Medicare Rights Center

Elimination of HMO Lock-In: A Vital Consumer Protection

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Executive Summary

Beginning in July 2006, people with Medicare will have limited opportunity to change health plans. They will be able to do so once during the Open Enrollment Period (January 1–June 30) and once in the Annual Coordinated Election Period (November 15–December 31). This is known as the lock-in. The Medicare Rights Center anticipates that this provision will threaten the ability of countless numbers of people enrolled in private Medicare plans to secure needed care. The ability to elect a different plan or return to Original Medicare in a timely fashion has often allowed people to get needed medical care or to lower financial liability. It preserved consumer choice (of doctors and hospitals) and acted as an essential countermeasure to inappropriate marketing, unexpectedly high-patient costs, network restrictions, and unjustified denials of coverage. Given the evidence that lock-in provides no benefit to the system and can hurt the most vulnerable people with Medicare, we urge Congress to lift lock-in to allow people to change health and drug plans anytime during the course of the year.

Introduction

Historically, many people with Medicare have enrolled in a Medicare HMO* without a clear understanding of how their health care will change. They often realize this only months or years after enrollment, when the HMO denies necessary and sometimes urgent care. Many also enroll after HMO marketing representatives gloss over the coverage restrictions or the cost-sharing details or engage in high-pressure sales tactics, such as unsolicited door-to-door marketing, to which older Americans are particularly susceptible.

Several of the consumer misconceptions the Medicare Rights Center (MRC) recounted in a September 1998 report "Systemic Problems with Medicare HMOs" are still prevalent. There are callers to MRC's hotlines who believe that a Medicare HMO is supplemental insurance secondary to Original Medicare. Some regularly spend several months of the year outside the region where their HMO operates and are surprised to find out that the HMO will refuse to cover nonurgent care outside the network. Others visit a specialist without the requisite referral from their primary care physician (PCP). And then there are people who believe it is "simply better to have more insurance."

Since 1989, MRC has assisted people with Medicare when they encountered problems with their health coverage under a Medicare HMO. The problems fall into three broad categories:

- Network restrictions limiting choice of doctor or hospital;
- Unexpectedly high cost-sharing, especially at a time of need; and
- Inappropriate coverage denials.

Often the remedy has been to disenroll people from their HMO. While prospective disenrollment is the solution for some, in other cases MRC has had to retroactively disenroll clients so that claims denied by the HMO may be paid by Original Medicare.

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* HMOs are the most common type of Medicare Advantage (MA) plans, private plans that medical benefits under Medicare. Other MA plans include preferred provider organization (PPOs), which charge higher cost sharing for out-of-network services, and private fee-for-service plans, which covers services at any provider that accepts its rates. Drug plans offered by MA plans are referred to as MA-PDs.

But starting July 1, 2006, people with Medicare will be locked into their HMO. The majority of people with Medicare in HMOs will have no recourse when faced with unexpected coverage denials, high cost-sharing or network restrictions. Those who receive the help of trained counselors may be able to disenroll with the use of a Special Enrollment Period (SEP—see table below for eligibility criteria), although how this process will work after lock-in starts remains unclear.

Table 1: Eligibility Criteria for Special Enrollment Period

From 2006 onward, people with Medicare will be limited in when and how often they can enroll in or change their Medicare HMO or drug plan. However, specific circumstances may qualify them for a Special Enrollment Period (SEP).* Reasons for SEPs include the following:

1. Loss of creditable drug coverage (union/employer coverage or otherwise);
2. Having Medicaid, Medicare Savings Program (MSP), Supplemental Security Income (SSI), and/or Extra Help;
3. Enrollment/disenrollment from a Program of All-Inclusive Care for the Elderly (PACE);
4. Institutionalization;
5. Relocation out of a plan's service area;
6. Contract violations by the plan or enrollment errors;
7. Termination of plan's Medicare drug plan contract;
8. Having had Medicare eligibility problems;
9. A first-time Medicare Advantage (MA) plan enrollee who enrolled in an MA plan at the same time he or she qualified for Medicare based on age, can disenroll from the MA plan to return to Original Medicare.**

* Because the first Part D enrollment periods are only drawing to a close, there is little data to evaluate how the Special Enrollment Periods work in practice. People with Medicaid and/or a Medicare Savings Program are the only ones who have had several months' experience with their SEPs: since January 1, 2006, they have been able to change drug plans (both stand alone prescription drug plans and drug plans offered by MA plans) once a month. For the most part, drug plans have recognized this SEP. It remains to be seen how the other SEPs will be recognized in practice by the drug plans and by the Centers for Medicare & Medicaid Services (CMS).

** People who enroll in an MA plan at the same time they qualify for Medicare based on age can return to Original Medicare within the first 12 months after the start of the MA coverage. In the one month after disenrolling from an MA plan that provided drug coverage, they can also enroll in a stand alone prescription drug plan (PDP).

An additional provision concerning Medigap (insurance that supplements Original Medicare) exists for people who disenroll from their first MA, regardless of whether they enrolled in the MA in the first months of their Medicare eligibility. Some states limit when people can purchase a Medigap policy. If they drop their Medigap policy to enroll in their first MA plan, and then disenroll within 12 months of the coverage start date, then they may select another Medigap plan with an SEP. In addition, they can enroll in a PDP within the same SEP.

