneficiaries say they felt pressured to join the HMO. Most beneficiaries who felt pressured cite persistence of the salesperson. Some say the salespersons kept calling them. Other beneficiaries say the salesperson repeatedly

extolled the benefits of the plan in a poor economy. Two beneficiaries were told enrollment in an HMO would not affect their way of getting medical care, and one was told her enrollment would help the salesperson.

Two beneficiaries say the salespersons misrepresented the agencies with which they were affiliated.

Who are the salespersons who visit beneficiaries?

The types of salespersons who market HMOs vary by plan. Most are either (1) HMO employees who market only the HMO, or (2) private independent insurance salespersons who market the HMO in addition to other products, such as Medicare supplemental policies. Florida law requires that all HMO salespersons be licensed as insurance agents.

In Miami, Humana has 140 salespersons employed by the HMO and 12 independent agents. In Tampa, Humana has a sales force of 75 employees.

The CAC plan has a sales force of 25-30 employees.

Health Options, which is owned by Blue Cross/Blue Shield, has contracted with 40 senior citizens who market the HMO and sell other Blue Cross/Blue Shield products.

CareFlorida employs six full-time salespersons. They also use 60-70 independent agents, although only 15 of them are said to generate significant business. Some of their 13 risk-contracted PCPs also have sales staffs of independent agents.

Av-Med has 7 salespersons employed by the HMO and 15 independent agents.

What type of training do salespersons receive?

Although HCFA has no requirement for training salespersons, each HMO provides some training for new staff.

Humana has the most extensive sales force training. Initially, each salesperson receives 30 hours of classroom training. He/she is tested and must score 72 (out of a possible 100) overall, and must correctly answer an essay question about "lock-in[2]." During the salesperson's first two weeks on the job, management observes five presentations. The salesperson is retested every six months and must score 77 overall and 100 on the "lock-in" question.

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[2]"Lock-in" refers to a requirement that all medical care must be received from HMO-affiliated providers.

Health Options provides eight or more hours of formal training for new salespersons and quarterly training for all the sales force. Health Options also tests its salespersons once a quarter.

The sales staff of CAC receive two to three days of formal training.

Both CareFlorida and Av-Med provide less formal training for their sales staffs.

Although only Humana and Health Options have formal retraining, all HMOs have regular meetings with their sales staff. The meetings are scheduled as follows:

HMO SALES STAFF MEET REGULARLY			
	Weekly	**Twice Monthly**	**Monthly**
HUMANA MIAMI	Yes		
HUMANA TAMPA	Yes		
CAC			Yes
HEALTH OPTIONS		Yes	
AV-MED	Yes		
CAREFLORIDA			
Employees	Yes		
Independent Agents *(Includes some PCP-based agents)*		Yes	
Independent Agents From 3 PCPs			Yes

How are sales staffs paid?

All HMOs pay salespersons a commission for each beneficiary enrolled. The amount per person enrolled increases with the number of enrollees per month. For example, the HMO may pay the salesperson $60 for each of the first 20 enrollees in a month and $75 for additional enrollees that month. The dollar amounts vary by HMO, as do the commission policies.

The CAC pays a retention fee of $2.00 for every month a beneficiary remains enrolled in the HMO. CAC believes this provides an incentive for sales staff to remain with the HMO and keep beneficiaries they have enrolled in the plan. When a salesperson moves to another HMO, he/she may persuade members to change to the other plan. Humana and Health Options pay salespersons a lump sum amount after a beneficiary has been enrolled a specified number of months. Humana pays $25 after a beneficiary has been enrolled for 13 months. Health Options pays $5 after six months.

CareFlorida staggers commission payments to its independent agents. Half is paid when the beneficiary enrolls. One-fourth is paid when the beneficiary has been enrolled three months, and the remaining fourth is paid when the beneficiary has been enrolled six months. CareFlorida does not pay a commission for the third time a beneficiary enrolls within 12 months.

Humana, CAC, and Av-Med revoke commissions if the beneficiary disenrolls within 90 days.

The following chart illustrates the differences in sales staff pay structures among the HMOs.

HMO COMPENSATION POLICIES DIFFER							
	Humana Miami	Humana Tampa	CAC	Health Options	Av-Med	Care Florida	
SALES COMPENSATION						Employee	Independent
Payment for enrolling 30 beneficiaries	$2,250	$2,250	$1,500	$1,662	$1,800	$2,875	$1,590
Penalty for early outs	90 Days	90 days	90 days	None	90 days	None	None
"Bonus" for longevity	Yes	Yes	Yes	Yes	No	No	Yes
"Bonus" on 30 enrollees staying 18 months	$750	$750	$1,080	$150	$0	$0	$1,500
Total payment on 30 enrollees staying 18 mo.	$3,000	$3,000	$2,580	$1,812	$1,800	$2,875	$3,090
Quotas: Employees	20	20	None	None	None	20	
Indep. Agents	None	None	None	None	None		None

How do HMOs monitor their salespersons' activities?

The HCFA has no specific requirement for monitoring enrollment practices of HMO salespersons. The HMOs we reviewed, however, have several methods for identifying and curtailing inappropriate enrollment practices by their sales staff. Some have also implemented processes for discouraging and correcting improper practices.

First, HMOs are required by Florida law to conduct an enrollment verification. Generally, HMO employees other than salespersons are expected to call potential enrollees before processing their application and ensure that they: (1) know they are joining and HMO and (2) understand the "lock-in" concept. Potential enrollees who do not understand are either provided further information or referred to the

marketing department for further explanation before enrollment. One of the six HMOs we reviewed, Humana, also telephones beneficiaries about 10 days after their enrollment to answer questions and ensure that they have received membership materials.

Second, each HMO receives beneficiary complaints and appeals which provide information on enrollment practices of salespersons.

Third, two HMOs, Humana and CAC, kept records on salespersons who appeared to have provided inadequate or erroneous information to potential enrollees. Humana referred such cases to a private company for investigation. Where such investigations confirmed inappropriate practices, Humana took disciplinary action, including warnings, retraining, and termination. One HMO, Health Options, did not keep records on claims of inappropriate enrollments by salespersons, stating that such practices were so few, records were not warranted.

MOST BENEFICIARIES UNDERSTAND HMO REQUIREMENTS BEFORE THEY ENROLL. HOWEVER, THIS VARIES BY HMO.

How do beneficiaries get information?

In most instances, beneficiaries talk to at least two HMO representatives and receive written material prior to enrolling. First, salespersons explain the program and provide some written information. Then, the HMO calls beneficiaries to verify their intent to enroll and their understanding of "lock-in." After enrollment, members are mailed additional written information, usually a handbook, that describes the program and requirements. Humana also calls the beneficiary again after 10 days and conducts group meetings for new enrollees.

The HCFA regulations require that HMOs provide prospective enrollees with written material which fully explains program requirements and beneficiary rights. The membership materials reviewed for this inspection have clear explanations of program requirements, particularly "lock-in."

Do beneficiaries understand the requirements before they enroll?

Overall, we found that most beneficiaries knew about HMO requirements before they joined. However, the number who understand varies by HMO.

- Ninety percent knew they were enrolling in an HMO when they signed the application form. Most who did not know thought they were applying for supplemental insurance or additional benefits. Five people did not remember signing an application.

- Eighty-nine percent knew they could only use medical providers affiliated with the HMO (except for emergency or urgently-needed care).

- Seventy percent knew they must pay for care incurred outside the HMO (except for emergency or urgently-needed care). Ten percent do not remember if they had known this when they enrolled.

The proportion of beneficiaries who are knowledgeable about program requirements varies by HMO of enrollment. To determine if factors other than the HMO of enrollment account for this variation, age and gender of the respondents were considered. The analysis showed that understanding of the "lock-in" provisions of HMO membership did correlate with age; that is, older respondents seem not to have understood the "lock-in" provisions as well as younger people.

To adjust for these differences, the responses to three survey questions were standardized by age and gender, and the response frequencies recalculated. The following table shows that knowledge of "lock-in" related program requirements still differs among enrollees in the six HMOs, even after standardization. (See page A-3 for the method used to standardize for age and gender.)

