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MEDICARE HMOS

Potential Effects of a Limited Enrollment Period Policy





United States
General Accounting Office
Washington, D.C. 20548

**Health, Education, and
Human Services Division**

B-275832

February 28, 1997

The Honorable William V. Roth, Jr.
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

Medicare, unlike most employer-sponsored health insurance coverage, allows beneficiaries the flexibility to change managed care plans or switch to fee-for-service arrangements monthly. This flexibility can cause problems for the Medicare program. For example, under this policy beneficiaries may decide to use managed care or other private plans while in relatively good health but may disenroll to fee for service when their health care needs increase. The result can be a disproportionate number of less healthy beneficiaries in fee for service, excess payments to health maintenance organizations (HMO), and unnecessary Medicare spending.

Recently, the Congress has considered making Medicare's policies more consistent with those of other large health care purchasing organizations by establishing a limited time each year during which Medicare beneficiaries could enroll in a particular plan and by restricting disenrollment outside that period. To help the Congress in its consideration of the effects of such a policy change, you asked us to assess how a limited enrollment period would affect the Medicare program, private health plans, beneficiaries, and employers who provide Medicare supplemental benefits to retirees. To do this, we examined the potential effects of policy changes on (1) the growth of Medicare's managed care program, (2) employers' attempts to administer their respective benefits seasons, (3) taxpayer savings measured against beneficiary protections, and (4) the resources needed by the federal agency that runs Medicare's day-to-day operations. Because a specific annual enrollment period could be established without also limiting beneficiaries' opportunities to change to fee for service, we have discussed the effects of the two policy changes (limiting the enrollment period and limiting disenrollment opportunities) separately.

We assumed that a new Medicare enrollment policy might be similar, but not necessarily identical, to the provisions contained in the proposed Balanced Budget Act of 1995 (BBA), H.R. 2491, as discussed in the act's

accompanying conference report.¹ Therefore, we developed and analyzed a limited enrollment period policy modeled on the BBA. Although the BBA would have provided for an expanded range of health care delivery and insurance options, we focused our attention on risk HMOs because they currently serve most beneficiaries not in Medicare fee for service.² To assess the likely effects of such a policy, we interviewed representatives of 10 Medicare risk HMOs, the Health Care Financing Administration (HCFA), employers who offer managed care options to retirees, and Medicare beneficiary advocacy organizations. We surveyed HMOs with Medicare risk contracts regarding their employer group business. To develop information on the potential financial effect on Medicare of limiting disenrollment, we analyzed HMO disenrollment data and fee-for-service claims in California. For more detailed information on our methodology, see appendix III. We did our work from March through November 1996 in accordance with generally accepted government auditing standards.

Results in Brief

Changing Medicare's current policy that allows beneficiaries to switch among HMOs or between an HMO and fee for service monthly would have far-reaching consequences for the Medicare program, beneficiaries, HMOs, employers, and HCFA. The specific effects would depend on the limits placed on switching plans. Medicare could, for example, emulate private insurance and establish a limited enrollment period—that is, a set time each year when beneficiaries would choose their health plan (a specific HMO or fee for service) for the coming year—but not restrict opportunities for beneficiaries to change to fee for service during the year. Alternatively, Medicare could combine a limited enrollment period with restrictions on changing to fee for service. Although both alternatives have advantages, any change that restricts beneficiary opportunities to enroll or disenroll would likely slow the growth of Medicare managed care.

A limited enrollment period for Medicare could have two principal advantages.

- To improve the quality and distribution of managed care information to beneficiaries: A focused enrollment period would create a natural opportunity for HCFA to provide objective, comparative information about health plans—information that beneficiaries now lack.

¹House Conference Report 104-350, pp. 1093-1102. The act was vetoed by the President; thus, these provisions did not become law.

²The scope of our study reflects the fee-for-service alternatives currently available to most beneficiaries, but many of the issues discussed in our report pertain to analysis of other types of insurance and delivery options under consideration.

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- To make impractical the current practice of in-home sales of HMOs, a source of marketing abuses: Although HCFA is alert to instances of HMO sales personnel misrepresenting HMO benefits and obtaining enrollment signatures under false pretenses, these abuses are difficult for HCFA to deter.

A limited enrollment period could also have several of the following disadvantages, the combined effect of which could slow Medicare managed care enrollment growth.

- Lessen the effectiveness of marketing of Medicare HMOs: HMOs would likely focus more of their marketing dollars on mass media campaigns concentrated around Medicare's enrollment season, but beneficiaries unfamiliar with managed care might not receive enough specifics through mass marketing to appreciate any advantages offered by an HMO over traditional fee-for-service Medicare. The Florida and New York Medicaid programs saw their managed care enrollment decline significantly after banning direct marketing by HMOs. Third-party contractors, if given exclusive responsibility for informing and enrolling beneficiaries under a limited enrollment period policy, might not be effective substitutes for health plans' sales agents.
- Lessen the attractiveness of HMOs to beneficiaries: Under a policy precluding the beneficiary's option to switch plans during a 12-month period, the only choice available to dissatisfied HMO enrollees might be to change to fee for service and pay either Medicare's deductibles and coinsurance or, if available, premiums for a supplemental Medigap policy. The new policy could also make Medicare HMOs impractical for beneficiaries who live in more than one part of the country during the year.
- Pose considerable administrative obstacles for employers: Regardless of the particular time of year selected for Medicare enrollment activities, some employers currently offering their retirees a managed care health insurance option could find that their health benefits seasons did not coincide with Medicare's. Accommodating Medicare's schedule could be so administratively difficult that some employers might simply stop offering a managed care option to their retirees.

Limiting beneficiaries' option to change to fee-for-service Medicare except during the officially appointed open season could also produce the following mixed effects:

- Medicare might achieve modest savings on money now spent on services for HMO members who change to fee for service. Medicare HMO members who disenroll and change to fee for service tend to use more services and more costly procedures than the average beneficiary under fee for service. Consequently, Medicare spends more money to serve an HMO member who changes to fee for service than it would have paid to the HMO to care for that beneficiary. For example, we found that, for beneficiaries who switched from managed care to fee for service in California during 1994, Medicare paid almost \$30 million more than it would have paid had these beneficiaries not been permitted to switch to fee for service mid-year. However, these savings may appear modest when measured against total 1994 California Medicare HMO outlays of \$4.2 billion.
- Beneficiaries would lose an important consumer protection and might be less willing to enroll in managed care. HMO members who are dissatisfied with their HMO may now change plans or switch to fee for service at the end of each month. HMO representatives, HCFA officials, and beneficiary advocates believe that eliminating this option would deter some beneficiaries from joining a managed care plan. HCFA and HMO officials predict that, because dissatisfied HMO members could not disenroll until the next open season, the number of managed care complaints, grievances, and appeals would rise dramatically.

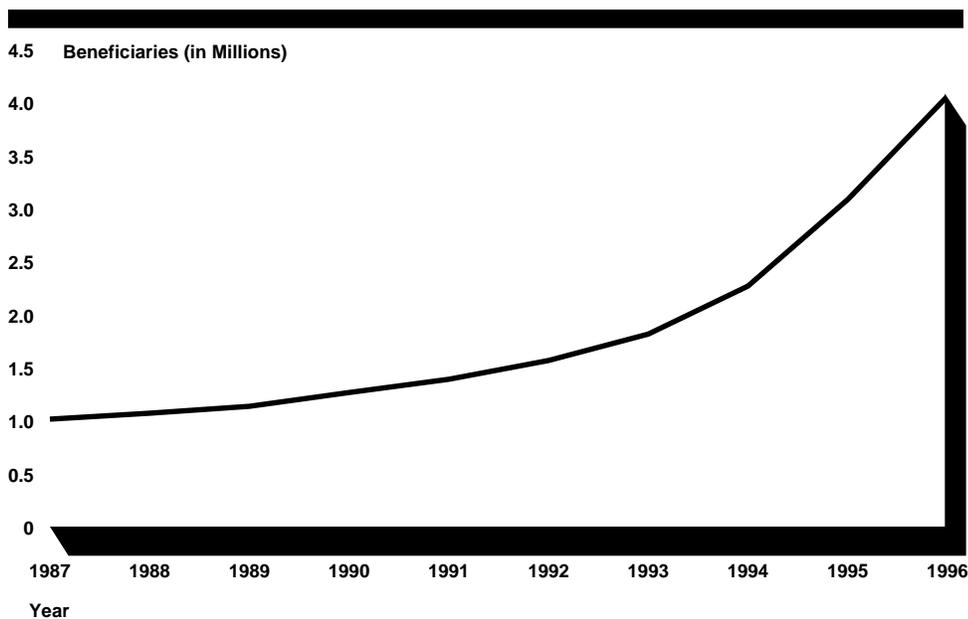
Ultimately, changing Medicare's HMO enrollment and disenrollment policies could have unintended effects. Although Medicare might achieve modest savings, these savings could be offset if policy changes also led to slowing or reducing the enrollment of Medicare beneficiaries in HMOs.

Background

Consistent with the national trend toward managed care, the number of Medicare beneficiaries enrolled in HMOs has grown significantly—from about 1 million in 1987 to about 4 million in 1996. This growth represents an increase from about 3 percent of all Medicare beneficiaries to about 10 percent. About 90 percent of Medicare beneficiaries enrolled in managed care are in risk-contract HMOs.³ The largest growth in Medicare managed care enrollment has occurred in the risk program. (See fig. 1.)

³HCFA, which administers the Medicare program, pays risk HMOs a per capita premium to provide a full Medicare package of benefits, regardless of the amount the HMO spends for each member's health care. Except for emergency and out-of-area urgent care, members must receive all their medical care through the HMO's network of providers. The remaining 10 percent of beneficiaries enrolled in managed care are in plans that Medicare reimburses on a cost basis (cost HMOs) or in plans that only cover Medicare part B services and may have restrictive enrollment policies (health care prepayment plans).

