Medicare HMO Marketing in the Information Age

A REPORT BY

MEDICARE RIGHTS CENTER

EXECUTIVE SUMMARY

Many seniors and people with disabilities on Medicare do not adequately understand the advantages and tradeoffs of joining a Medicare HMO. At least part of their confusion stems from HMO marketing activities.

Evidence of a Problem: A number of studies and reports by the General Accounting Office (GAO), the Office of Inspector General and consumer advocacy organizations have documented past marketing abuses. Evidence suggests that these problems have not been adequately addressed.

Marketing issues remain a significant problem in the Medicare program. This policy brief includes a number of recent anecdotal accounts of improper marketing from the files of the Medicare Rights Center that indicate that at least some marketing agents mislead vulnerable people on Medicare. Recent reports by the GAO and Families USA document high HMO disenrollment rates in some states and in some communities, an indication of serious marketing abuse. Although people disenroll from HMOs for a variety of reasons, high disenrollment rates are one sign that some enrollees may have joined without fully understanding the implications.

Although people on Medicare can disenroll until the year 2002 from an HMO at any time, there are costs to uninformed or misinformed marketing, including disruptions in medical care, inability to purchase a Medicare supplemental insurance ("Medigap") policy and large unpaid medical bills.

The Marketing of Medicare HMOs: HMOs spend millions of dollars on marketing their Medicare products. One study found that marketing has a major influence on an individual's decision to join a Medicare HMO. Some marketing practices can mislead and result in misinformed or poorly informed enrollments. For example, plans may:

— Pay marketing agents a commission for each new enrollment;

— Fail to provide adequate education to the non-English speaking and the Medicaid-eligible Medicare populations;

— Market primarily to the physically active Medicare elderly population; and

— Fail to adequately train and monitor their sales representatives.

What Can Be Done? This policy brief suggests several reforms to address marketing issues, including:

— Require the Health Care Financing Administration or an independent enrollment broker to perform all enrollment functions;

— Require a standardized enrollment form for all HMO enrollments in an individual's primary language;

— Require standardized training and examination for all plan marketing staff and private insurance agents who market Medicare HMOs, and limit financial incentives that encourage marketing abuse;

— Expand opportunities to purchase a Medigap policy for people who leave a Medicare HMO.

HMO marketing that confuses or misinforms the Medicare population can cause serious harm to vulnerable individuals and to the Medicare system. With reforms and better oversight, HMO marketing violations need not be a permanent fixture of the Medicare program.

MARKETING OF HMOS TO THE MEDICARE POPULATION

Since 1985, HMOs have been marketing to the Medicare population. Many HMOs have much of value to sell: systems that promote preventive and primary care; added benefits, especially some prescription drug coverage; and significant reductions in out-of-pocket costs for enrollees. Yet, HMOs also have some disadvantages for people on Medicare. Individuals on Medicare may not understand that, once in an HMO, they must obtain care through a primary care physician or gatekeeper; that access to specialists and certain treatments will be restricted; that they may have to change their doctors or hospitals; or that the prescription medication they use may not be on the plan's drug formulary.

The Medicare population does not understand Medicare HMOs well. Researchers at the University of Oregon recently surveyed people on Medicare living in areas with high Medicare HMO enrollment rates to assess their understanding of the difference between Medicare HMOs and traditional fee-for-service Medicare. They found that over one-third of respondents had such a poor

understanding of the issues that they could not participate in the survey. This was true for those who were enrolled in HMOs as well as those in traditional Medicare.

Recent focus groups held by the National Academy of Social Insurance also found that the decision to join an HMO is frequently ill-informed. People on Medicare often make the decision to join based on direct sales approaches, advertisements and word-of-mouth, not on a careful comparison of the advantages and disadvantages of enrollment. Other studies have found that the elderly rely heavily on one-on-one communication to get information about health care. While such information sources can be helpful, information from friends, relatives, and especially plan marketing representatives is subjective. Therefore, people are often not making well-informed decisions.

At least part of the confusion stems from the way Medicare HMOs are marketed. Obviously, the purpose of marketing is to get the consumer to buy a product—in this instance, to join the Medicare HMO. But marketing to the disabled and elderly populations on Medicare should also aim to educate them about what joining an HMO will mean for their health care. Unfortunately, this education doesn't always happen and too many people on Medicare who join an HMO are ill-informed or misinformed about the consequences of their enrollment decision.

EVIDENCE OF A PROBLEM

In the past few years, a number of reports have described problems with the marketing of Medicare HMOs. A 1993 report by the Los Angeles-based Center for Health Care Rights documented extensive marketing problems in the Los Angeles market. Marketing agents pressured people into joining, asked them to sign enrollment forms under false pretenses ("just sign to show I've been here"), and enrolled cognitively-impaired elderly.

More recent reports by the General Accounting Office (GAO) and the Office of Inspector General also have raised concerns that Medicare HMOs are improperly marketing to the Medicare population.