BENEFICIARIES' KNOWLEDGE OF REQUIREMENTS DIFFERS BY HMO

When Signed Application:	Human Miami	Human Tampa	CAC	Health Options	Av-Med	Care Florida
Did Not Know Enrolling in an HMO	9%	5%	15%	4%	13%	26%
Did Not Understand Lock-In	11%	6%	13%	4%	17%	25%
Did Not Know Could "Back Out" Prior to Enrollment Becoming Effective	21%	6%	26%	8%	14%	36%

This table indicates that some HMOs, such as Health Options and Humana in Tampa, have been more successful in imparting program information than others, such as CareFlorida.

At the time they applied for HMO coverage, almost 90 percent of the beneficiaries knew when their enrollment would be effective and how to get medical services. Eighty-three percent knew what to do in regard to coverage for emergency treatment. About three-fourths knew how to see a specialist and to get other information they needed about the HMO.

Although 81 percent knew they could have "backed out" prior to their date of enrollment, only 61 percent knew how to disenroll. The marketing materials beneficiaries receive prior to enrolling inform them of their ability to disenroll and

their right to appeal. The procedures for these actions, however, are described in the handbooks beneficiaries receive after enrolling.

Enrollees of HMOs maintain their Medicare right to appeal denials of claims. They may appeal denials of payments for emergency and urgently needed care received outside the HMO. They may also appeal refusals of service. However, only 35 percent know how to appeal these HMO decisions.

Most beneficiaries (88 percent) say they think their salespersons gave them accurate information. Only five percent say they were given inaccurate information. The others either do not know if the information is accurate or they do not remember.

How do the HMOs compare in marketing approaches and operations?

The chart on the following page provides a summary of HMO operations and some findings from the telephone survey of beneficiaries. Responses to the survey have been standardized to accommodate the respondents' age and gender differences among the HMOs.

SUMMARY OF HMO SURVEYS

	Humana Miami	Humana Tampa	CAC	Health Options	Av-Med	Care Florida Employee	Care Florida Independent
HMO SURVEY							
Sales Staff							
Employees	140	75	25+		7	6	
Independent Agents	12				15		60+
Contracted				40+			
Sales Compensation							
Payment For Enrolling 30 Beneficiaries	$2,250	$2,250	$1,500	$1,662	$1,800	$2,875	$1,590
Penalty For Early Outs	90 Days	90 Days	90 Days	NONE	90 Days	NONE	NONE
"Bonus" For Longevity	YES	YES	YES	YES	NO	NO	YES
"Bonus" on 30 Enrollees Staying 18 Months	$750	$750	$1,080	$150	$0	$0	$1,500
Total Payment On 30 Enrollees Staying 18 Mo.	$3,000	$3,000	$2,580	$1,812	$1,800	$2,785	$3,090
Quotas: Employees	20	20	NONE	NONE	NONE	20	
Indep. Agents	NONE	NONE	NONE	NONE	NONE		NONE
Sales Staff Training							
Initial Training	30 hr	30 hr	2-3 Days	8+hr	Informal	Informal	Informal
Retraining	YES	YES	No	YES	No	No	No
Marketing Approaches							
Television	YES	YES	YES	YES		YES	
Radio			YES	YES			
Newspapers			YES	YES		YES	
Mass Mailings	YES	YES			YES		
"Open Houses"	YES	YES	YES	YES			
Phone Solicitation						YES	
BENEFICIARY SURVEY RESPONSES							
Aspects of Enrollment ...							
Pressured to Join	3.7%	4.6%	2.5%	0.0%	4.2%	5.0%	
Not Clear Enrolling in HMO	9.0%	4.8%	14.5%	4.4%	12.7%	25.8%	
Unaware of Lock-In	11.2%	5.8%	13.1%	3.8%	16.8%	24.5%	
Unaware of Back-Out	20.8%	5.6%	25.6%	7.6%	14.1%	36.3%	
Initiation of HMO Contact							
HMO Initiated Contact	22.2%	35.6%	28.3%	16.6%	8.2%	40.6%	
Sales Rep. Visited Home	7.4%	9.8%	7.9%	9.1%	2.1%	17.9%	
Aspects of Services.......							
Seen MD Since Joining	81.7%	86.3%	82.1%	80.7%	78.3%	70.9%	
Services Found Later Not To be covered	16.3%	11.4%	10.1%	13.7%	16.6%	7.6%	
Unable to See Needed Physician	11.2%	13.0%	7.4%	8.1%	7.4%	6.6%	
Services Worse Than Previous Care Source	15.0%	18.7%	11.2%	7.9%	5.4%	13.3%	

SOME HMOs FAIL TO ADEQUATELY MONITOR SALES STAFF, LEAVING BENEFICIARIES VULNERABLE TO INAPPROPRIATE MARKETING PRACTICES.

Although HMOs have changed several policies within the last few years to better monitor sales staffs and curtail inappropriate practices, several HMO practices may still leave beneficiaries vulnerable to inappropriate enrollment. For example, HMOs have little or no control over salespersons attached to PCPs and clinics or independent agents. Further, HMOs sometimes compromise the integrity of enrollment verification by conducting the verification while salespersons are present in beneficiaries' homes.

- Salespersons Attached to PCPs or Clinics

  The HMO has little control over salespersons attached to PCPs or clinics. When PCPs or clinics are financially responsible for all care provided to their enrollees (e.g., "at risk"), their interest in who is enrolled and who is not may be influenced by the health status of the member. Having the means to control enrollments and disenrollments makes it possible for PCPs to enroll beneficiaries while healthy, then disenroll them when sick.

  Also, a beneficiary may feel compelled to join an HMO if his doctor's agent (a PCP salesperson) approaches him about enrolling. Further, if he enrolls in an HMO because of his own primary physician's affiliation with it, he may be less likely to understand "lock-in" as it relates to ancillary health care providers.

  CareFlorida currently uses salespersons attached to PCPs or PCP-groups.

- Use of Independent Agents

  Again, HMOs currently exercise little control over salespersons not in their employ. Although these agents have signed Codes of Ethics and other affidavits agreeing to adhere to HCFA and HMO marketing guidelines, they may not be as committed to follow them as an HMO employee would be. They do not have as much to lose if found using inappropriate marketing methods. These sales agents may lose their association with the HMO, but they would not jeopardize their eligibility to market other products.

  The fact that these agents market products in addition to HMOs could also hamper a beneficiary's understanding of "lock-in." If the salesperson discusses several products, the beneficiary may not realize it is an HMO for which he/she has applied. Nine percent of the beneficiaries in the survey did not realize they had applied for an HMO when they signed the application.

  CareFlorida, Av-Med, and Humana in Miami currently use independent agents.

- Enrollment Verification Conducted from Beneficiary's Home

  Consistent with Florida law, most HMOs telephone potential enrollees for verification after the salesperson has left the home and submitted the application for processing. However, one HMO, Humana, telephones the HMO from the beneficiary's home immediately after taking the application. The HMO interviewer completes the telephone verification at that time. A beneficiary who has felt pressured to join or does not understand the requirements may not be willing to tell the interviewer while the salesperson is present. Making the verification call several days after the application is signed enables a beneficiary who has changed his mind to more easily "back out." Although Humana calls beneficiaries again, it is <u>10 days after they have been enrolled</u>.

  Also, verification conducted from the beneficiary's home may make the HMO vulnerable to claims of fraudulent enrollments. Since the salesperson places the call to the HMO, the verifier has no assurance that the individual the salesperson has him talk to is an actual applicant.

SOME BENEFICIARIES HAVE BEEN VULNERABLE TO UNETHICAL SALES PRACTICES.

Some beneficiaries are not fully aware of their actions when enrolling in or changing HMOs, and may be particularly vulnerable to unethical sales practices.

The HCFA Region IV office identified several blatant cases of abuse. According to their records, the five HMOs in the Miami area had enrolled 26 beneficiaries a total of 424 times since 1981. According to Florida newspaper articles, one of these beneficiaries was reported to have been unaware that she had enrolled 16 times in at least five HMOs since 1987.