Figure 1: Medicare Risk HMO Enrollment, 1987-96

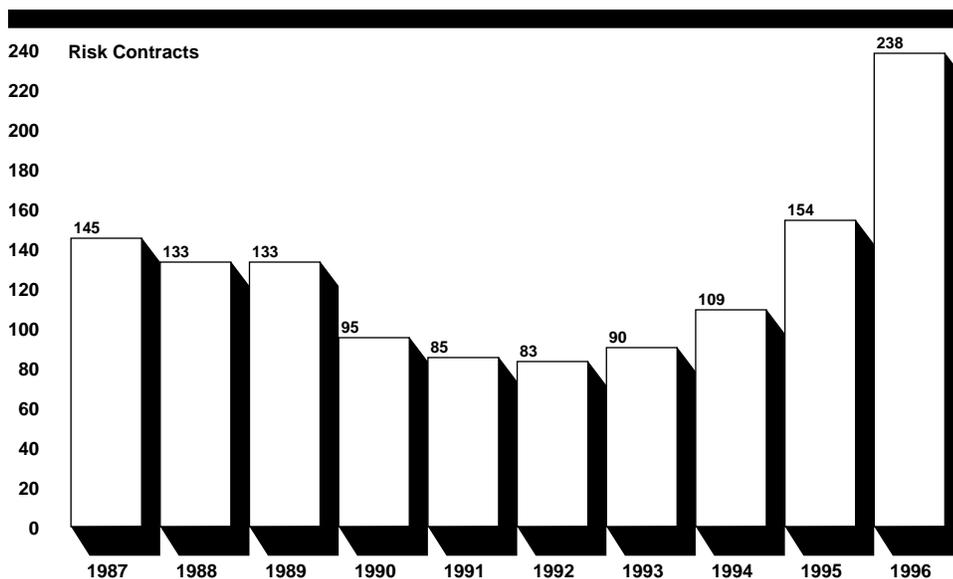


Note: Enrollment is as of December of each year except for 1996, for which November data are used.

Source: Monthly reports, Office of Managed Care, HCFA.

The number of HMOs in the risk program fluctuated somewhat in the program's first 5 years, but since 1992 the number of risk HMOs has grown steadily. (See fig. 2.) As of November 1996, HCFA had entered into 238 risk contracts. Most beneficiaries have at least one risk HMO available in their area, and, in some markets, beneficiaries can choose from as many as 14 different HMOs.

Figure 2: Number of Risk HMO Contracts, 1987-96



Note: Enrollment is as of December of each year except for 1996, for which November data are used.

Source: Medicare Managed Care Program Update, HCFA, 1995.

Risk HMOs are required to offer at least one 30-day enrollment period each year, but, in practice, most accept enrollment continuously. Although HCFA provides beneficiaries some general information about HMOs when beneficiaries first become eligible for Medicare, they typically learn about their options from the HMOs. Unlike leading private and public health care purchasing organizations, Medicare does not provide its beneficiaries with comparative information about available HMOs. HMOs provide beneficiaries with enrollment forms, collect the forms, and notify HCFA of enrollments. Beneficiaries may disenroll from a plan as often as once each month.

As discussed in the BBA conference report, the BBA included provisions that would have amended Medicare's enrollment policy in the following ways:

- Each October, Medicare would have an annual, coordinated election period, or "open season," during which beneficiaries could change their Medicare election. Elections of coverage would become effective the following January 1. However, newly eligible Medicare beneficiaries could elect coverage and have their choice become effective when they first became eligible for benefits.

- The Secretary of the Department of Health and Human Services (HHS) would conduct a nationally coordinated educational and publicity campaign during October. At least 15 days before the election period, the Secretary would mail all Medicare beneficiaries and prospective beneficiaries general election information and information comparing benefits, premiums, and measures of quality at available health plans.
- Disenrollment could occur only within 90 days of the time elected coverage began. Beneficiaries who disenrolled could elect a different HMO for the remainder of the year. This disenrollment option would only apply the first time a beneficiary enrolled in a particular managed care plan and would not apply more than twice for any beneficiary in a calendar year. Exceptions would include disenrollment for beneficiaries who moved out of a service area.

A Limited Enrollment Period Policy Could Slow Managed Care Growth Despite Better Consumer Information

Establishing a limited enrollment period could slow managed care growth for two reasons. First, marketing practices possible under a limited enrollment policy might be less effective in attracting beneficiaries to managed care. These changes could have a positive by-product, however, as the incidence of in-home sales and associated abusive sales practices would likely diminish. Second, restrictions on health plan switches outside the established enrollment period—even if no restrictions existed on changing to traditional fee-for-service Medicare—could deter some beneficiaries from enrolling in HMOs. In particular, a limited enrollment period policy would have three main disadvantages for beneficiaries: (1) dissatisfied beneficiaries and those encountering problems gaining access to desired treatments could be exposed to higher health care expenses, (2) beneficiaries who spend part of each year in a different location (“snowbirds”) could find they had no choice other than fee for service, and (3) all beneficiaries enrolled in HMOs could face delays in obtaining physician appointments at the start of each benefit year because of a large volume of new beneficiaries seeking services.

HMO Marketing Abuses Associated With In-Home Sales Would Probably Be Reduced

One-on-one sales presentations, often conducted in the privacy of beneficiaries’ homes, leave beneficiaries vulnerable to abusive sales tactics and serious marketing problems. Reported abuses include HMO representatives’ lying to prospective enrollees about the benefits of HMO enrollment, pressuring beneficiaries to join HMOs, enrolling beneficiaries who could not make informed enrollment decisions, and obtaining enrollment signatures under false pretenses. Although HCFA cannot

determine the frequency of these problems, agency officials are concerned about the potential for in-home sales marketing abuses.

According to our HMO survey results, about half of the beneficiaries who enrolled in a Medicare HMO as individuals (not as members of an employer group) in 1995 participated in a one-on-one sales presentation. However, the likelihood of a beneficiary's participating in a one-on-one sales presentation varied greatly by HMO.⁴

A limited enrollment period lasting just 1 or 2 months each year could make it impractical for HMOs to conduct as many in-home sales presentations. Each one-on-one meeting can last from 1/2 hour to 2 hours and is conducted by an HMO sales agent who sells only to Medicare beneficiaries. HMO representatives told us that sales agents who sell Medicare plans sell them exclusively. Agents are trained not only in the details of their HMO's offering, but also in traditional Medicare and the rules governing Medicare managed care. Some HMO representatives implied that maintaining a large, dedicated Medicare sales force year-round would be impractical if most sales would take place during a 1- or 2-month limited enrollment period.⁵ Furthermore, HMO representatives said it would be unrealistic to expect non-Medicare agents to be able to sell Medicare products. Because beneficiaries are particularly susceptible to abusive sales practices in their homes, reducing or eliminating in-home sales presentations would better protect beneficiaries from the possibility of sales abuses. This protection, however, would be a by-product of the enrollment policy change and could be achieved by more direct methods.

Comparative Information Distributed During a Limited Enrollment Period Would Aid Beneficiary Decision-Making

Under the BBA, before the start of a limited enrollment period, the Secretary of HHS would have been responsible for producing and distributing (1) a list of plans available in a given area and (2) comparative information about those plans, including benefits, premiums, and measures of quality. The Secretary would also have been responsible for maintaining a toll-free number that beneficiaries could call to receive specific information.

⁴For example, about one-fourth of the HMOs responding to our survey reported that 90 percent or more of the beneficiaries who joined their plan had participated in a one-on-one sales presentation. In contrast, one-fifth of HMOs reported that less than 10 percent of their enrollees had participated in such presentations.

⁵Some sales would occur outside the limited enrollment period. Depending upon how such a policy would be implemented, such sales would probably include sales to newly entitled Medicare beneficiaries and beneficiaries who had moved outside of their previous HMO's service area.

Beneficiaries' ability to make informed health care choices would be enhanced by the availability of objective, comparative information and access to a hot line. We recently reported that beneficiaries who wish to compare plans face difficult, if not daunting, steps.⁶ First, they must call a toll-free telephone number to obtain a list of HMOs available in their area. Next, they must contact those HMOs and request marketing brochures. Finally, they must compare plans' benefit packages and cost information described in the brochures. The last step can be difficult because HMOs are not required to use standard formats or terminology in describing their products.

A limited enrollment period would facilitate an annual HMO marketing campaign and create a natural opportunity for HCFA to distribute comparative plan information to beneficiaries. Some experts believe that HMOs' concentrated advertising during the open season would help inform beneficiaries of alternative Medicare options. Another potential advantage is that any comparative information produced by HCFA would be up to date at the time most beneficiaries were making health care choices.⁷

Mass Marketing Campaign Might Not Adequately Inform Beneficiaries Unfamiliar With Managed Care

HMO representatives told us that if Medicare established a limited enrollment period, plans would turn to a marketing approach more conducive to a limited enrollment time frame. HMOs would focus more of their marketing dollars on mass media campaigns—including print, radio, and television advertising—concentrated around Medicare's enrollment season.

Some experts believe that a concentrated mass marketing campaign could increase beneficiary awareness of Medicare options, including managed care. These experts suggest that the Medicare advertising blitz could be similar to the advertising campaigns that occur in the Washington, D.C., area during the Federal Employees' Health Benefits Program (FEHBP) open season each fall. Whether Medicare HMOs' advertising campaigns would be as intense as FEHBP plans' is uncertain. FEHBP subscribers represent about 9 percent of the Washington, D.C., metropolitan area's total population.⁸

⁶Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

⁷HCFA cites the changing health care marketplace as one reason the agency has no plans to distribute printed comparison charts directly to beneficiaries. However, HCFA is planning to make some basic HMO comparative information available on the Internet. The agency will periodically update the information.

⁸This percentage does not include dependents of active workers or retirees.

Nationwide, Medicare beneficiaries represent about 14 percent of the total population. However, only about 1 in 10 Medicare beneficiaries currently enrolls in managed care. If advertising intensity is driven by the proportion of potential customers, the intensity of a campaign for Medicare beneficiaries would depend upon whether HMOs believe the potential market is all Medicare beneficiaries or only 1 in 10.

Representatives of HMOs, however, believe that an advertising campaign without the benefit of one-on-one sales would be less effective at convincing Medicare beneficiaries to try managed care. Representatives of most HMOs we contacted stated that limiting Medicare's enrollment period would slow the growth of managed care because plans would not (1) have time to educate beneficiaries about Medicare's managed care option and (2) be able to hire enough trained sales staff on a seasonal basis to answer beneficiary questions during the limited enrollment period. Although abuses have been reported in conjunction with one-on-one sales, HMOs believe this sales approach is both necessary and effective, in part because many beneficiaries have had no experience with managed care.