Although new Medicare+Choice regulations increase marketing protections in some areas, evidence suggests that marketing problems have not been adequately addressed. Medicare prohibits HMOs (and other Medicare plans) from discriminating in marketing and enrollment based on health status (*i.e.,* marketing to only healthy individuals and discouraging those with chronic and disabling conditions from enrolling). Yet, a few HMOs continue to violate this basic protection. HCFA recently sanctioned one plan and notified another of its intent to sanction for "health screening violations." At the end of 1997, the Texas Attorney General negotiated an agreement with one Medicare HMO requiring it to modify its enrollment practices, which had been the object of numerous consumer complaints, including complaints about pressure by marketing agents and marketing agents misleading beneficiaries. The anecdotal accounts described below and studies of HMO disenrollment rates further indicate that marketing issues remain a problem for people on Medicare.

Anecdotal Accounts of Improper Marketing

The Medicare Rights Center has documented a number of cases of questionable marketing practices in 1997 and 1998, including the following:

Mr. H, a 69-year-old New Yorker, does not understand English well. His first language is Creole. When an HMO marketing agent came to his English as a second language class, Mr. H signed up, not fully understanding how an HMO works. He only discovered that something was amiss when he received denials for doctors' bills because he had received care out of his HMO's network. He was never given any written materials in French or Creole.

In early 1998, Ms. D, who was dying of cancer, lost her retirement benefits. She scheduled an appointment with an HMO salesman and signed up with the HMO in the belief that she was purchasing a Medigap policy to replace her lost retirement benefits. She continued to see her cancer specialists and was admitted to a hospital that was not part of the HMO's network. When she was discharged, she returned home to find that she had thousands of dollars worth of unpaid medical bills.

Mr. and Mrs. B already were enrolled in a Medicare HMO for two years when a sales representative from a second Medicare HMO visited their home. When Mr. and Mrs. B asked for further information, the agent, who had not brought any printed materials with him, asked them to sign a form, which they believed simply requested the information. Instead, they had signed an enrollment form. Not understanding that he had changed plans, Mr. B, who has a heart condition, continued to go to his old HMO. He only learned that he and his wife were enrolled in the second HMO when the first HMO denied payment and Mr. B started to receive bills for his care.

Mrs. G was told by a Medicare HMO sales representative that he would not process the enrollment paperwork she had completed unless she gave verbal authorization. The HMO then enrolled her without her permission. Mrs. G called the HMO three times to make sure that the HMO had not enrolled her, and was falsely reassured each time that she had not been enrolled.

People on Medicare who misunderstood or were misled about their HMO enrollment face serious consequences. They may have continued with their doctors and hospitals who are not in the HMOs' networks, and, as a consequence, face thousands of dollars in unpaid medical bills that neither Medicare nor the HMO will pay. If they obtain assistance from an organization like the Medicare Rights Center or another State Health Insurance Assistance Program (SHIP), they can get help. In some instances, Medicare will allow them to disenroll retroactive to the day they joined the HMO. In addition, until January 2002, Medicare HMO enrollees can disenroll from their HMO at any time, with disenrollment effective the first of the following month. However, there is a cost to marketing abuse—one paid by the elderly and disabled who may not know where to seek assistance, who face disruptions in their medical care, and who experience the anxiety of large unpaid medical bills.

Moreover, beneficiaries who want to rejoin traditional Medicare may not be able to obtain a Medigap policy. Under the Balanced Budget Act of 1997 (BBA), Medicare beneficiaries who join an HMO may disenroll if the plan or its agents "materially misrepresented" the plan's provisions. In this case, beneficiaries can purchase one of four different Medigap policies—A, B, C, or F. Still, their premiums may be significantly higher because of Medigap insurers' pricing policies. Further, if individuals enroll not because of any misrepresentation by a plan's sales representative, but because they misunderstood what was explained to them, they will not qualify under this BBA provision.

Medicare Disenrollment Studies

High disenrollment rates are one indication of marketing problems. Recent studies of 1996 disenrollment rates by the GAO and by Families USA show that these rates vary dramatically by plan. Some plans keep most of their members while others experience excessive turnover, where almost as many Medicare members leave as join. For example, the GAO study found that in Tampa, Florida, one plan had an annual disenrollment rate of 59 percent compared to a 10 percent disenrollment rate at another plan. Because the same market conditions exist for the eight Tampa plans, these vastly different disenrollment rates are, according to the GAO, likely the result of improper marketing by the plans with high disenrollment rates.

A large number of members who disenroll from an HMO within the first three months of joining (often referred to as "rapid disenrollment") when combined with high disenrollment rates is also reason for concern because it indicates that some people may have joined HMOs without understanding the limitations of a managed care system. The Families USA study found that one in four Medicare beneficiaries who disenrolled during 1996 left their plans within three months of joining and that 16 plans had disenrollment rates of over 20 percent and rapid disenrollment rates of over 40 percent.