The HCFA records show that all 26 of these beneficiaries were enrolled in an HMO plan during the period of this inspection. We conducted face-to-face interviews with 22 of them. Four could not be located.

These beneficiaries were especially vulnerable people. Some could not read. Some had no transportation. Most did not have a regular physician. Many had problems remembering their health coverage circumstances. Some seemed unconcerned about these enrollment issues. Seventeen stated that they didn't know they would be disenrolled automatically from their current HMO if they enrolled in another one.

The disorientation of such individuals can make them more susceptible to aggressive or unscrupulous sales representatives. In fact, 16 of the 22 people (over 70 percent) said that they had been influenced to change HMOs by sales representatives of the

HMOs. This reason had been given by only 20 percent of the beneficiaries in a survey of a general sample of 136 multiple enrollees. (OEI-04-91-00640).

The enrollment records of these 26 individuals showed that virtually all of the multiple enrollments were in three HMOs in 1990. The table below shows these activities.

ENROLLMENT ACTIONS OF 26 BENEFICIARIES TOTALLED 86 IN 1990		
Number of Enrollment Actions	**In:**	**Average Length of Enrollment**
26	CAC	3.88 Months
36	CareFlorida	3.14 Months
24	Humana	3.58 Months
86		3.49 Months

Each beneficiary was shown his/her enrollment history which identified the current and all previous enrollments. When these beneficiaries were asked about their reasons for changing, the most common answers were:

- convinced by an HMO representative;
- did not like previous HMO; and
- services were restricted or limited.

Several of these beneficiaries described actions by HMO representatives which violate HCFA regulations and indicate abusive practices.

- Several beneficiaries reported that HMO representatives came to the their homes or communal gathering places and persuaded them to join an HMO, while assuring them that their enrollment actions would not affect their Medicare coverage.
- One beneficiary said a "driver" picked him up to keep a medical appointment at his HMO. However, the driver took the beneficiary to a new HMO, whereupon he was enrolled in that HMO plan. The beneficiary thought he was merely keeping his appointment with his current HMO.
- One beneficiary who was barely able to move said an HMO representative forcibly placed a pen in her hand and told her to sign the enrollment application. She signed.

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 addressing troublesome situations encountered during this inspection of South Florida HMOs.

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

South Florida HMOs now engage salespersons in three ways:

- as HMO employees;
- as contracted agents marketing only that company's products; and
- as independent agents who sell a variety of insurance products in addition to HMO coverage.

Training and monitoring of these salespersons vary widely by HMO and by type of sales agent. Medicare-contracted HMOs must be accountable for the actions and sales practices of their agents, regardless of the manner of employment.

The HCFA should develop standards for the content, duration and frequency of training of sales agents, and should require HMOs to certify that those standards are being upheld. Appropriate training of new salespersons must apply equally to independent agents and HMO marketing staff. Periodic sales meetings should be held to impart information on new HCFA regulations and policies. Such meetings should also be used to correct aberrant sales practices detected by the HMOs.

Salespersons should be tested to assure that they understand all germane Medicare rules, HMO services, and restrictions, as well as individual company policies. Salespersons should be retrained as necessary and retested periodically. The HMOs should maintain records of each agent's participation in training and performance on tests.

The HCFA should require that each HMO maintain records on and investigate enrollee complaints about sales staff. Where a determination is made that individual agents have been involved in inappropriate marketing and enrollment activities, such as "cold calls" to Medicare beneficiaries' homes, HCFA should require that disciplinary measures be taken.

2. *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 30 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. 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 the criteria for determining whether sufficient "cause" is established.

3. *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., 6 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 #2 above or Recommendation #4 below.

4. ***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 sales person 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 sales person and even of the HMO.

We recommend that HCFA contract, on a 2 to 3 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 are provided to the contractor, this recommendation would obviate Recommendations #2 and #3 above.

5. ***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 SELECTION

Information for this inspection was obtained from:

- a review of HCFA regulations to determine Federal requirements for HMOs;
- a review of the marketing materials used by each HMO to determine if they meet HCFA requirements;
- discussions with officials representing each HMO to learn each company's policies and practices;
- a telephone survey of 601 randomly selected Medicare beneficiaries to ascertain their experiences joining an HMO; and
- face-to-face interviews with 22 beneficiaries who had 15 or more multiple enrollments to determine their reasons for changing HMOs frequently.

Review of HCFA Regulations

The HCFA regulations relating to HMO requirements were examined to compare with HMO practices. Monitoring requirements for HCFA site visits and reports of HCFA visits to each of the HMOs were also reviewed.

Review of HMO Marketing Requirements

Marketing and membership materials from each HMO were examined for compliance with HCFA requirements. Particular attention was paid to each HMO's explanation of "lock-in," instructions for obtaining emergency and urgently-needed care, and procedures for filing complaints and appeals.

Discussions with HMO Officials

Site visits were made to all HMOs to verify their marketing policies and procedures. Discussions were held with HMO officials such as Chief Operating Officers and Medicare Compliance Directors. In each location, Marketing Directors and Customer Service Managers were always included in the discussions.

Telephone Survey of Beneficiaries

The survey universe consisted of 37,423 beneficiaries who enrolled in one of the six selected South Florida HMOs between January and October 1990. This was their first, and only, enrollment in an HMO. Eighty-two percent of them were still members as of November 1. Eighteen percent had disenrolled and returned to the regular fee-for-service Medicare program.

A stratified sample of 839 of these beneficiaries was selected. The sample was reduced to 833 because 6 beneficiaries were deceased.

The survey was conducted between January 7 and 25, 1991. A letter was sent to each person in the sample explaining the purpose of the survey. Each was asked to provide his/her telephone number by returning a postcard enclosed with the letter. Phone numbers were also obtained from Directory Assistance and directories that list telephone numbers by street addresses.

Postcards were sent to beneficiaries for whom no telephone numbers could be found, and to beneficiaries who could not be reached after calling their homes at least three times. Those beneficiaries were asked to call a toll-free telephone number so an appointment to conduct the survey could be arranged.

From the sample of 833 beneficiaries, 601 interviews were conducted yielding an overall response rate of 72 percent.

The sample and response rate from each HMO was as follows:

HMO	NUMBER IN SAMPLE	NUMBER OF RESPONSES	RESPONSE RATE
Humana - Miami	210	135	0.64
Humana - Tampa	95	94	0.98
CAC	132	81	0.61
Av-Med	133	92	0.69
Health Options	132	103	0.78
CareFlorida	131	96	0.73
	833	601	

To compute overall findings for the report, responses to the questionnaire were weighted according to each HMO's proportion of the universe. The unweighted actual frequencies of responses, however, are shown in appendix B.

In addition to the 601 beneficiaries interviewed, another 10 beneficiaries were contacted, but could not be interviewed. They maintained they had not been in an HMO and could not answer questions about enrollment. HCFA records indicate all 10 had been in HMOs, and that, as of November 1, 1990, 5 were still enrolled. The enrollments were distributed fairly evenly among the HMOs:

- two in Humana-Miami;
- one in Humana-Tampa;
- two in CAC;
- one in Av-Med;
- two in Health Options; and
- two in CareFlorida.

Standardization of Responses

Due to differences in the age and gender distribution of enrollees among the HMOs, the proportions of respondents answering each question were standardized to eliminate differences that might be attributable solely to the age and gender of an enrollee. Using the total population of respondents as the referent group, the direct method of standardization was used.[1] Within the two genders, three age groups were created: under 65 years of age, 65 to 74 years of age, and 75 years of age or older. The six categories, with the appropriate weights are:

Age Group	Sex	Weight
< 65 Yrs.	Male	0.070
	Female	0.073
65-74 Yrs.	Male	0.297
	Female	0.347
75 + Yrs.	Male	0.085
	Female	0.128

The responses in tables on pages 12 and 14 present standardized proportions.

[1] Harold A. Kahn and Christopher T. Sempos, Statistical Methods in Epidemiology, Oxford University Press, 1989

Face-to-Face Interviews

The HCFA Region IV office identified 26 beneficiaries whom HMOs had enrolled a total of 424 times in the last 10 years. Face-to-face interviews were conducted with these beneficiaries.