The effectiveness of an FEHBP-like mass marketing campaign for Medicare may depend on whether HCFA develops ancillary mechanisms to inform beneficiaries. Participants in FEHBP do not rely exclusively on mass marketing to obtain information. All active and retired FEHBP enrollees are given comparative information on available plans and can obtain detailed, plan-specific information brochures that follow a standard format. Active federal workers can also discuss their health care options with colleagues or their agency's benefits administrator. Furthermore, most workers can easily attend health fairs sponsored by their agency, where health plan representatives distribute literature and answer questions. The 20 percent of FEHBP members who are retired also have some advantages over individuals in Medicare. As former federal workers, FEHBP participants are familiar with the program's enrollment and disenrollment rules. In addition, federal retirees receive guidance from the National Association of Retired Federal Employees. This organization, with over 1,700 chapters nationwide, works closely with FEHBP in answering questions and resolving problems. Finally, some members of the Congress sponsor annual FEHBP health fairs attended by retirees.

Third-Party Enrollment Brokers Are Objective but May Be Less Effective Promoting HMOs

Requiring third-party contractors, or brokers, to conduct all enrollment activities would better protect beneficiaries from abusive sales practices, minimize the opportunity for HMOs to favorably select only the healthiest beneficiaries, and provide beneficiaries a convenient source of objective information. Beneficiaries might welcome such a change in enrollment practices partly because they would have the convenience of “one-stop shopping” and also appreciate a source of objective, comparative information. A recent focus group conducted for HCFA found that most beneficiaries did not view insurance plan representatives as trustworthy sources of impartial information. Nonetheless, HMO representatives maintain that personal contact with an HMO sales agent can be reassuring to beneficiaries and that industry sales abuses are few.

HCFA plans to test the effect of third-party enrollment contractors in a future Medicare demonstration project. Scheduled to begin sometime in 1997,⁹ this project will use a third-party contractor to conduct marketing, education, counseling, and enrollment activities. HCFA’s design—as of August 1996—will permit HMOs to provide information to beneficiaries directly and even help beneficiaries fill out enrollment forms. The third-party contractor will provide comparative information about the plans, counsel beneficiaries who want to consult with a neutral party, and perform all enrollment transactions. The potential effect of this approach on enrollment is not clear, and the demonstration’s effects may not be fully evaluated for years.

If the Medicare program relies solely on enrollment brokers and prohibits HMOs from marketing to individual beneficiaries, however, growth of Medicare managed care might slow. HMO representatives with whom we discussed this issue were concerned that brokers would be less knowledgeable about the advantages of specific plans and thus not as effective as sales agents in selling managed care to Medicare beneficiaries. Recent experience in the Medicaid program suggests that prohibiting direct marketing by HMOs could slow enrollment growth.¹⁰ Because of abuses, Florida and New York prohibited HMOs from marketing to beneficiaries directly. Both states experienced significant declines in

⁹HCFA’s Medicare Competitive Pricing Demonstration Project is designed to test both the feasibility and effects of (1) setting Medicare payments for HMOs using competitive market forces, (2) providing beneficiaries with comparative information, and (3) using third-party contractors to enroll beneficiaries in HMOs. The demonstration also includes plans for a coordinated enrollment period. Currently, the demonstration is behind schedule, and HCFA has encountered difficulties selecting a site.

¹⁰Medicaid: States’ Efforts to Educate and Enroll Beneficiaries in Managed Care (GAO/HEHS-96-184, Sept. 17, 1996).

Medicaid HMO enrollment. Florida reported that, in a recent 3-month period since banning direct marketing, enrollment levels fell by an average of 10,000 enrollees per month. New York temporarily suspended its ban on direct marketing to help increase HMO enrollment but implemented other steps to prevent HMO marketing abuses. In fact, in many Medicaid programs in which beneficiary participation in managed care is voluntary, states rely on HMOs to inform beneficiaries about managed care and encourage them to enroll.

Potential Costs If
Dissatisfied Could
Dissuade Some
Beneficiaries From
Enrolling in Medicare
HMOs

Although a limited enrollment period could add some consumer protections for beneficiaries, it could expose dissatisfied beneficiaries to additional out-of-pocket costs. Under the limited enrollment period policy discussed here, beneficiaries dissatisfied with their HMOs would have three choices: (1) remain in the HMO, (2) switch to traditional Medicare fee for service and pay the deductible and coinsurance for submitted claims, or (3) switch to traditional Medicare fee for service and purchase a Medigap policy if one was available to them. Beneficiaries dissatisfied with access to desired treatments could remain in their HMO and purchase those services privately. However, going outside the HMO for treatment or changing to fee for service would cost most beneficiaries more money than they would have spent had they been able to enroll in another HMO.¹¹

Changing to traditional fee for service could be an expensive option for many dissatisfied Medicare HMO members. HMOs are cheaper than fee for service for many Medicare beneficiaries because 65 percent of HMOs do not charge a monthly premium (so-called “zero premium HMOs”).¹² In addition, HMOs frequently offer benefits, such as outpatient prescription drugs, that are not provided by traditional Medicare. Beneficiaries in HMOs are responsible for copayments for certain services but often fewer services than in a fee-for-service arrangement. Beneficiaries in fee for service who

¹¹Although switching HMOs during a 12-month period is not typical beneficiary behavior, neither is it uncommon. Of the 161,792 beneficiaries who enrolled in HMOs at the start of 1995, 9,727 switched to another HMO or left and returned to their original HMO in less than 1 year—a choice that would not be permitted under the limited enrollment scenario discussed here.

¹²Monthly premiums for the remaining HMOs are often lower than premiums for Medigap policies. As of September 1996, less than 6 percent of risk HMOs had monthly premiums that exceeded \$60. In addition to any premium charged by the HMO, beneficiaries must continue to pay their Medicare part B premium (\$42.50 per month in 1996).

need services covered under Medicare part B must fulfill a deductible and pay a portion of additional expenses.¹³

Dissatisfied HMO members who change to fee for service may want to purchase supplemental health insurance, known as Medigap, to help cover out-of-pocket costs.¹⁴ However, Medigap policies can cost over \$1,000 per year—more than most beneficiaries would pay to an HMO. Furthermore, beneficiaries have no guarantee that a Medigap policy will be available upon disenrolling from an HMO. During the 6 months after a person turns age 65 and enrolls in Medicare part B, federal law guarantees beneficiaries the opportunity to purchase a Medigap policy. After that, Medigap insurers are permitted to refuse to sell policies because of an applicant’s health history or status. We recently reported that, although some insurers do exercise their option to refuse coverage, all beneficiaries currently have at least one Medigap policy available to them after the 6-month guarantee period, regardless of their health history or status.¹⁵ Nevertheless, no federal requirement exists to ensure that beneficiaries will always have such alternatives.

Fee for Service Could Be Only Option for Medicare “Snowbirds”

Beneficiaries who temporarily relocate for the winter, commonly known as “snowbirds,” might find joining a Medicare HMO impractical and would probably choose the fee-for-service option instead. HMOs are required to provide emergency, but not routine, care to members outside the HMO service area. Furthermore, HMOs are required to disenroll any member who leaves his or her HMO’s service area for more than 90 days. Currently, snowbirds can disenroll from an HMO and switch to fee for service or another HMO each time they relocate. If a limited enrollment period policy prohibited such plan switching, snowbirds would be left with only one realistic option—enrolling in Medicare’s fee-for-service program. Although data are not available on the number of Medicare snowbirds, their existence is widely recognized.

¹³Beneficiaries’ payments under Medicare part A (hospital insurance) vary depending on factors such as their length of hospital stay or whether they receive care in a skilled nursing facility. For Medicare part B (medical insurance), beneficiaries must pay a \$100 annual deductible, after which they are responsible for 20 percent of the Medicare-approved amount for most services. For outpatient hospital services, beneficiaries are responsible for 20 percent of the charges, regardless of the Medicare-approved amount. Beneficiaries are responsible for 50 percent of the Medicare-approved amount of outpatient mental health services.

¹⁴The 10 standard Medigap policies cover Medicare coinsurance. Some policies also cover Medicare deductibles and benefits not covered by Medicare such as prescription drugs.

¹⁵Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting (GAO/HEHS-96-180, Sept. 10, 1996).

HMOs might respond to a limited enrollment period policy by offering flexible service arrangements not commonly available today, such as reciprocal agreements and point-of-service options, partly to attract snowbirds. Reciprocal agreements among health plans—which permit HMO members traveling outside their plan service area to receive routine care and nonemergency services from another HMO—would make temporary relocations less problematic for beneficiaries who wished to enroll in managed care. Several HMOs now offer reciprocity but only within their own companies or affiliates. For example, a member of the Kaiser Foundation Health Plan in Los Angeles may receive services from Kaiser HMOs in other parts of the country. A representative of the American Association of Retired Persons said her organization is interested in encouraging the development of reciprocal agreements among plans, although no such agreements currently exist. Similarly, if many HMOs offer the point-of-service option—a hybrid of HMOs and fee-for-service plans—a Medicare policy limiting plan switching would be less of a deterrent to snowbirds who wished to enroll in HMOs.¹⁶

HMO Enrollees Could Face Delays Obtaining Physician Appointments at Start of Health Benefits Year

Most of the HMOs we contacted believe that a limited enrollment period would cause beneficiaries to face delays in receiving health care services at the beginning of each health benefit year. HMO representatives said a heavy demand for services would be caused by new Medicare members' "trying out" their new physicians soon after enrolling. One HMO told us that a large percentage of that HMO's new members see their primary care physician within 60 days of enrolling to receive health care or renew a prescription. In fact, some plans strongly suggest that new members undergo initial health assessments within 30 days of joining. Although demand for provider services also increases after the start of a commercial contract, the effect of an influx of new Medicare members is greater because Medicare beneficiaries tend to use physician services more frequently than younger HMO members.

Beneficiaries who would likely face delays in scheduling physician office visits might be those who join HMOs that employ providers directly ("staff model" HMOs) or have exclusive contracts with providers ("captive group model" HMOs) or those who join HMOs with relatively small provider networks. Beneficiaries who join HMOs with exclusive provider arrangements will, by definition, change providers when changing plans. New members in HMOs with small provider networks are more likely to

¹⁶With a point-of-service plan, beneficiaries have the option of receiving services within their HMO's provider network or, for an additional cost, receiving some services from nonparticipating providers.

need to select a new provider than beneficiaries joining plans with large networks. However, for some beneficiaries, joining an HMO or switching among plans will not require switching physicians and an introductory visit because physicians often contract with multiple HMOs.