Both the GAO and Families USA studies documented that HMOs that are relatively small and new to the Medicare market are more likely than older and larger plans to have higher disenrollment rates. Because of recent Medicare changes, the program may experience an increase in the number of new HMOs and other managed care plans which will have no experience in marketing to the elderly and disabled.* Thus, we may soon witness an increase in improper marketing to vulnerable Medicare beneficiaries.

THE MARKETING OF MEDICARE HMOS

Marketing activities play a critical role in the decision to join an HMO. These plans spend millions on radio, television and print advertisements, hold marketing fairs at senior centers and at restaurants, bombard the elderly with unsolicited mailings and phone solicitations, and visit the homes of prospective enrollees. For many of these activities, plans hire and train marketing agents.

Individuals on Medicare often fill out and sign a plan's enrollment form at a marketing presentation or in their homes during a visit by one of these agents.

Evidence suggests that all these marketing activities pay off in increased enrollment. In one study, Medicare beneficiaries cited the following sources as the most influential in their decision to enroll in an HMO: friends and relatives (32 percent); an HMO-sponsored open house (23 percent); direct mail (19 percent); direct contact with an HMO representative (11 percent); television (5 percent); and newspapers (4 percent).

While influential, some plan marketing practices are problematic:

Plans market to the physically active Medicare elderly population. Plan advertisements generally feature physically active elderly. Moreover, the names given to HMOs' Medicare products imply that they are not open to the disabled Medicare population. In Los Angles County, for example, Medicare HMO products are called Golden Medicare Plan, Senior Secure, Shield 65, Golden Outlook and Secure Horizons.

Plans often pay marketing agents a commission for each new enrollment. Although basing agent compensation on the number of new enrollees provides a strong financial incentive for agents to market the HMO, it also provides incentives for salespersons to misrepresent their product, to pressure individuals to enroll, and to gloss over any negative consequences of enrollment.

Plans fail to translate materials and provide other assistance in marketing to the non-English speaking Medicare population. A 1996 study by the Medicare Rights Center found that New York Medicare HMOs provided almost no written information in Spanish to the state's monolingual Spanish-speaking Medicare populations.

• Plans fail to adequately train and monitor plan sales representatives. Even with the most conscientious sales representative, some individuals on Medicare will join a plan without an adequate understanding of the consequences of their decision. However, cases of marketing fraud would not continue to plague the program if plans better trained their sales staff and closely monitored their actions.

WHAT CAN BE DONE?

A number of Medicare reforms could address the marketing issues raised in this policy brief. The following recommendation would need congressional authority for HCFA to implement:

• Prohibit plans from enrolling individuals on Medicare directly, and instead require HCFA or an independent enrollment broker contracting with HCFA to perform all enrollment functions. The BBA requires HCFA to implement a demonstration project on the use of enrollment brokers. The results of this demonstration won't be available for several years. If, under the new Medicare+Choice program, the number and severity of marketing problems increases, Congress

should consider prohibiting plans and their sales representatives from directly enrolling Medicare beneficiaries. Plans could still market to the population, but all enrollment functions, including verification that beneficiaries understood their choice, would be handled by either HCFA or its contractor.

The following recommendations could be adopted immediately by the Health Care Financing Administration to address marketing problems:

• Require a standardized enrollment form for all HMO enrollments. Page one of the enrollment form should include easy-to-understand information about the main features of the plan including choice and cost-sharing implications.

• Require enrollment forms to be translated in a beneficiary's primary language.

• Require standardized training and examination for all plan marketing staff. HCFA-prepared training materials and exams that all plan sales representatives must pass will ensure that marketing staff have a common understanding of the Medicare rules and how their plans differ from traditional Medicare and other Medicare+Choice plans.

• Prohibit agent compensation until a beneficiary has been enrolled in a Medicare+Choice plan for three months and limit the amount of commission. Taken together, these two provisions will reduce incentives for HMO marketing agents to misrepresent their products to obtain enrollments.

• Broadly publish all instances where plans have been penalized for marketing problems.

Finally, Congress could expand opportunities for Medicare beneficiaries who disenroll from an HMO to purchase a Medigap policy. Specifically, Congress should consider:

• For beneficiaries who dropped their Medigap policy to join an HMO and are later granted retroactive disenrollment, requiring Medigap insurers to offer the same Medigap policy at the same premium beneficiaries would have paid had they not joined the HMO.

• Requiring all Medigap insurers to offer their Medigap policies in a yearly coordinated guaranteed-issue open enrollment period.

CONCLUSION

HMO marketing violations need not be a permanent fixture of the Medicare program. Viable solutions do exist that could fix this problem. As more of the Medicare population has the option of joining an HMO (or other Medicare+Choice plan), policy makers need to better address the

vulnerability of this population to marketing excesses. New marketing protections are needed as well as better enforcement of current protections.

A current goal of the Medicare program is to increase the choices available to the Medicare population. But for choice to be meaningful, it must be informed. If HMO marketing helps beneficiaries make an informed choice, it furthers the program's goals. If it confuses or misinforms the population, serious harm is done to vulnerable beneficiaries and to the Medicare program.