We interviewed 21 of the 26 beneficiaries and the spouse of a recently deceased beneficiary. We were unable to locate the remaining four beneficiaries. The interviews were performed between January 28 and 31, 1991. The response rate was 85 percent. Appendix C contains the survey instrument and response frequencies.

APPENDIX B

RESPONSES TO TELEPHONE SURVEY OF BENEFICIARIES

The answers shown below in capital letters were not read to respondents. No prompts of possible answers were given to respondents.

- The first number listed shows the frequency of responses for the 601 respondents to the survey. Numbers in parenthesis reflect the unweighted percent of responses overall and within each HMO. The sum of the individual percentages may not equal 100 percent due to independent rounding.

- Not all respondents answered every question.

- Legend:

H(M)	=	Humana - Miami
H(T)	=	Humana - Tampa
CAC	=	Comprehensive American Care
Av-Med	=	Av-Med Health Plan
Health Op	=	Health Options
CFL	=	CareFlorida

1. **How did you first hear about (Name of HMO)?**
(Respondents could mention more than one means.)

FROM FRIEND OR RELATIVE: 316

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
81	50	42	53	51	39

TELEVISION ADVERTISING: 96

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
31	21	15	12	12	5

HMO SALESPERSON CAME TO HOME: 52

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
6	11	9	0	7	19

NEWSPAPER ADVERTISING: 47

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
8	4	5	17	10	3

ADVERTISEMENTS IN THE MAIL: 28

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
4	7	4	8	4	1

FROM DOCTOR'S OFFICE: 21

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	6	5	3	7

RADIO ADVERTISING: 17

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3	3	7	0	2	2

AT SENIOR CITIZEN'S GROUP: 8

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3	1	0	0	1	3

FROM SOCIAL SECURITY OFFICE: 4

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2	0	1	0	0	1

OTHER: 112

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
18	9	22	10	27	26

2. a. **Did you call (Name of HMO) to get information, or did (Name of HMO) contact you to ask you to enroll?**

BENEFICIARY INITIATED CONTACT: 433 (72%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
100(74%)	62(66%)	55(68%)	78(85%)	83(81%)	55(57%)

HMO INITIATED CONTACT: 150 (25%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
30(22%)	31(33%)	24(30%)	9(10%)	17(17%)	39(41%)

BENEFICIARY DOES NOT REMEMBER: 17 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(4%)	1(1%)	1(1%)	5(5%)	3(3%)	2(2%)

Number Not Responding: 1 (0.1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	1(1%)	0	0	0

b. **How did the HMO contact you?**
(Asked only of the 150 who said the HMO contacted them.)

SALESPERSON STOPPED BY HOME: 57 (38%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
10(33%)	10(32%)	7(29%)	2(22%)	11(65%)	17(44%)

SALESPERSON CONTACTED BENEFICIARY BY PHONE: 51 (34%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
12(40%)	13(42%)	8(33%)	5(56%)	3(18%)	10(26%)

SALESPERSON STOPPED BY A "GROUP GATHERING PLACE" (like a Senior Citizen's Center): 3 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(3%)	1(3%)	0	0	0	1(3%)

SALESPERSON CONTACTED BY OTHER MEANS: 39 (26%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
7(23%)	7(23%)	9(38%)	2(22%)	3(18%)	11(28%)

3. **a. Do you know how the salesperson got your name?**
(Asked only of the 150 who said the HMO contacted them.)

NO: 87 (58%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
19(63%)	25(81%)	9(38%)	6(67%)	8(47%)	20(51%)

YES: 52 (35%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
9(30)	5(16%)	10(42%)	3(33%)	7(41%)	18(46%)

Number Not Responding: 11 (7%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(7%)	1(3%)	5(21%)	0	2(12%)	1(3%)

b. Where?
(Asked only of the 52 who answered YES to 3.a.)

SALESPERSON GOT NAME FROM FRIEND OR RELATIVE: 13 (25%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(33%)	3(60%)	1(10%)	2(67%)	2(29%)	2(11%)

SALESPERSON GOT NAME FROM BENEFICIARY'S DOCTOR: 7 (13%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	2(20%)	0	1(14%)	4(22%)

SALESPERSON GOT NAME FROM MEDICARE: 5 (10%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(22%)	1(20%)	2(20%)	0	0	0

SALESPERSON GOT NAME FROM SOCIAL SECURITY: 4 (8%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(11%)	1(20%)	0	0	0	2(11%)

SALESPERSON GOT NAME FROM OTHER SOURCE: 23 (44%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(33%)	0	5(50%)	1(33%)	4(57%)	10(56%)

4. **Where did the salesperson say he or she was from?**

THE HMO: 504 (84%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
120(89%)	84(89%)	62(77%)	83(90%)	77(75%)	78(81%)

THE GOVERNMENT: 2 (0.3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	1(1%)	0	0	1(1%)

SALESPERSON DID NOT SAY: 7 (1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	1(1%)	2(2%)	1(1%)	3(3%)

BENEFICIARY DOES NOT REMEMBER: 31 (5%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
10(7%)	4(4%)	5(6%)	1(1%)	7(7%)	4(4%)

Number Not Responding: 57 (9%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(4%)	6(6%)	12(15%)	6(7%)	18(17%)	10(10%)

5. **Who filled out the application form?**

SALESPERSON: 323 (54%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
80(59%)	61(65%)	42(52%)	40(43%)	37(36%)	63(66%)

BENEFICIARY: 188 (31%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
39(29%)	20(21%)	15(19%)	40(43%)	52(50%)	22(23%)

FRIEND OR RELATIVE: 24 (4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(2%)	4(4%)	5(6%)	4(4%)	4(4%)	4(4%)

DOCTOR'S OFFICE: 5 (1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	2(2%)	0	0	3(3%)

SOCIAL SECURITY OFFICE: 2 (0.3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	1(1%)	0	0	1(1%)

OTHER: 28 (5%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(4%)	4(4%)	11(14%)	4(4%)	2(2%)	2(2%)

BENEFICIARY DOES NOT REMEMBER: 28 (5%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
8(6%)	5(5%)	3(4%)	3(3%)	8(8%)	1(1%)

Number Not Responding: 3 (0.4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	2(2%)	1(1%)	0	0

6. **a. When you signed the application, was it clear to you that you were enrolling in a Health Maintenance Organization?**

YES: 525 (87%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL

122(90%)	88(94%)	67(83%)	80(87%)	97(94%)	71(74%)

NO: 66 (11%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
13(10%)	5(5%)	11(14%)	10(11%)	5(5%)	22(23%)

BENEFICIARY DOES NOT REMEMBER SIGNING APPLICATION: 5 (1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	1(1%)	1(1%)	0	3(3%)

Number Not Responding: 5 (1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	1(1%)	2(2%)	1(1%)	1(1%)	0

b. Do you recall what you thought you were signing?
(Asked only of the 66 who answered NO to 6.a.)

NO: 18 (27%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(38%)	0	6(55%)	1(10%)	0	6(27%)

YES: 46 (70%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
6(46%)	5(100%)	5(45%)	9(90%)	5(100%)	16(73%)

Number Not Responding: 2 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(15%)	0	0	0	0	0

c. What did you think you were signing?
(Asked only of the 46 who answered YES to 6.b.)

APPLICATION FOR SUPPLEMENTAL INSURANCE: 15 (33%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(17%)	1(20%)	2(40%)	3(33%)	3(60%)	5(31%)

APPLICATION FOR ADDITIONAL BENEFITS: 8 (17%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(50%)	1(20%)	0	2(22%)	0	2(13%)

FORM FOR MEDICARE/GOVERNMENT: 7 (15%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	1(20%)	3(60%)	2(22%)	0	1(6%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	1(20%)	3(60%)	2(22%)	0	

OTHER: 5 (11%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(17%)	1(20%)	0	0	0	3(19%)

Number Not Responding: 11 (24%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(17%)	1(20%)	0	2(22%)	2(40%)	5(31%)

7. **When you signed the application, did you know that unless it was an emergency, or you were outside the service area and urgently needed care, you could only go to (Name of HMO's) doctors, hospitals, and medical providers?**

YES: 527 (88%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
120(89%)	88(94%)	68(84%)	78(85%)	98(95%)	75(78%)

NO: 69 (11%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
15(11%)	6(6%)	10(12%)	13(14%)	4(4%)	21(22%)

Number Not Responding: 5 (1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	3(4%)	1(1%)	1(1%)	0

8. **When enrolled in the HMO, did the salesperson ask if you:**

a. Were in good health?