Obtaining appointments at the start of each health benefit year might be difficult for beneficiaries in some HMOs because a limited enrollment period policy would probably result in dramatic, once-a-year membership spikes. From December 1994 to December 1995, 24 plans enrolled more than 10,000 new members, including 1 that enrolled close to 55,000 members. (Table 1 shows the distribution of new members among plans.) These membership increases, however, were absorbed by the plans over 12 months, not during a single month, as might occur under a limited enrollment period policy.

Table 1: Medicare Risk HMO Membership Growth, December 1994 to December 1995

HMO membership growth	Number of HMOs
10,000 new members or more	24
5,000-9,999 new members	22
1,000-4,999 new members	54
Less than 1,000 new members	22
Membership decline	14

Note: Based on 136 risk HMOs that had members in 1994 and 1995.

Source: HCFA Medicare Market Penetration Report File.

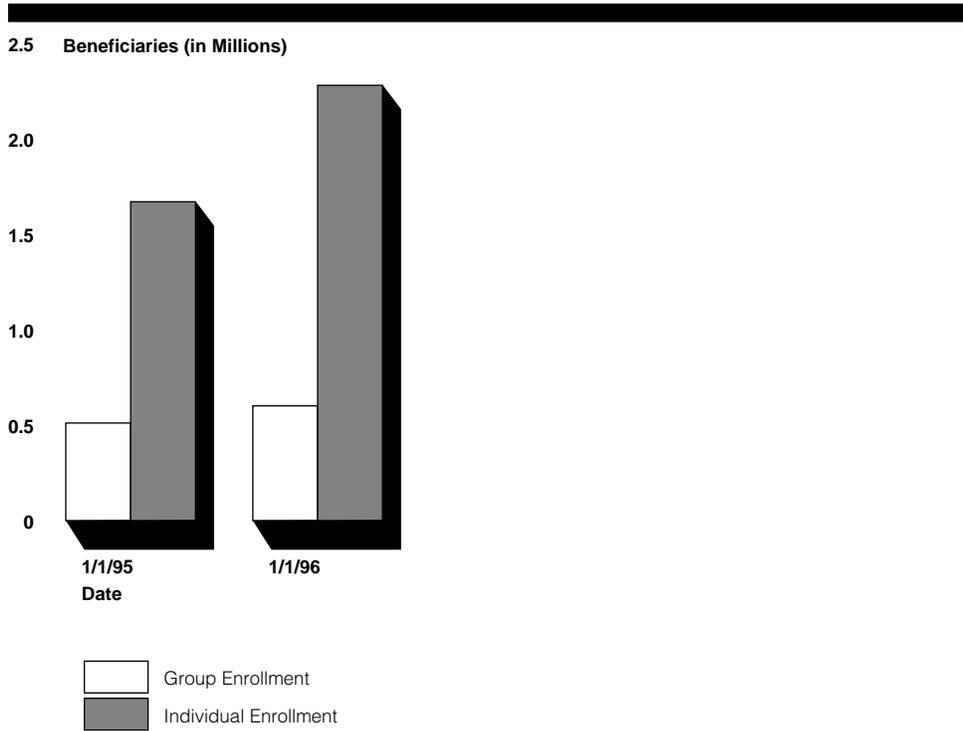
The annual enrollment change resulting from a limited enrollment period could be difficult for HMOs to predict accurately; any unanticipated HMO enrollment growth could contribute to provider access problems. Representatives of one large HMO described what happened when they grossly underestimated the response to their Medicare product in a new market area. Although the plan had contracted with a large number of physicians, it underestimated the need for primary care physicians and certain specialists. Demands on plan physicians' time and the level of beneficiary complaints were so high that some physicians quit. The plan contracted with new physicians (a process that took about 6 months) and cut back its marketing efforts to hold down additional enrollment, but 1-1/2 years passed before the plan's provider network could comfortably meet members' demand for services.

A January start date for the Medicare benefits year, as specified in the BBA, could cause longer delays in receiving health services than if another time of year was selected. January is already a particularly busy month for providers because so many members of employer-based health plans begin their benefits years on January 1. Furthermore, according to HMO representatives, demand for physician office visits is already high in January because of winter respiratory illnesses. However, choosing a month other than January could increase the number of employers that are inconvenienced, as discussed in the next section.

A Limited Enrollment Period Policy Could Discourage Some Employers From Offering Managed Care to Retirees

Limiting Medicare's enrollment period would create varying degrees of administrative problems for employers and could, as a result, discourage some employers from offering managed care to their retirees. Our survey results indicated that in January 1996 about 21 percent of all beneficiaries in Medicare risk HMOs enrolled through employer groups. Moreover, between January 1995 and January 1996, the number of Medicare beneficiaries in HMOs sponsored by employer groups grew by 17.5 percent. The number of Medicare beneficiaries individually enrolled in HMOs grew even more—by 36.2 percent. (See fig. 3.)

Figure 3: Number of Medicare Beneficiaries Enrolled in Risk HMOs Responding to Our Survey, by Type of Enrollment

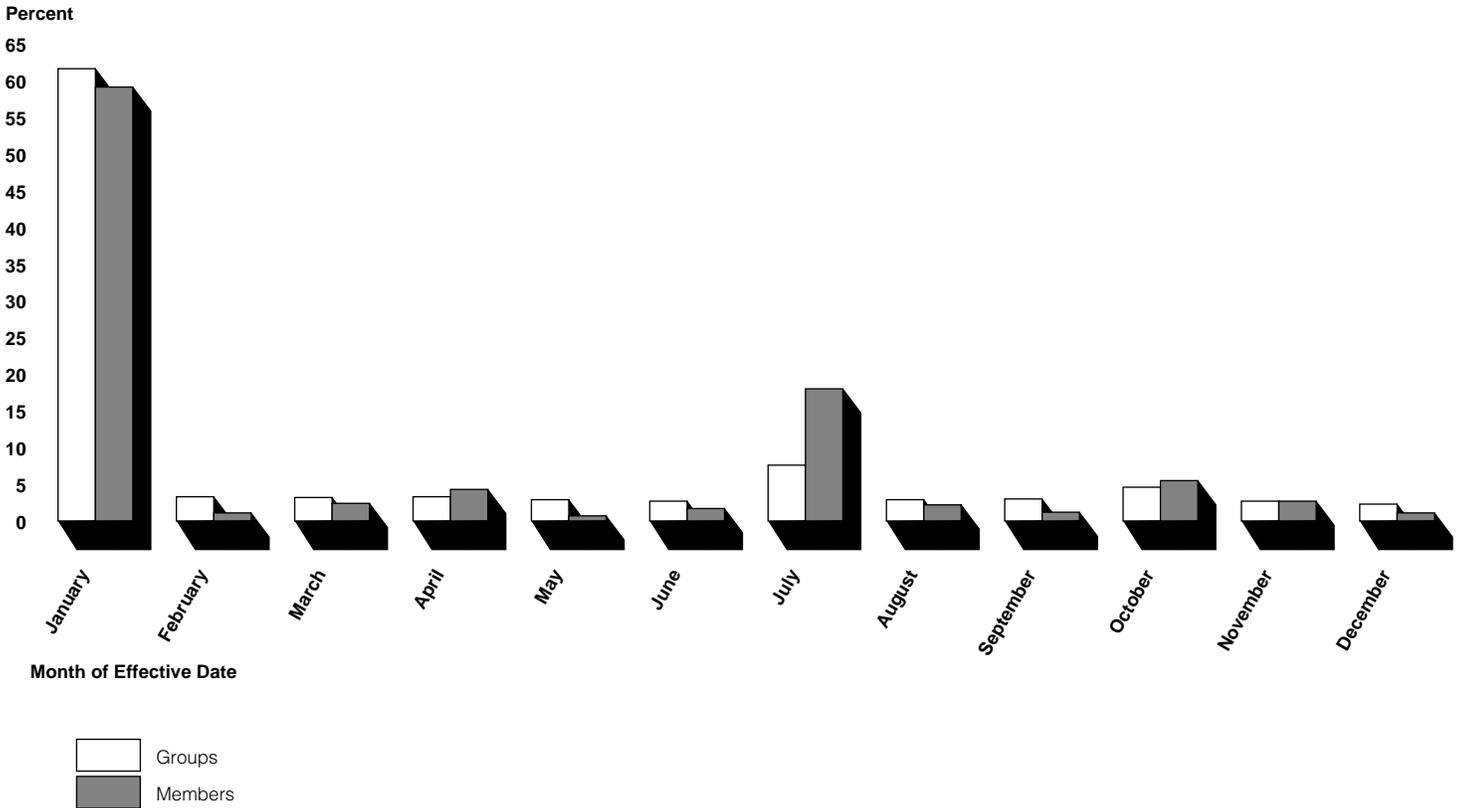


Source: GAO survey.

Start Dates of Many Employers' Health Benefits Years Would Not Coincide With Medicare's Dates

Almost all employer groups offering coverage through the risk HMOs we surveyed limit the period during which members can enroll, but not all these groups choose the same times of year to enroll members and to begin benefits. Under a limited enrollment policy, unless exempted from complying with Medicare's specific enrollment period and effective date, some proportion of employers would need to shift their health benefits calendar. The BBA proposed an October enrollment period with Medicare beneficiaries' choices effective January 1. This timing would have coincided with the dates used by 62 percent of the employers offering managed care to retirees in 1995. (See fig. 4.)

Figure 4: Distribution of Employee Groups' Enrollment Dates and Membership in These Groups



Source: GAO survey.

If legislation mandates a specific health benefits open season for all Medicare beneficiaries, it is unlikely that employers with different benefit seasons would all respond in the same manner. Rather, these employers could take one of three courses: (1) shift all employees' and retirees' benefits seasons and run a single season that would coincide with Medicare's season, (2) shift seasons for Medicare retirees only and run one season for retirees and another for active employees, or (3) choose not to offer the Medicare risk program to retirees.

January Start Date Would Inconvenience Some Employers

Some employers could face problems shifting their benefits season to coincide with Medicare's. Employers and benefit consulting firms we contacted discussed two major reasons why nearly 4 of 10 employers have

their group coverage begin in a month other than January. First, employers often select a benefits year that coincides with the start of their fiscal year, which may not be January. Second, employers with seasonal businesses often choose slow business months to conduct an enrollment process. For example, representatives of a major benefits consulting firm and several national retailers told us that because the winter holiday season is the busiest and most demanding time of year for retailers, these employers try to avoid other activity at that time. One of the health benefits consultants we contacted said that his firm had tried unsuccessfully to get some of its clients to begin their coverage in a month other than January to ease the firm's administrative burden.