YES: 282 (47%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
76(56%)	50(53%)	31(38%)	36(39%)	45(44%)	44(46%)

NO: 181 (30%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
31(23%)	23(24%)	39(48%)	24(26%)	33(32%)	31(32%)

BENEFICIARY DOES NOT REMEMBER: 127 (21%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
28(21%)	21(22%)	9(11%)	29(32%)	19(18%)	21(22%)

Number Not Responding: 11 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	2(2%)	3(3%)	6(6%)	0

b. Had health problems?

YES: 246 (41%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
66(49%)	47(50%)	27(33%)	37(40%)	37(36%)	32(33%)

NO: 229 (38%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
43(32%)	28(30%)	44(54%)	28(30%)	42(41%)	44(46%)

BENEFICIARY DOES NOT REMEMBER: 117 (19%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
26(19%)	19(20%)	8(10%)	26(28%)	18(17%)	20(21%)

Number Not Responding: 9 (1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL

0	0	2(2%)	1(1%)	6(6%)	0

c. Were being treated by a doctor?

YES: 252 (42%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
67(50%)	49(52%)	27(33%)	35(38%)	34(33%)	40(42%)

NO: 201 (33%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
41(30%)	20(21%)	38(47%)	26(28%)	41(40%)	35(36%)

BENEFICIARY DOES NOT REMEMBER: 138 (23%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
27(20%)	25(27%)	14(17%)	30(33%)	21(20%)	21(22%)

Number Not Responding: 10 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	2(2%)	1(1%)	7(7%)	0

d. Needed medical services at the time?

YES: 177 (29%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
48(36%)	30(32%)	19(23%)	23(25%)	25(24%)	32(33%)

NO: 263 (44%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
60(44%)	37(39%)	45(56%)	27(29%)	52(50%)	42(44%)

BENEFICIARY DOES NOT REMEMBER: 140 (23%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
26(19%)	27(29%)	15(19%)	31(34%)	19(18%)	22(23%)

Number Not Responding: 21 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(1%)	0	2(2%)	11(12%)	7(7%)	0

9. Did the salesperson push you or pressure you to join (Name of HMO)?

YES: 21 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(4%)	5(5%)	2(2%)	4(4%)	0	5(5%)

NO: 564 (94%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
130(96%)	88(94%)	73(90%)	87(95%)	95(92%)	91(95%)

Number Not Responding: 16 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	1(1%)	6(7%)	1(1%)	8(8%)	0

10. Were you offered any incentives, like a gift, to join (Name of HMO)?

YES: 0

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	0	0	0	0

NO: 589 (98%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
135(100%)	94(100%)	76(94%)	91(99%)	97(94%)	96(100%)

Number Not Responding: 12 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	5(6%)	1(1%)	6(6%)	0

11. I'm going to read to you some methods a salesperson might use to try to get people to join an HMO. Did the salesperson that signed you up use any of these?

a. Keep encouraging you to join even if you said you were not interested?

YES: 20(3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	7(7%)	3(4%)	1(1%)	2(2%)	7(7%)

NO: 540 (90%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
132(98%)	85(90%)	67(83%)	86(93%)	89(86%)	81(84%)

BENEFICIARY DOES NOT REMEMBER: 22 (4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(2%)	1(1%)	4(5%)	3(3%)	3(3%)	8(8%)

Number Not Responding: 19 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	1(1%)	7(9%)	2(2%)	9(9%)	0

b. Promise to leave as soon as you signed?

YES: 37 (6%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(4%)	9(10%)	6(7%)	4(4%)	8(8%)	5(5%)

NO: 487 (81%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
123(91%)	74(79%)	47(58%)	81(88%)	78(76%)	84(88%)

BENEFICIARY DOES NOT REMEMBER: 41 (7%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
7(5%)	6(6%)	11(14%)	4(4%)	6(6%)	7(7%)

Number Not Responding: 36 (6%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL

0	5(5%)	17(21%)	3(3%)	11(11%)	0

c. Tell you it would be more difficult to sign up if you waited until later?

YES: 24 (4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
4(3%)	8(9%)	0	3(3%)	5(5%)	4(4%)

NO: 518 (86%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
123(91%)	77(82%)	67(83%)	83(90%)	83(81%)	85(89%)

BENEFICIARY DOES NOT REMEMBER: 39 (6%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
8(6%)	7(7%)	7(9%)	4(4%)	6(6%)	7(7%)

Number Not Responding: 20 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	2(2%)	7(9%)	2(2%)	9(9%)	0

d. Tell you it would be hard to get medical care if you did not join?

YES: 8 (1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(1%)	3(3%)	0	0	1(1%)	3(3%)

NO: 546 (91%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
129(96%)	88(94%)	66(81%)	87(95%)	91(88%)	85(89%)

BENEFICIARY DOES NOT REMEMBER: 28 (5%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(4%)	2(2%)	8(10%)	3(3%)	2(2%)	8(8%)

Number Not Responding: 19 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	1(1%)	7(9%)	2(2%)	9(9%)	0

e. Is there anything else you would like to say about the methods the salesperson used to try to get you to sign up?

YES: 88 (15%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
23(17%)	26(28%)	12(15%)	7(8%)	11(11%)	9(9%)

NO: 490 (82%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
112(83%)	67(71%)	58(72%)	83(90%)	83(81%)	87(91%)

Number Not Responding: 23 (4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	1(1%)	11(14%)	2(2%)	9(9%)	0

12. **After you signed the application, did you know you could change your mind and "back out" before the enrollment took effect?**

YES: 480 (80%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
104(77%)	86(91%)	58(72%)	75(82%)	93(90%)	64(67%)

NO: 109 (18%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
29(21%)	6(6%)	20(25%)	14(15%)	8(8%)	32(33%)

Number Not Responding: 12 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	2(2%)	3(4%)	3(3%)	2(2%)	0

13. **At the time you signed up, did you know:**

a. The date your enrollment would take effect?

YES: 511 (85%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
115(85%)	87(93%)	68(84%)	78(85%)	92(89%)	71(74%)

NO: 34 (6%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
12(9%)	3(3%)	1(1%)	7(8%)	2(2%)	9(9%)

BENEFICIARY DOES NOT REMEMBER: 44 (7%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
7(5%)	2(2%)	9(11%)	4(4%)	6(6%)	16(17%)

Number Not Responding: 12 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(1%)	2(2%)	3(4%)	3(3%)	3(3%)	0

b. How to get medical services?

YES: 523 (87%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
119(88%)	83(88%)	63(78%)	83(90%)	94(91%)	81(84%)

NO: 43 (7%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
10(7%)	6(6%)	8(10%)	3(3%)	5(5%)	11(11%)

BENEFICIARY DOES NOT REMEMBER: 22 (4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(4%)	3(3%)	7(9%)	2(2%)	1(1%)	4(4%)

Number Not Responding: 13 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(1%)	2(2%)	3(4%)	4(4%)	3(3%)	0

c. What you should do in emergency situations?

YES: 482 (80%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
117(87%)	76(81%)	62(77%)	69(75%)	87(84%)	71(74%)

NO: 76 (13%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
15(11%)	12(13%)	8(10%)	13(14%)	9(9%)	19(20%)

BENEFICIARY DOES NOT REMEMBER: 29 (5%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	4(4%)	8(10%)	6(7%)	4(4%)	5(5%)

Number Not Responding: 14 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(1%)	2(2%)	3(4%)	4(4%)	3(3%)	1(1%)

d. What to do if you needed to see a specialist?

YES: 454 (76%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
101(75%)	66(70%)	57(70%)	79(86%)	94(91%)	57(59%)

NO: 95 (16%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
27(20%)	20(21%)	12(15%)	6(7%)	4(4%)	26(27%)

BENEFICIARY DOES NOT REMEMBER: 38 (6%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
6(4%)	6(6%)	9(11%)	3(3%)	2(2%)	12(13%)

Number Not Responding: 14 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(1%)	2(2%)	3(4%)	4(4%)	3(3%)	1(1%)

e. How to get other information you needed?

YES: 426 (71%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
98(73%)	70(74%)	53(65%)	72(78%)	86(83%)	47(49%)

NO: 98 (16%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
21(16%)	12(13%)	11(14%)	12(13%)	13(13%)	29(30%)

BENEFICIARY DOES NOT REMEMBER: 61 (10%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL

13(10%)	10(11%)	14(17%)	4(4%)	1(1%)	19(20%)

Number Not Responding: 16 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(2%)	2(2%)	3(4%)	4(4%)	3(3%)	1(1%)

f. How to disenroll, or "get out" of the HMO?

YES: 368 (61%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
80(59%)	60(64%)	48(59%)	55(60%)	74(72%)	51(53%)

NO: 175 (29%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
43(32%)	24(26%)	21(26%)	27(29%)	24(23%)	36(38%)

BENEFICIARY DOES NOT REMEMBER: 45 (7%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
11(8%)	8(9%)	9(11%)	6(7%)	3(3%)	8(8%)

Number Not Responding: 13 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(1%)	2(2%)	3(4%)	4(4%)	2(2%)	1(1%)

g. How to appeal decisions (Name of HMO) makes concerning your medical care?

YES: 219 (36%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
43(32%)	39(41%)	23(28%)	35(38%)	51(50%)	28(29%)

NO: 259 (43%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
68(50%)	39(41%)	28(35%)	38(41%)	36(35%)	50(52%)

BENEFICIARY DOES NOT REMEMBER: 109 (18%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
23(17%)	14(15%)	26(32%)	15(16%)	14(14%)	17(18%)

Number Not Responding: 14 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
1(1%)	2(2%)	4(5%)	4(4%)	2(2%)	1(1%)

14. In addition to the things I just mentioned, is there anything you later learned about being in an HMO that you wished you had known before you signed up?

YES: 100 (17%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
27(20%)	19(20%)	9(11%)	16(17%)	16(16%)	13(14%)

NO: 483 (80%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL

106(79%)	73(78%)	66(81%)	72(78%)	84(82%)	82(85%)

Number Not Responding: 18 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	2(2%)	6(7%)	4(4%)	3(3%)	1(1%)

15. **Before you signed up for (Name of HMO), or at the time you signed up, did the salesperson give you a Member's Handbook or other written material that explained how the HMO worked?**

YES, SALESPERSON LEFT SUCH MATERIAL: 443 (74%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
114(84%)	80(85%)	57(70%)	71(77%)	73(71%)	48(50%)

SALESPERSON DID NOT LEAVE MATERIAL, BUT IT WAS MAILED: 83 (14%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
10(7%)	8(9%)	9(11%)	14(15%)	16(16%)	26(27%)

SALESPERSON DID NOT LEAVE ANY MATERIAL: 19 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
4(3%)	3(3%)	2(2%)	0	2(2%)	8(8%)

SALESPERSON LEFT SOME MATERIAL, BUT BENEFICIARY DOES NOT REMEMBER WHAT IT WAS: 15 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	0	3(4%)	0	0	10(10%)

BENEFICIARY DOES NOT REMEMBER IF RECEIVED ANY MATERIAL: 13 (2%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(2%)	1(1%)	2(2%)	2(2%)	2(2%)	3(3%)

Number Not Responding: 28 (5%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	2(2%)	8(10%)	5(5%)	10(10%)	1(1%)

16. **Were you later mailed a notification of the date your enrollment in (Name of HMO) began?**

YES: 512 (85%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
111(82%)	81(86%)	66(81%)	78(85%)	95(92%)	81(84%)

NO: 22 (4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
7(5%)	3(3%)	2(2%)	2(2%)	1(1%)	7(7%)

BENEFICIARY DOES NOT REMEMBER: 51 (8%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
14(10%)	9(10%)	9(11%)	8(9%)	4(4%)	7(7%)

Number Not Responding: 16 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(2%)	1(1%)	4(5%)	4(4%)	3(3%)	1(1%)

17. **Thinking about the things the salesperson told you about (Name of HMO), would you say the salesperson gave you accurate information?**

YES: 504 (84%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
120(89%)	88(94%)	63(78%)	76(83%)	87(84%)	70(73%)

NO: 34 (6%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
6(4%)	3(3%)	7(9%)	6(7%)	2(2%)	10(10%)

DO NOT KNOW: 18 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
5(4%)	0	2(2%)	3(3%)	0	8(8%)

OTHER RESPONSES: 20 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	1(1%)	2(2%)	2(2%)	8(8%)	5(5%)

BENEFICIARY DOES NOT REMEMBER: 5 (1%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
0	0	3(4%)	1(1%)	0	1(1%)

Number Not Responding: 20 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	2(2%)	4(5%)	4(4%)	6(6%)	2(2%)

18. **When the salesperson talked to you about enrolling in (Name of HMO), did he or she explain that when you are in an HMO...**

a. Unless it was an emergency, you needed to get (Name of HMO)'s permission before you went to doctors or hospitals not part of (Name of HMO)?

YES: 428 (71%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
101(75%)	72(77%)	49(60%)	67(73%)	74(72%)	65(68%)

NO: 87 (14%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
20(15%)	12(13%)	15(19%)	11(12%)	11(11%)	18(19%)

BENEFICIARY DOES NOT REMEMBER: 59 (10%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
12(9%)	7(7%)	10(12%)	10(11%)	9(9%)	11(11%)

Number Not Responding: 27 (4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	3(3%)	7(9%)	4(4%)	9(9%)	2(2%)

b. If you did not get (Name of HMO)'s permission, and it was not an emergency, you would have to pay for visits to doctors and hospitals that are not affiliated with (Name of HMO)?

YES: 399 (66%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
100(74%)	67(71%)	45(56%)	66(72%)	62(60%)	59(61%)

NO: 112 (19%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
18(13%)	17(18%)	17(21%)	13(14%)	20(19%)	27(28%)

BENEFICIARY DOES NOT REMEMBER: 63 (10%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
15(11%)	7(7%)	12(15%)	9(10%)	12(12%)	8(8%)

Number Not Responding: 27 (4%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	3(3%)	7(9%)	4(4%)	9(9%)	2(2%)

c. Medicare would be paying (Name of HMO) for your medical care and would not make payments directly to doctors?

YES: 399 (66%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
93(69%)	69(73%)	48(59%)	70(76%)	65(63%)	54(56%)

NO: 106 (18%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
23(17%)	13(14%)	16(20%)	10(11%)	18(17%)	26(27%)

BENEFICIARY DOES NOT REMEMBER: 68 (11%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
17(13%)	9(10%)	10(12%)	7(8%)	11(11%)	14(15%)

Number Not Responding: 28 (5%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	3(3%)	7(9%)	5(5%)	9(9%)	2(2%)

19. Since you have been in (Name of HMO), have there been times when you needed to see a doctor, but haven't been able to?

YES: 56 (9%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
14(10%)	13(14%)	6(7%)	7(8%)	9(9%)	7(7%)

NO: 529 (88%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
119(88%)	79(84%)	71(88%)	80(87%)	92(89%)	88(92%)

Number Not Responding: 16 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
2(1%)	2(2%)	4(5%)	5(5%)	2(2%)	1(1%)

20. Since you have been enrolled in (Name of HMO), have you been told that some services you wanted were not covered?

YES: 80 (13%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
21(16%)	13(14%)	8(10%)	15(16%)	15(15%)	8(8%)

NO: 503 (84%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
111(82%)	79(84%)	69(85%)	72(78%)	86(83%)	86(90%)

Number Not Responding: 18 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(2%)	2(2%)	4(5%)	5(5%)	2(2%)	2(2%)

21. How would you compare the care you have received while in (Name of HMO) with the medical care you received before you joined? Would you say the care you have received while in (Name of HMO) is?