Running Separate Benefits Season for Retirees May Present Problems for Some Employers

To comply with a mandated health benefits season for Medicare, some employers might choose to run two seasons—one for retirees and one for active workers. One business group told us that some employers already run two separate seasons because retirees tend to take more time and ask more questions of health benefits personnel than do active employees. However, executives of one national health benefits consulting firm also said that running two separate seasons costs employers more money than running a single season.

Executives of one large national retailer anticipated that running two health seasons would create serious administrative problems. The retailer would have to (1) untangle its contracts with HMOs so that coverage for Medicare-eligible retirees could be separated from coverage for active employees, retirees, and retirees' dependents under age 65; (2) renegotiate contracts with plans; and (3) revise internal policies and communications. Executives said untangling contracts could take 2 to 3 years to complete. They further noted that if they ran two seasons, members of the same family could find themselves with different health benefit years. Because of all these problems, the executives said they probably would not offer Medicare risk plans if they had to change benefit years. They further predicted that other employers whose benefits seasons would not coincide with Medicare's would do the same.

Employers Would Need Time to Transition to New Health Benefits Cycle

Employers who were willing to switch their health benefits season would probably need 9 months to 1 year of planning time to make the transition, according to representatives of employers and benefit consulting firms. For example, one retailer we contacted had been operating a single season for employees and retirees with a benefits year beginning at the start of its

fiscal year on February 1. This company recently shifted the start of its benefits year for its active employees because the February health benefits year required a November or December enrollment period, which interfered with holiday business. The retailer started actively planning 1 year before the change. It encountered some administrative difficulties but found that making the change was relatively inexpensive.

The California Public Employees' Retirement System (CalPERS) also recently shifted its health benefits season for both employees and retirees. Before this change, benefits became effective on August 1; now benefits are effective January 1.¹⁷ CalPERS changed its season to coordinate with preferred provider organizations and other state benefit programs that operate on a calendar year. CalPERS found the process of shifting its health benefits cycle manageable and not very costly but did need about 15 months to prepare for the change.

Limiting Disenrollment Might Save Medicare Money but Cause Problems for Beneficiaries and HMOs

If a new enrollment policy also limited HMO members' opportunities to disenroll and change to fee for service, the Medicare program might save some money; however, the policy could also result in reduced beneficiary protections, increased beneficiary dissatisfaction, and slower HMO growth.

Limiting Disenrollment Might Generate Some Medicare Savings

Limiting opportunities for beneficiaries to disenroll from HMOs mid-year might generate some cost savings for Medicare. These savings would occur because payments to HMOs are based on our assumption that HMO enrollees' health and medical requirements are the same as those of the average beneficiary in fee for service. However, beneficiaries who leave managed care plans and switch to a fee-for-service arrangement are not average—they tend to use more services and incur higher costs than the average fee-for-service beneficiary.

Nonetheless, our analysis indicates that Medicare's maximum potential savings from limiting disenrollment might be small, relative to overall program expenditures, because few managed care enrollees change to fee for service. To quantify potential savings, we studied the behavior of all 738,000 California Medicare beneficiaries who were enrolled in a risk HMO

¹⁷To accomplish this shift, CalPERS established an interim benefit "year" 17 months long.

at the start of 1994. Of the beneficiaries who did not change residences, only 15,772 switched from managed care to fee for service during 1994.¹⁸ Medicare paid fee-for-service claims for 11,382 of these beneficiaries, amounting to almost \$73 million. If these beneficiaries had not been allowed to disenroll from their plans, the Medicare program would have paid \$42 million in capitated payments to HMOs to cover these same beneficiaries. Thus, the potential savings of limiting disenrollment would have been, at most, \$31 million in California during 1994—compared with total Medicare risk HMO expenditures in California of \$4.2 billion.

Table 2: Medicare’s Potential Savings Had Disenrollment Opportunities Been Limited for Beneficiaries in California, 1994

	Actual Medicare expenditures, HMO and fee for service (in millions)	Medicare expenditures had beneficiaries stayed in HMO entire year (in millions)	Potential savings from limiting HMO disenrollment (in millions)
15,772 beneficiaries in HMOs in January 1994 who switched to fee for service for at least 1 month that year ^a	\$72.6	41.6	31.0
11,684 beneficiaries in HMOs in January 1994 who switched to fee for service April 1 or later for at least 1 month ^a	48.4	26.1	22.3

^aExcludes beneficiaries who changed county of residence.

Source: GAO analysis of Medicare Claims Database and HCFA Group Health Plan Master File.

Potential savings, as a percentage of payments to HMOs, may be slightly higher in states other than California. Beneficiaries in California have many HMOs from which to choose and can readily join a competing HMO if dissatisfied with their own. In other states, however, beneficiaries have fewer choices, and the rate of changing to fee for service among dissatisfied beneficiaries may be higher than in California. Since limiting the opportunity to change to fee for service during the year produces cost savings, the potential savings, as a percentage of payments to HMOs, may be higher in states with few HMOs. However, national Medicare savings would still likely be small because California represents about 44 percent of all Medicare risk-contract HMO expenditures.

The less restrictive the disenrollment policy is—in other words, the more opportunities beneficiaries have to change to fee for service—the smaller

¹⁸We did not include in our analysis the 25,918 beneficiaries who moved out of their county, or service area, during 1994. These beneficiaries could have left their HMOs’ service areas and would presumably have been able to change coverage mid-year, even under a limited enrollment and disenrollment policy.

the potential savings. For example, if beneficiaries were permitted to disenroll and switch to fee for service during the first 90 days of membership, Medicare would realize some savings but fewer than under a more restrictive disenrollment policy. Our analysis of 1994 California data indicates that Medicare would have saved, at most, \$22 million if beneficiaries had been permitted to disenroll to fee for service only within the first 90 days.

These estimated savings probably represent the upper limit of what Medicare could have saved in California in 1994. Our estimates assume that beneficiary behavior and enrollment patterns would not change as the result of a limited disenrollment policy. However, as the following section discusses, beneficiary behavior will likely be affected by such a policy. (See app. III for further information regarding our analyses of potential Medicare savings.)

Limiting Disenrollment Would Reduce Beneficiary Protections and Could Increase Beneficiary Dissatisfaction

According to HCFA officials and beneficiary advocates, limiting beneficiaries' ability to disenroll from plans would remove a valuable beneficiary protection. Medicare's current policy allows any beneficiary who is dissatisfied to disenroll and join a new plan or change to fee for service at the end of each month. Changing the disenrollment policy could also weaken plans' incentive to maintain the quality of the services and care they provide. Finally, without the ability to disenroll, HCFA and HMOs believe that beneficiaries are likely to file more grievances and appeals.

Although most beneficiaries do not change plans frequently,¹⁹ some HMOs have high member disenrollment rates, which can signal member dissatisfaction. We recently reported that one HMO in Miami and one in Los Angeles had 1995 disenrollment rates of 37 percent and 42 percent, respectively.²⁰ One Miami HMO with high disenrollment rates had a 7-year history of Medicare deficiencies, including those involving beneficiary appeal rights and quality assurance. Thus, although most members appear to be satisfied with their HMO, problems do exist, and the freedom to disenroll provides a course of action for dissatisfied plan members.

Some beneficiary advocates believe that to ensure continuity of care, beneficiaries should be able to disenroll from an HMO if their physician

¹⁹Of the beneficiaries who enrolled in a risk HMO in January 1995, about 82 percent were still in their same plan in May 1996. Of the 18 percent of beneficiaries no longer in their original plan, some had moved out of their HMO's service area or had died.

²⁰GAO/HEHS-97-23, Oct. 22, 1996.

leaves the plan. In fact, this may be a common reason for switching HMOs or changing to fee for service. A 1992 study reported that 26 percent of beneficiaries who disenrolled from an HMO cited their doctor's leaving the HMO as a reason for disenrolling.²¹ One large HMO told us that after terminating a contract with one of its physician groups, nearly all 1,668 members assigned to those physicians disenrolled from the HMO. Representatives of the plan believe that these members followed their physicians to a competing HMO that also contracted with the physician group. The Physician Payment Review Commission recently recommended that if a limited disenrollment policy is established, beneficiaries have the right to disenroll before year-end or to purchase services on a special point-of-service basis for the rest of the year if a plan makes a major change in its network of providers during the year.²² However, the Commission acknowledged that defining the precise circumstances for permitting disenrollment could be difficult.

HMO representatives believe that beneficiaries' current ability to disenroll at the end of any month is good for competition and, thus, good for consumers. The need to retain members who can disenroll motivates plans to maintain quality, work for member satisfaction, and improve benefits continuously throughout the year. For example, officials at one large HMO told us that it increased benefits three times in 1995 to remain competitive. The HMO increased its pharmaceutical benefit, reduced beneficiary copayments for office visits, and improved its dental coverage.

Representatives of several HMOs told us that an enrollment policy that includes a 90-day disenrollment option would be better for beneficiaries than no disenrollment option at all but that the current practice of permitting monthly disenrollment is far better for industry competition and for beneficiaries. Many beneficiaries who disenroll from their risk HMO do so within the first 90 days. For example, of about 326,000 beneficiaries who joined a risk HMO during the first 3 months of 1995, 14.4 percent disenrolled within 1 year or less, but a disproportionate amount—5.6 percent—disenrolled in less than 90 days.

On the other hand, representatives of one HMO speculated that if beneficiaries were permitted just 90 days to disenroll, short-term disenrollment rates would soar. Beneficiaries who are less than

²¹Frank W. Porell and others, *Factors Associated With Disenrollment From Medicare HMOs: Findings From a Survey of Disenrollees* (Boston: Health Policy Research Consortium of Brandeis University, 1992).

²²Physician Payment Review Commission, *1996 Annual Report to Congress* (Washington, D.C.: Physician Payment Review Commission, 1996).

completely satisfied with their HMO might quickly disenroll, rather than give their plan a chance to address their complaints.

HCFA officials predict that without the option of disenrolling, dissatisfaction among HMO members would manifest itself in other ways, such as an increase in grievances to HMOs and appeals to HCFA—a prediction that was echoed throughout our visits to HMOs. This prediction is supported by data we obtained from one HMO. In 1995, over 90 percent of this plan's Medicare group membership was "locked into" the HMO for the year. Because of conditions set by the beneficiaries' former employers, these members could change plans only during annual enrollment periods.²³ Group members filed grievances at a rate 100 times greater than that of individual members who could disenroll monthly. Group members filed 60 times more appeals than individual members. HMO representatives speculated that individual members who were dissatisfied simply disenrolled, rather than file grievances or appeals.