BETTER THAN YOUR PREVIOUS CARE: 116 (19%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
30(22%)	13(14%)	18(22%)	16(16%)	16(15%)	23(24%)

ABOUT THE SAME AS YOUR PREVIOUS CARE: 245 (41%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
41(30%)	47(50%)	31(38%)	46(50%)	50(49%)	30(31%)

NOT AS GOOD AS YOUR PREVIOUS CARE: 73 (12%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
20(15%)	18(19%)	9(11%)	5(5%)	8(8%)	13(14%)

BENEFICIARY CAN'T OR WON'T COMPARE CARE: 147 (24%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
41(30%)	14(15%)	18(22%)	20(22%)	27(26%)	27(28%)

Number Not Responding: 20 (3%)

H(M)	H(T)	CAC	Av-Med	Health Op	CFL
3(2%)	2(2%)	5(6%)	5(5%)	2(2%)	3(3%)

APPENDIX C

RESPONSES TO FACE-TO-FACE INTERVIEWS WITH BENEFICIARIES

The following are the results of face-to-face interviews with 22 of 26 beneficiaries who were identified by HCFA as having enrolled in HMOs an excessive number of times. Four beneficiaries could not be located. Each beneficiary was shown his/her HMO enrollment history which identified the current and all previous enrollments.

RESULTS: PERSONS INTERVIEWED:

21 BENEFICIARIES
1 RESPONSIBLE PARTY: Spouse

I would like to ask you some questions about your experiences with Health Maintenance Organizations.

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

RESPONSES 22 - LIVE IN FLORIDA YEAR-ROUND

2. *Are you currently enrolled in an HMO?*

RESPONSES 1 - NO - (GO TO #4)
19 - YES
2 - DON'T KNOW

3. *In which HMO are you (currently) enrolled?*

RESPONSES 10 - Humana Gold Plus Plan (Dade, Broward, & Palm Beach)
5 - CAC-RAMSAY
5 - CareFlorida
2 - DON'T KNOW

Show and briefly explain to the beneficiary his/her HMO enrollment history

4. *Do you remember signing an application form to enroll in these HMO plans?*

RESPONSES 5 - NO
17 - YES

5. *What were the reasons you changed from each of these plans (PLANS IDENTIFIED IN QUESTION #4) to another?*

REASONS
- 7 - DOES NOT KNOW WHY
- 11 - HMO REPRESENTATIVE CONVINCED BENEFICIARY TO CHANGE
- 4 - UNHAPPY WITH SERVICES OF HMO

6. *Did any of these plans make a special offer; give you a free gift; or give you money to enroll in their plan?*

RESPONSES
- 4 - BENEFICIARY DOESN'T REMEMBER
- 18 - NO

7. *When you signed the application form, was it clear that by enrolling in this new HMO, you would be automatically <u>dis</u>enrolled from your current HMO? (PROVIDE ILLUSTRATION TO BENEFICIARY BASED ON HIS/HER HMO ENROLLMENT HISTORY AND INDICATE HMO BY NAME.)*

RESPONSES
- 8 - BENEFICIARY DOESN'T REMEMBER
- 5 - YES, IT WAS CLEAR
- 9 - NO, IT WAS NOT CLEAR

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

8. *Because you needed to see a doctor more often than your plan would allow?*

RESPONSES
- 5 - BENEFICIARY DOESN'T REMEMBER
- 16 - NO
- 1 - YES

9. *Have you ever changed plans because you needed services of a specialist and those services were not available in your plan?*

RESPONSES
- 4 - BENEFICIARY DOESN'T REMEMBER
- 18 - NO
- 0 - YES

10. *Have you ever changed plans because you wanted to use a specific doctor and he/she was not in your plan?*

RESPONSES 4 - BENEFICIARY DOESN'T REMEMBER
16 - NO
2 - YES

11. Have you ever changed plans because your doctor left the plan and you wanted to continue with that doctor?

RESPONSES 4 - BENEFICIARY DOESN'T REMEMBER
15 - NO
3 - YES

12. Have you ever changed plans because your doctor advised you to change to another plan?

RESPONSES 3 - BENEFICIARY DOESN'T REMEMBER
16 - NO
3 - YES

13. Have you ever changed plans because <u>an HMO sales representative</u> advised you to join a new plan? (NOTE: A SALESMAN COULD ADVISE AN ENROLLEE TO JOIN HIS PLAN <u>OR</u> JOIN ANOTHER PLAN IN ORDER TO DISENROLL A BENEFICIARY.)

RESPONSES 5 - BENEFICIARY DOESN'T REMEMBER
1 - NO
16 - YES

(A) *What HMO did that salesman represent?*

<u>RESPONSES</u>

16 - BENEFICIARY DOESN'T REMEMBER

(B) *Do you know the salesman's name?*

<u>RESPONSES</u>

16 - NO

(C) *Which plan did he/she suggest you to enroll in?*

<u>RESPONSES</u>

16 - BENEFICIARY DOESN'T REMEMBER

14. Have you ever changed plans because a friend or relative suggested that you join a different plan?

RESPONSES 4 - BENEFICIARY DOESN'T REMEMBER
17 - NO
1 - YES

15. Have you ever changed plans because you didn't like the plan you were in?

RESPONSES 4 - BENEFICIARY DOESN'T REMEMBER
12 - NO
6 - YES

(A) *IF YES, Which plan did you dislike and why?*

RESPONSES

6 - BENEFICIARY DOESN'T REMEMBER

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

RESPONSES 7 - BENEFICIARY DOESN'T REMEMBER
15 - NO

17. Do you plan to change from (CURRENT HMO PLAN) to another plan?

RESPONSES 4 - BENEFICIARY DOESN'T REMEMBER
17 - NO
1 - YES

18. Would you like to tell us anything else regarding why you have changed HMOs?

RESPONSES 18 - NO FURTHER COMMENT WAS MADE
4 - YES

APPENDIX D

ANALYSIS OF RESPONDENTS VS. NONRESPONDENTS

Much of the information regarding marketing practices of South Florida HMOs was gathered directly from Medicare beneficiaries who had recently enrolled in those HMOs. A statistically representative sample of the recent-enrollee population was selected to be interviewed by phone.

A response rate of 72 percent was achieved. However, the possibility of a nonresponse bias must be considered. That is, it must be assured that the survey results would have been the same if the entire sample had been interviewed.

Since it is not possible to know how those not interviewed would have responded to the questions, certain assumptions must be made, based on what is known about the nonrespondents.

The data base from which the sample was drawn contains certain demographic information for each individual, notably gender and age. With these data elements, it is then possible to compare the demographic characteristics of nonrespondents to respondents.

If the characteristics are different, it is necessary to determine whether these characteristics correlate with certain responses from the individuals interviewed. Assuming the same correlations exist for the nonrespondents, it can be determined whether survey results would have been different if all individuals in the sample had responded.

VARIABLES ANALYZED

For this analysis, three characteristics of individuals in the sample were used: age, gender, and HMO in which the individual is/was enrolled. The frequencies of these characteristics in the respondent group were compared against the nonrespondent group.

Where frequencies differed among the two groups (and it might be suspected that different survey results would be found if all persons in the sample had been interviewed), it was determined if any of these three characteristics affected responses to our interview questions.

Three questions on the survey instrument were chosen for comparison of responses:

Q #2. Did you call (Name of HMO) to get information, or did (Name of HMO) contact you to ask you to enroll?

Possible answers:
____ Beneficiary initiated contact
____ HMO initiated contact
____ Beneficiary does not remember

Q #6. When you signed the application form, was it clear to you that you were enrolling in a Health Maintenance Organization?

Possible answers:
____ Yes
____ No
____ Beneficiary does not remember signing application

Q #7. When you signed the application form, did you know that unless it was an emergency, or you were outside the service area and urgently needed care, you could only go to (Name of HMO)'s doctors, hospitals, and medical providers?

Possible answers:
____ Yes
____ No

ANALYSIS BY GENDER

The analysis by gender showed no indication of nonresponse bias.

Examining the proportions of males and females in the overall sample, in the respondent group, and in the nonrespondent group, no significant difference was found:

TABLE 1

	Male		Female	
	Number	Percent	Number	Percent
Sample (n = 833)	372	45%	460	55%
Respondents (n = 601)	271	45%	329	55%
Nonrespondents (n = 232)	103	44%	129	56%

Even if males and females <u>did</u> answer questions differently, it can be assumed that the survey results would not have been different if the nonrespondents had been interviewed.

ANALYSIS BY AGE

The analysis by age revealed no indication of nonresponse bias.

The proportions of individuals age 73 or younger and those age 74 or older were determined for the overall sample, the respondent group, and the nonrespondent group. It was found that the percentage of younger <u>nonrespondents</u> was slightly lower than the percentage of younger <u>respondents</u>:

TABLE 2

	73 or Younger		74 or Older	
	Number	Percent	Number	Percent
Sample (n = 833)	612	73%	221	26%
Respondents (n = 601)	451	75%	150	25%
Nonrespondents (n = 232)	161	69%	71	31%

Given these differences, the survey responses to the three questions were examined to determine if individuals in the younger group answered differently than those in the older group. We found that for two of the questions, responses differed only slightly by age:

TABLE 3

Q #2. Did you call (Name of HMO) to get information, or did (Name of HMO) contact you to ask you to enroll?

	73 or Younger (n = 451)		74 or Older (n = 150)	
	Number	Percent	Number	Percent
Beneficiary Initiated Contact	327	72%	106	71%
HMO Initiated Contact	111	25%	39	26%
Beneficiary Does Not Remember	12	3%	5	3%
Response Missing	1	---	0	---

TABLE 4

Q #7. When you signed the application form, did you know that unless it was an emergency, or you were outside the service area and urgently needed care, you could only go to (Name of HMO)'s doctors, hospitals, and medical providers?

	73 or Younger (n = 451)		74 or Older (n = 150)	
	Number	**Percent**	**Number**	**Percent**
Yes	393	87%	133	89%
No	54	12%	15	10%
Response Missing	4	1%	2	1%

Regarding the third question used in our nonresponse analysis, it was found that age of the respondent did relate to the answers given. Younger respondents more frequently reported that it was clear to them that they were joining an HMO when they signed the application form:

TABLE 5

Q #6. When you signed the application form, was it clear to you that you were enrolling in a Health Maintenance Organization?

	73 or Younger (n = 451)		*74 or Older (n = 150)*	
	Number	***Percent***	***Number***	***Percent***
Yes	402	89.1%	123	82.0%
No	43	9.5%	23	15.3%
Beneficiary Does Not Remember	3	.6%	2	1.3%
Response Missing	31	.9%	2	1.3%

Assuming that the nonrespondents might answer this question as did their age-group peers in the respondent group, the responses were recalculated to include the nonrespondents. The result was compared to our original finding:

TABLE 6

	Actual Respondents (n = 601) Answered:		The Entire Sample (n = 833) Might Have Answered:	
	Number	Percent	Number	Percent
Yes (It was clear)	525	87.3%	725	87.0%
No (It was not clear)	66	10.9%	92	11.0%
Beneficiary Does Not Remember	5	.8%	8	.9%
Response Missing	5	.8%	8	.9%

The actual response to this question and the potential response (after rounding) were almost identical.

ANALYSIS BY HMO

Similarly, a comparison of response rates for each of the five HMOs showed no evidence of bias.

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 technical change suggested by HCFA and ASPE.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MAY 29 1991

IG	✓
PDIG	✓
DIG-AS	✓
DIG-EI	✓
DIG-OI	
AIG-MP	
OGC/IG	✓
EX SEC	
DATE SENT	5/31

RECEIVED
OFFICE OF INSPECTOR GENERAL
1991 MAY 31 AM 9:29

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.

- <u>OEI-04-91-00630: Marketing Practices</u>

  - **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 <u>Miami Area HMO's</u> 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.

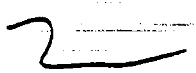
- I support the concept of a "cooling off" period for Medicare risk enrollees.

o <u>OEI-04-91-00640: Enrollment Patterns</u>

- 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 <u>Editorial Comments</u>

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

RECEIVED OFFICE OF INSPECTOR

Memorandum

Date AUG 15 1991

From Gail R. Wilensky, Ph.D
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
PDIG
DIG-AS
DIG-EI
DIG-OI
AIG-MP
OGC/IG
EX SEC
DATE SENT

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.

SPECIFIC COMMENTS

1. Page 5

Were the 22 beneficiaries who have changed HMOs multiple times identified during a review of the initial sample size of 833 beneficiaries? If not, all references to this separate sample should be segregated in a separate section of the report with separate descriptions of how these individuals were chosen.

OIG Response: Clarification has been added to the Methods section to show that the 22 beneficiaries were not part of the random sample of 833.

2. Page 7

The impression created by the statement "Although HCFA regulations prohibit door-to-door solicitations, 34 percent of those the HMO contacted (8 percent of all the beneficiaries) say salespersons stopped by their homes" is misleading. HCFA regulations at 42 CFR 417.428(b)(4) prohibits door-to-door solicitations; however, they do not prohibit any personal contact at home between a sales representative and a prospective or current HMO member. Sales calls at a person's home may be the result of telemarketing interest follow-up or mail-in response follow-up.

OIG Response: The text has been clarified to show that beneficiaries who say salespersons stopped by their homes are those who say the HMO initiated the contact.

3. Page 7

The fact that "sixty-four percent of the beneficiaries the HMO contacted do not know where the salespersons who contacted them got their names" is relevant only if it can be shown that an at-home marketing visit was made without having been requested by the beneficiary. If the contacts were phone contacts or mass mailings, for example, the HMO may have obtained the person's name from any number of direct marketing sources. There is no prohibition on direct marketing of this nature. However, a small number of individuals, as noted on page B-3, stated that the salesperson got their names from Social Security or Medicare. SSA and HCFA do not release beneficiaries' names; therefore, the statement may indicate that the marketing representative alleged that the person's name had been provided by SSA or HCFA, or the respondents may be confused on this point.

4. Page 8

Although initial training may be as stated, follow-up sessions for CAC-RAMSAY agents occur every 2 weeks.

OIG Response: No revisions made to text. When the information was verified with the HMO prior to release of the Draft report, CAC-Ramsay did not disagree with the wording.

5. Page 13

Comments made in regard to non-marketing issues such as, "things about HMOs" disenrollees "had wished they had known before joining," without substantiating data or further discussion should be deleted from the report. The report itself conceded that "these do not relate to marketing issues."

OIG Response: Section has been removed from the report.

6. Page 15

The conclusions reached on page 15 and page 16 in regard to the statement that "Some HMOs fail to adequately monitor sales staff, leaving beneficiaries vulnerable to inappropriate marketing practices," are not supported by the data summarized on page 14.

OIG Response: The chart on page 14 reflects general practices of the HMOs. Pages 15 and 16 refer to specific practices.

7. Page 15

The State of Florida has now enacted a statutory prohibition regarding the use of agents attached to PCP's and/or clinics as marketing agents.

OIG Response: We understand this legislation has been enacted since our inspection was completed; however, the report has not been revised as there is no national prohibition regarding this practice.

6. Pages 16-18

It would appear that the conclusion that "some beneficiaries have been vulnerable to unethical sales practices" is based upon the 22 beneficiaries discussed on these pages which do not appear to be part of the large sample study upon which the rest of the report is based. It is questionable why this should be included in the report which is based primarily on a selected sample size.

OIG Response: The text on pages 16-18 does refer to the 22 beneficiaries identified by HCFA. Their experiences are included in this report as they relate to HMO marketing practices.

7. Appendix B

Regarding item 8b, the interviewer is required to ask a person whether or not they have end-stage renal disease or have elected Medicare hospice coverage. In either case, such a person would not be eligible to enroll in a Medicare HMO.

OIG Response: This data is included in the appendix for information only. No conclusions were reached from the beneficiaries' responses to questions 8a-8d.