Limited Disenrollment Could Further Slow Managed Care Growth

HCFA officials and nearly all the HMOs we contacted shared a strong belief that limiting disenrollment opportunities would deter some beneficiaries from joining managed care, although none of the representatives could quantify the extent to which this would occur. Managed care is a relatively new concept to some Medicare beneficiaries, and a 1-year lock-in requirement could discourage beneficiaries from trying managed care. Some beneficiaries might not join HMOs because, even if dissatisfied with the care they received or denied a procedure they believed was critical, they would have little recourse available. Medicare has an appeals process in place, but, of course, beneficiaries have no guarantee that the appeal will be resolved in their favor. Some beneficiaries might not enroll in a plan if they knew they would not be able to follow their physicians, should the physicians leave the plan mid-year.

HCFA Would Face Peak Load Problems and Additional Responsibilities

Implementation of a limited enrollment period could strain HCFA's resources by creating a peak load and by increasing HCFA's responsibilities. HCFA's enrollment and disenrollment activities would be concentrated in a short period of time, rather than spread out during the year. Also, HCFA would need to provide beneficiaries access to a consumer hot line and comparative plan information, both of which would likely be required under a limited enrollment period policy.

²³These beneficiaries could have disenrolled at any time and joined another HMO as individuals but would have lost the additional health coverage benefits offered by their previous employer.

HCFA Would Need to Adapt to Peak Workload

HCFA could face problems in completing tasks such as processing enrollments. Currently, HCFA processes about 100,000 transactions a month, or 1.2 million transactions a year, which include enrollments, disenrollments, and status changes. Plans electronically submit these data, which are processed by computers at HCFA—generally within a few days. However, problems could arise, such as incomplete data or discrepancies in data, which could require follow-up work by HCFA. Some HCFA officials told us that the agency could manage the peak workload associated with a limited enrollment period. However, representatives of HMOs, other organizations, and even some HCFA officials said the agency sometimes had difficulty managing its current workload and meeting deadlines; they were skeptical of HCFA's ability to handle a peak workload with current resources.

CalPERS²⁴ and FEHBP²⁵ both operate a single annual enrollment period and face a peak load each year. CalPERS hires temporary workers and allows the permanent staff to work overtime hours. FEHBP contracts with a private firm to handle enrollment changes for federal retirees. (Each federal agency handles enrollment changes for its current employees.) HMOs that experience a peak load from their commercial business often hire temporary workers or shift employees from other departments within the HMO.

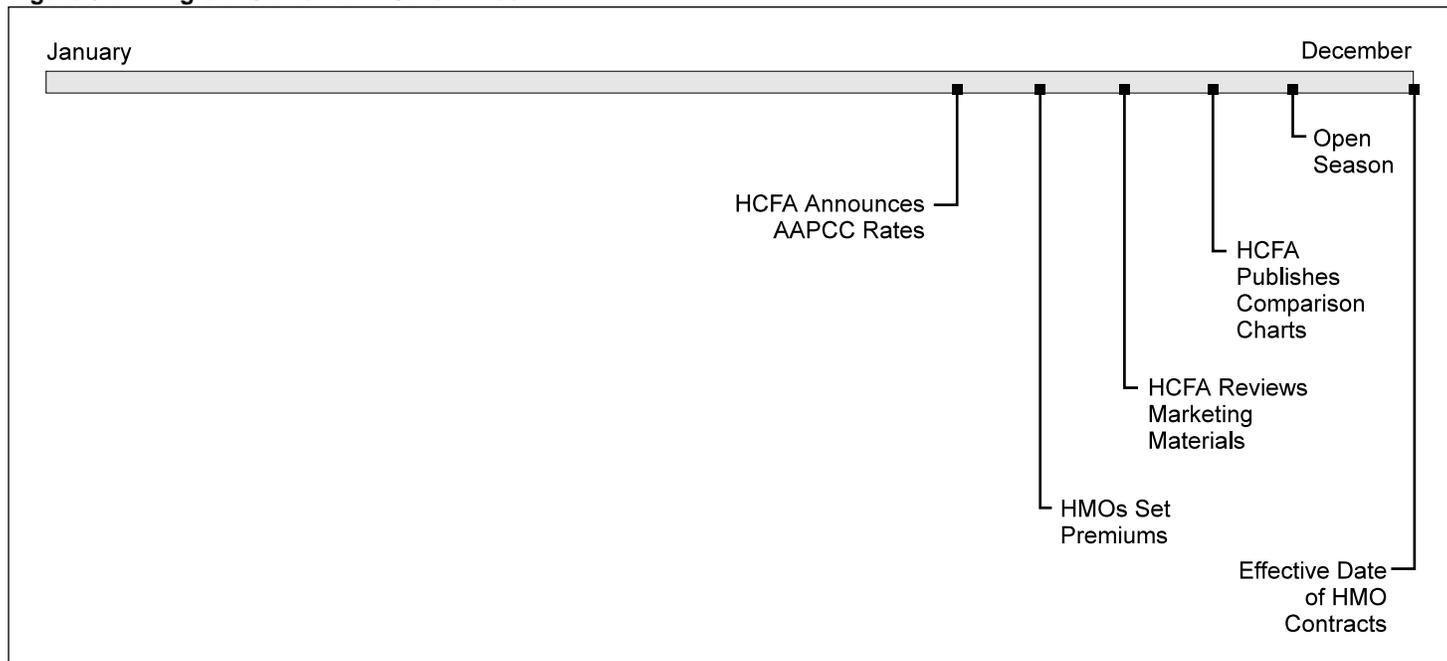
HCFA might need to change other activities to accommodate the timing of a limited enrollment period. For example, every year HCFA announces risk HMO capitation payment rates in September.²⁶ This allows HMOs time to decide whether they will renew their contract and to adjust premiums and benefits before the new contract cycle begins in January. Depending on the timing of the enrollment period, the announcement of the payment rates might need to occur earlier in the year so that HMOs could set premiums and benefits before Medicare's open season. Sufficient time would also be needed for HCFA to produce and publish comparison charts as well as to review HMOs' marketing materials. (See fig. 5.)

²⁴CalPERS manages health benefits for about 1 million public employees and retirees. It operates one open season, during which employees and retirees make about 120,000 enrollment changes annually. See app. II for additional information on CalPERS.

²⁵FEHBP manages health benefits for about 9 million employees, retirees, and dependents. See app. I for additional information on FEHBP.

²⁶The capitation payment is based on the adjusted average per capita cost (AAPCC), an actuarial projection of what Medicare expenses will be for a given category of Medicare beneficiaries in traditional fee-for-service Medicare. The rates change each calendar year.

Figure 5: Timing of HCFA and HMO Activities



Source: GAO analysis.

HCFA Would Have Additional Responsibilities Under Limited Enrollment Period Policy

Under a limited enrollment period policy, HCFA would likely be responsible for additional tasks. Some tasks would be new for HCFA; for example, the BBA envisioned that the agency would prepare and distribute comparative information. Other tasks would represent expansions of HCFA's current role—for example, operating an information hot line for beneficiaries and resolving an increased volume of beneficiary complaints. The amount and extent of these tasks would, of course, depend on the specifics of the limited enrollment period policy enacted.

HCFA has efforts under way to produce comparative health plan information but would need to take additional steps to distribute that information to beneficiaries. Two of HCFA's regional offices have developed charts that compare local HMOs' premiums and benefits, but these charts—although available upon request—are not widely distributed.²⁷ The agency is working to make some HMO comparative information available on the Internet but has no plans to distribute printed information directly to

²⁷HCFA's regional offices in San Francisco and Philadelphia have developed charts comparing the benefits and premiums of local HMOs. The charts are distributed to news organizations and insurance counselors primarily. (See GAO/HEHS-97-23, Oct. 22, 1996, for additional information.)

beneficiaries. Currently, HCFA intends to leave information distribution to beneficiary advocates and federally supported insurance counselors.²⁸

Although HCFA has an information hot line for Medicare beneficiaries with questions about Medicare, the system would likely be inadequate to handle the volume of calls generated under a limited enrollment period policy.²⁹ Representatives of HMOs, beneficiary advocacy groups, and benefit consulting firms cautioned us that older people need time to understand their options. Older people also seek considerable information before deciding to join an HMO. Some large national brokers operate hot lines for their client companies. These hot lines, staffed by trained counselors who are familiar with Medicare and the company's specific plan, answer questions posed by the company's retirees. Officials told us that these hot lines need to be able to handle a large volume of calls. For example, the hot line for one company (with 57,000 retirees) received about 1,000 calls a day from the retirees during the 1995 enrollment season—even though retirees not changing plans did not have to re-enroll.³⁰ Some retirees called repeatedly with questions about each step of the application and enrollment process.

HCFA plans to test the distribution of special handbooks and detailed comparison charts as part of its Medicare Competitive Pricing Demonstration Project.³¹ These documents would contain information on managed care plans and fee for service with Medigap that would help beneficiaries make enrollment choices. HCFA also intends to make a telephone counseling center and educational seminars available to beneficiaries with questions. However, the demonstration project has already been postponed once. According to HCFA officials, it is now scheduled to begin during 1997.

In addition to preparing comparative information and operating a hot line, HCFA would need both guidelines and procedures under which it would allow beneficiaries to change plans outside the open season. With a limited enrollment period, beneficiaries would be expected to change

²⁸These counselors, many of whom are volunteers, are available through the federally supported, but state-managed, Information, Counseling, and Assistance program. Counselors can provide beneficiaries with general information about Medicare, Medicaid, managed care plans, and various types of health insurance to supplement Medicare.

²⁹Currently, the hot line receives about 50,000 calls a month from beneficiaries with questions on various issues—including managed care.

³⁰Officials explained that this type of enrollment system, so-called "passive enrollment," tends to reduce the number of beneficiary hot line calls.

³¹See footnote 9 for information on the Competitive Pricing Demonstration Project.

plans only during the designated open season. However, as in other programs with limited enrollment periods, exceptions would likely be allowed.³² The BBA specified several conditions under which beneficiaries could change plans outside the enrollment period. Some conditions—for example, a beneficiary’s moving out of a plan’s service area—would be easy for HCFA to evaluate and determine whether a plan switch would be allowed. However, other conditions specified in the BBA would require HCFA to investigate the specific case before making a determination. For example, the BBA would have allowed beneficiaries to disenroll if they could demonstrate that the health plan had materially misrepresented the plan’s provisions in its marketing.

Conclusions

Encouraging enrollment in a managed care plan can help the government’s efforts to reduce high service utilization in the Medicare program without unduly diminishing beneficiary access to services. To the extent that enrollment and disenrollment policy revisions force health plans to retain and serve Medicare’s more costly beneficiaries, the government can battle the effects of the high utilization tendency inherent in unmanaged fee-for-service reimbursement. However, these same policy revisions could produce disincentives and obstacles to greater managed care enrollment—for beneficiaries, health plans, employers, and HCFA—thereby undermining the government’s very effort to lower utilization.

In fact, an annual limited enrollment period, along with restricted disenrollment options, could have little impact on overall Medicare spending. Although such a policy would reinforce the concept of managed care and reduce the opportunities for less healthy HMO enrollees to change to Medicare fee for service, our analysis suggests that the savings might be relatively small. For example, if enrollment and disenrollment had been limited for California beneficiaries in 1994, Medicare savings would have been—at most—\$20 million to \$30 million. In contrast, Medicare spent \$4.2 billion on payments to California HMOs during that year.

Moreover, an enrollment policy change would likely have several unintended consequences, including the loss of important beneficiary protections and complications for many employers who offer managed care to their retirees. The result could well be substantially slower growth

³²For example, the 1995 criteria FEHBP used to allow enrollment changes outside open season included 27 events, such as changes in marital or family status, changes in employment status, relocation to another part of the country or to another country, the member becoming eligible for Medicare, the member’s or a family member’s losing Medicaid coverage, and changes in the member’s health plan.

in Medicare managed care and increased beneficiary dissatisfaction. The magnitude of these impacts would depend, however, on the details of the adopted policy, beneficiary and employer reaction to those details, and the effects of any other policy changes made at the same time.

Agency Comments

We provided copies of this report to officials of HCFA's Office of Managed Care. HCFA agreed that the monthly disenrollment option is an important consumer protection. Our report indicates that changing Medicare's current policy of allowing beneficiaries to switch among HMOs or between an HMO and fee for service could have far-reaching consequences. We reported that this view is shared by beneficiary advocates and HMO officials, who also believe that eliminating this option would deter some beneficiaries from joining a managed care plan.

HCFA also stated that any analysis of beneficiary choice issues should examine Medigap policy. Our report notes that under current law, beneficiaries have no guarantee that a Medigap policy will always be available to them when they disenroll from an HMO. As a result, they may be reluctant to join an HMO. HCFA commented that it supports changes to the Medigap statute so that beneficiaries dissatisfied with their managed care plan would be able to return to fee for service and to the Medigap policy of their choice. In a 1996 report, we made a similar recommendation.³³ HCFA's comments appear in appendix IV.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 5 days after the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services. We will make copies available to others on request.

³³Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting (GAO/HEHS-96-180, Sept. 10, 1996).

Please contact me at (202) 512-7114 if you or your staff have any questions. Major contributors to this report are listed in appendix V.

Sincerely yours,

A handwritten signature in black ink that reads "William J. Scanlon". The signature is written in a cursive style with a large, prominent "S" at the end.

William J. Scanlon
Director, Health Financing and
Systems Issues

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Abbreviations

AAPCC	adjusted average per capita cost
BBA	Balanced Budget Act of 1995
CalPERS	California Public Employees' Retirement System
FEHBP	Federal Employees' Health Benefits Program
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
NCS	National Computer System
OPM	Office of Personnel Management

The Federal Employees' Health Benefits Program

Overview

To help us analyze the impact of a limited enrollment period, with limited disenrollment, we looked at the Federal Employees' Health Benefits Program (FEHBP). We selected FEHBP because it is a large employer-sponsored health insurance program that conducts an annual enrollment period (called an "open season") and, like Medicare, offers members a choice of health plans.

FEHBP is the largest employer-sponsored health insurance program in the world. The Office of Personnel Management (OPM) administers the program, which went into effect on July 1, 1960. FEHBP currently provides voluntary health insurance coverage for about 9 million people, including 2.3 million active employees, 1.8 million retirees, and 5 million dependents. In fiscal year 1995, FEHBP spent about \$17.7 billion to cover its members. FEHBP outperforms Medicare—and probably private plans—in controlling health care costs.

The federal government and FEHBP members share program costs. The government contribution is readjusted annually. For 1997, the federal government's maximum annual contribution is \$1,630 for individuals and \$3,510 for families.³⁴ The beneficiary's contribution for individual coverage ranges from about \$400 to \$2,000 or more, and family coverage ranges from \$800 to almost \$5,000.

In 1994, 59 percent of FEHBP retirees aged 65 or older also enrolled in Medicare, although enrollment is not mandatory.³⁵ When a retiree enrolls in Medicare, FEHBP serves as a supplemental insurance policy. FEHBP plans must waive deductibles, copayments, and coinsurance for services covered by both programs. Retirees pay the same premiums as current employees.

FEHBP offers a selection of several types of health plans, including many managed care plans. As in Medicare, the number of plans offered to members varies by location. Most of the fee-for-service plans (12 of 15) offer a preferred provider organization option. Under FEHBP, individual health plans establish their own relationships with providers, process individual claims, develop benefits, and devise marketing strategies.

³⁴The federal government cannot pay more than 75 percent of a plan's total premium.

³⁵A 1983 amendment to the FEHBP legislation extended Medicare coverage to FEHBP members aged 65 or older. Before 1983, such members were prohibited from participating in the Medicare program.

Since 1980, the number of HMOs has increased significantly. By 1995, about 29 percent of FEHBP members were enrolled in HMOs.³⁶ Like the Medicare population, however, a much lower proportion of older retirees were enrolled in HMOs; by 1996, only about 12 percent of FEHBP members aged 65 and older and 10 percent of Medicare beneficiaries were enrolled in HMOs. Studies have shown that FEHBP members who choose an HMO are generally younger and healthier than members who select fee-for-service plans.

Role of OPM and Employing Agencies

OPM administers FEHBP, although each federal agency collects information and premiums from employees. OPM also interprets the health insurance laws, writes regulations, and resolves disputed claims. OPM approves qualified plans for participation in the program and negotiates with plans nationwide to determine benefits and premiums for the following year. OPM also publishes enrollment and health plan information, including charts that compare benefits and premiums. OPM requires that the same premium be offered to employees and retirees, regardless of their age, gender, or health status. It also requires that national plans offer the same premium nationwide. Local plans may offer local rates.

Enrollment

FEHBP holds one annual open season, during which employees and retirees may voluntarily enroll in a plan, change plans or options within a plan, or change from individual to family coverage. Most changes by retirees occur during the first 2 weeks of the enrollment season. In 1996, open season occurred between November 11 and December 9; changes made during open season became effective on January 5, 1997—the first day of the next insurance year. Each year, about 5 to 10 percent of beneficiaries change plans.

Enrollment for Retirees

Most federal employees remain members of FEHBP when they retire; they are familiar with how the open season works and with how to obtain their health plan information. However, retirees who choose to disenroll from the program cannot return unless they had joined a Medicare risk HMO. They are required to sign a form to show they understand that they cannot subsequently rejoin.

Retirees can receive health plan information from health fairs; from FEHBP directly; and from the National Computer System (NCS), an Iowa City,

³⁶Enrollment by Medicare beneficiaries in HMOs has increased from 1 million in 1987 to about 4 million in 1996.

Iowa, contractor that conducts retiree enrollment activities. Each year, some members of the Congress sponsor local health fairs for federal employees and retirees. Most of the people who attend such fairs are retirees, in part because current employees attend employer-sponsored health fairs. Retirees can also call FEHBP directly to request information or to discuss their options. The Retirement Information Office receives about 6,000 calls a month, with about 25 percent of the calls focusing on health plans. During open season, the Health Benefits Branch receives about 500 calls a day requesting information. NCS, however, does not deal directly with retirees. Occasionally, it receives calls from retirees but refers them to OPM.

For the past 10 years, OPM has had a contract with NCS to handle printing, distribution, processing, and brochure requests. OPM sought a contractor because it wanted to use technology, such as scanning and other automated equipment, that OPM did not have. Also, NCS can hire temporary workers during busy times of the year; OPM does not have the staff to handle retiree enrollment. OPM believes that the third-party contract with NCS is more efficient and less expensive than if OPM was to do the work in house.

About June of each year, OPM designs a health benefits application form and sends it and a computer tape of the retiree rolls to NCS. NCS waits until approximately the first week in September, when the OPM Policy and Information Office produces the final list of plans and premiums. Then, NCS prints a final list of available plans. In addition, it prints the comparative information with a rate sheet and envelopes with addresses. At the end of October, NCS mails to retirees an E-Z application form, an instruction form with the rates, and a return envelope. Retirees who want to change plans return their forms to NCS, which enters the change on its computer and sends the information to OPM weekly during open season.³⁷ OPM notifies plans of any changes.

When retirees receive the information from NCS, they can request an enrollment change or request additional information on specific plans. Unless they request information from NCS, they will only receive it from their current plans. Those who do not return their forms automatically remain in the plan to which they belonged the previous year.

³⁷Currently, OPM also allows retirees to make enrollment changes by telephone.

Role of HMOs

HMOs supply plan information to FEHBP, which distributes it to retirees through NCS. HMOs can also market to retirees through advertisements in newspapers, radio, and on television. However, they generally do not contact retirees directly unless a retiree is already a member of the HMO. In contrast, Medicare risk HMOs are responsible for marketing to prospective members; HCFA does little to provide plan information directly to beneficiaries. In addition to doing the same kind of mass media advertising as FEHBP HMOs, Medicare risk HMOs are permitted to conduct one-on-one and group meetings. Medicare HMOs rely heavily on these techniques to attract new members.

The California Public Employees' Retirement System

Overview

To help us understand the impact of a limited enrollment period, we examined the California Public Employees' Retirement System (CalPERS). As with FEHBP, CalPERS is a large organization that conducts an open season each year and offers members a choice of health plans. For about 35 years, CalPERS has offered health insurance to employees of public agencies. In 1995, CalPERS had about 1 million members and paid \$1.5 billion in health care premiums.

The organization has two divisions. The Health Plan Administration Division negotiates contracts and rates with the HMOs. The Health Benefit Services Division handles enrollments or changes in plans and conducts educational activities for members.³⁸ Each year, the Health Benefit Services Division processes about 120,000 enrollment documents.

CalPERS offers members a choice of 22 plans. During the open season, plans must accept enrollees regardless of health status, age, or previous medical condition. CalPERS encourages its members to join an HMO by allowing members to choose from among 16 HMOs, including 9 Medicare risk HMOs. Currently, about 76 percent of CalPERS members are enrolled in HMOs. For people who are eligible for Medicare, the advantage of enrolling in an HMO through CalPERS is that CalPERS will reimburse them for the Medicare part B premium. If retirees were not enrolled in a CalPERS health plan at the time they retired, they are not eligible to enroll during their retirement. Also, CalPERS offers HMO benefits, such as prescription drugs, that are better than the benefits people could obtain individually.

To make comparisons easier for members, CalPERS requires HMOs to offer similar coverage. In addition, plans cannot charge more than the standard premium, which is the same for anyone enrolling in the specific plan. The amount an employer contributes to a premium varies among the public agencies participating in CalPERS.

Enrollment

CalPERS has one annual open season. During 1996, the dates were changed from an open season beginning May 1 with an effective date of August 1 to an open season beginning September 1 with an effective date of January 1, 1997. CalPERS changed its season to coordinate its deductibles with its preferred provider organizations and with other state benefits such as the vision and dental care programs. The preferred provider organizations with which CalPERS contracts and the other state programs operate on a calendar year. CalPERS officials told us that they found the process of

³⁸In 1995, about 4 percent of CalPERS members changed plans.

shifting the health benefits cycle manageable and not very costly but that the organization needed about 15 months to prepare for the change.

Retirees who want to change plans visit the CalPERS office in person or submit a written request. Medicare beneficiaries must notify CalPERS in writing of a change in enrollment. CalPERS instructs Medicare beneficiaries to mail their enrollment information directly to the HMO of their choice during open season. The plan sends the new enrollment information to HCFA.

CalPERS officials characterized the peak load associated with open season as a time when the staff members are “basically busier.” To handle the peak load, the organization hires temporary workers and allows its permanent staff to work overtime hours.³⁹

Educating members is an important task for CalPERS, especially educating older people who fear signing over their Medicare cards to an HMO. CalPERS sponsors retirement seminars for active employees who are within 5 years of retirement. It also offers 4-hour individual sessions for people who will retire soon. During the open season, CalPERS provides generic educational information to its members. For example, CalPERS publishes a booklet annually that describes the features of each plan. It also publishes a companion booklet that contains comparisons of the quality and performance of plans. In 1995, CalPERS sent the books directly to all members. In past years, CalPERS held quarterly informational seminars for retirees; however, the seminars were discontinued because of poor attendance.

CalPERS mails an exit survey to members who leave a plan to determine why they left. Last year, it mailed 15,227 surveys to members with basic coverage and 1,535 to members with supplemental and managed care plans. In 1995, CalPERS also sent members a survey that measured member satisfaction. This survey was sent to a random sample of members of various plans. Findings from the exit survey allow CalPERS staff to evaluate the medical care and services the members receive as well as discuss areas of dissatisfaction with HMO representatives during contract negotiations. CalPERS officials believe that the two surveys provide members with a balanced perspective of member experience with their health plan.

³⁹Officials could not provide us with data on the amount of overtime worked.

Appendix II
The California Public Employees'
Retirement System

CalPERS, like FEHBP, restricts HMOs' ability to market directly to members, although general marketing takes place statewide. Plans are not allowed to use gifts as incentives and are prohibited from directly soliciting people who are not members of their plan.

CalPERS officials have no data on the number of members who travel seasonally ("snowbirds"). However, they estimate that between 8 and 10 percent of their Medicare enrollees might be snowbirds. To assist such members in receiving health services, CalPERS has encouraged HMOs to develop reciprocal agreements with other plans.

Methodology

We assumed that a new Medicare enrollment policy might be similar, but not necessarily identical, to the provisions contained in the conference report that accompanied the Balanced Budget Act of 1995 (BBA), H.R. 2491.⁴⁰ Therefore, we developed and analyzed a limited enrollment period policy modeled on the BBA. Although other alternatives are available to Medicare beneficiaries, we focused our attention on enrollment in risk HMOs because they currently serve most beneficiaries not in Medicare fee for service. The hypothetical policy we used to guide our analysis had three basic characteristics:

- One enrollment period and one date when benefits became effective would be specified. However, beneficiaries could elect coverage when they first became eligible for Medicare benefits regardless of the time of year this occurred.
- The Secretary of HHS would be responsible for producing and distributing comparative plan information to beneficiaries as well as making a hot line available to them.
- Beneficiaries could disenroll from an HMO during the year, but they would automatically be enrolled in fee for service. Beneficiaries could switch to another HMO during the year only under limited circumstances, including moving out of their HMO's service area.

We also analyzed the effect of limiting beneficiaries' disenrollment options under two alternative scenarios:

- no disenrollment would be allowed, except under specified circumstances, such as moving out of the health plan's service area; and
- disenrollment would be allowed for any reason during the first 90 days after coverage was effective, but no disenrollment would be allowed after 90 days except under specified circumstances.

To gather information on the likely effects of a limited enrollment period and limited disenrollment opportunities, we interviewed representatives of 10 Medicare risk HMOs, the American Association of Health Plans, HCFA, national benefits consulting firms, selected large employers who offer managed care options to retirees, Medicare beneficiary advocacy organizations, FEHBP, and CalPERS. In addition, we surveyed HMOs with Medicare risk contracts regarding their employer group business.

⁴⁰House Conference Report 104-350, pp. 1093-1102. Because the act was vetoed by the President, these provisions did not become law.

We analyzed HMO disenrollment data and fee-for-service claims in California to estimate potential Medicare savings from limiting disenrollment.

Estimate of Potential Savings From Limiting Disenrollment

To estimate the potential Medicare savings that a policy limiting disenrollment opportunities might generate, we compared 1994 Medicare expenditures for California beneficiaries who changed from an HMO to fee for service with the expenditures that Medicare would have incurred had these beneficiaries been required to remain in their HMO throughout the year. We limited our analysis to California beneficiaries to reduce the computational burden. Nonetheless, because Medicare HMO enrollment is concentrated in a relatively small number of states—including California—our analysis covers about 36 percent of all Medicare beneficiaries enrolled in a risk HMO in 1994.

We selected our sample population using 1994 data from HCFA's Enrollment Database. We identified 738,000 Medicare beneficiaries who met the following criteria: in January 1994 they belonged to a risk HMO, they were eligible for Medicare parts A and B, and they reported living in the same county 1 year later (in January 1995).⁴¹ We then identified a subset of 15,772 beneficiaries who changed to fee for service for 1 or more months during 1994.

We computed the amount that Medicare would have paid for each of the 15,772 beneficiaries if they had remained in their HMO for the entire year. This amount varies by beneficiaries' county of residence and demographic and other factors.⁴² We then calculated the amount Medicare actually spent on these beneficiaries in 1994—that is, the capitation payments for the period they were enrolled in an HMO plus their claims payments⁴³ for the period they were in fee for service.

Finally, we estimated potential savings by subtracting the amount Medicare would have paid if the 15,772 beneficiaries had remained in HMOs from the amount Medicare actually paid during the year. To estimate

⁴¹Because the BBA would have allowed beneficiaries who moved out of their HMOs' service areas to return to fee for service, we excluded 25,918 beneficiaries who reported living in a county in 1995 that was different from the county they reported in January 1994.

⁴²The demographic characteristics that affected HMO capitation payments in 1994 were age, sex, institutional status, and Medicaid status. Capitation rates also depend on whether a beneficiary is disabled or has end-stage renal disease.

⁴³The claims payments covered inpatient services, outpatient services, physician/supplier services, care in a skilled nursing facility, care in a hospice, home health care, and durable medical equipment.

potential savings of a policy that would allow beneficiaries to return to fee for service during the first 90 days, we followed the same steps, but included only those 11,684 beneficiaries who changed to fee for service on April 1, 1994, or later. (These estimates are reported in table 2.)

Our estimates are probably upper bounds on potential savings in California. If a limited disenrollment policy discouraged some beneficiaries from initially enrolling in an HMO, potential savings could be lower. Whether potential national savings can be extrapolated using our estimates for California depends on whether beneficiaries switch to fee for service at the same rate in other states as they do in California. Nonetheless, the behavior of Californians would heavily influence estimates of national savings because that state accounted for 44 percent of all payments to Medicare risk HMOs in 1994.

Survey of Medicare Risk HMOs

To collect information on contracts between Medicare HMOs and employer groups, we mailed a survey to all 118 HMOs that had risk contracts in effect on January 1, 1995. Eighty-three percent of the HMOs responded to our survey and provided us with summary data on retiree group contracts, including whether the contracts had a limited enrollment period and a lock-in requirement.

Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

FEB - 7 1997

TO: William J. Scanlon
Director, Health Financing and
Systems Issues
General Accounting Office

FROM: Bruce C. Vladeck *Bruce Vladeck*
Administrator

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare: Potential Effects of a Limited Enrollment Period Policy"

We oppose changes in the current Medicare HMO disenrollment policy, which allows a beneficiary to disenroll from a managed care plan on a monthly basis. The monthly disenrollment option is an important consumer protection and provides an incentive for plans to maintain high quality standards. Further, we believe any examination of beneficiary choice issues should include an examination of Medigap policy. In that regard, we support changes to the Medigap statute that would provide beneficiaries with an annual open enrollment opportunity in addition to other open enrollment opportunities triggered by certain events (e.g., a managed care enrollee's primary care physician leaves the plan). These types of reforms would ensure that beneficiaries who join a managed care plan and are dissatisfied would be able, during the open enrollment period, to return to fee-for-service and to the Medigap plan of their choice.

We appreciate the opportunity to review the report. Should you have questions or require additional information, kindly contact Ron Miller of the Executive Secretariat at (410) 786-5237.

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Appendix V
Major Contributors to This Report

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Related GAO Products

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

Medicaid: States' Efforts to Educate and Enroll Beneficiaries in Managed Care (GAO/HEHS-96-184, Sept. 17, 1996).

Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting (GAO/HEHS-96-180, Sept. 10, 1996).

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-75, Jan. 18, 1996).

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

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