Lock-in was intended to improve continuity and coordination of care, as well as to make people with Medicare more accountable for their health plan choices and use of health services. The concept was that people would stay within a network of doctors and hospitals for a minimum period

of time. The primary care physician (PCP) would achieve a balance between meeting the patient's needs and minimizing waste. Plans would also have an incentive to pay for preventive services with a locked-in enrollee population, as healthier enrollees would require fewer expensive services in the future.

These benefits are unlikely to materialize. First, enrollees are locked into their plan while their doctors are not. When doctors drop out of the plan, their patients must find new doctors within the network or return to Original Medicare to follow their doctor. Allowing for changes in health plans in fact promotes continuity of care: one study found that over half of plan enrollees chose to move with their doctor when forced to choose between their doctor and staying with their health plan. Nationally, an average of 14 percent of primary care physicians stayed with their Medicare health plans for a year or less.[1] Taking away the option of changing insurance, lock-in would force a sizable number of patients to search for new doctors, thus disrupting continuity of care.

Likewise, under Medicare Part D, plans can change their formulary or formulary restrictions if they provide 60-days' notice or a 60-day transitional supply. Enrollees, however, are locked into the plan for the year despite these changes. Lock-in gives plans a free hand to disrupt existing drug therapy. The Centers for Medicare & Medicaid Services (CMS) requires plans to "grandfather" approval for drugs removed from coverage that the plan has already covered for its enrollees, but not for prescriptions that were filled prior to joining the plan. The onset of Part D has already affected continuity of care for those who face new restrictions on drugs they have taken for years. Lock-in will only exacerbate the situation.

Further, only 1.7 percent of enrollees switched plans in 2001.[2] Those who do switch at higher rates are traditionally vulnerable groups: people under 65 with disabilities and people with Medicaid. CMS allows people receiving Medicaid and Medicare to switch plans on a monthly basis, but the same protections do not apply to under-65 individuals who receive Medicare because of a disability. Lock-in would impose an unnecessary restriction for the majority of the population and curtail access to services for the minority that needs it most.

Finally, proponents of lock-in point to the potential savings that coordination of care may bring over time. Ideally, if people have access to the services that they need—no more and no less—then both savings and quality of care would increase. For example, regular preventive services would reduce the need for hospital care, one of the most expensive portions of health care budgets. But a one-year lock-in alone, without a comprehensive care management program, will not bring about these results.

A study of disease-specific care management programs found that cost savings were not significant over the course of six years (1996-2002).[3] It suggested several possibilities for the programs' inability to reduce cost, such as their lack of individualization and the rising cost of medical services in general.

As the following case examples demonstrate, frequent denials and inappropriate marketing practices have a negative impact on continuity of care. Follow-up services and diagnostic services are routinely denied, and sales representatives often do not tell people that they may not be able to continue to receive care from their doctors once they join the plan.

Given the evidence that lock-in provides no overall benefit to the system and can hurt the most vulnerable people with Medicare, the lock-in provision should be eliminated.

Marketing Abuses

Sales representatives are often at least partly responsible for people's uninformed decision to enroll. Many MRC callers claim that sales representatives leave out essential information, such as the possibility that their current doctors do not belong to the HMO's network. They also offer nonmedical benefits, such as discount cards for groceries, as incentives to enroll. When new enrollees discover that the HMO does not deliver what the representative promised, they usually disenroll immediately.

To protect people with Medicare from high-pressure marketing, sales representatives are not allowed to make home visits without an invitation. However, violations of this rule come up regularly, according to callers to MRC's hotlines. Moreover, MRC caseworkers who visit the community note that sales representatives are ubiquitous at places where people with Medicare gather, such as senior centers. They garner trust by being in a familiar environment or where people feel particularly vulnerable. A few senior centers admit that they receive monetary or in-kind "donations" from HMOs in exchange for permission to market on their premises.

Most marketing activity occurs in private conversations, and it is impossible to measure the representative's role in an uninformed enrollment. However, we present here cases where the enrollee was directly misinformed or enrolled under questionable circumstances.

True Stories

Ms. D is a social worker in a senior living community in New York. In March 2006, several residents came to her because their HMOs were rejecting their doctors' claims. They told her that sales representatives from another HMO had knocked on their doors while they were eating breakfast and convinced them to enroll. They had never had contact with this HMO and did not invite a representative into their home. Ms. D pursued retroactive disenrollments for her clients, helped them re-enroll in their previous HMOs, and complained to the state Department of Insurance.

Ms. T, a New York City resident, was on Original Medicare in August 2002 when a representative from an HMO called her. The representative claimed that he had called her primary care physician (PCP) and confirmed that the PCP accepts the HMO the representative was selling. Ms. T was convinced to enroll. Her PCP then referred her to a hospital for tests, which were denied because her PCP had not obtained prior authorization. When she questioned her PCP, she found out that he had never received a call from the HMO representative and that, in fact, he did not accept the HMO. MRC helped Ms. T disenroll retroactively from the HMO and put the claims through Original Medicare.

In March 2006, Mrs. M of New York enrolled in an HMO after seeing a presentation it hosted in her neighborhood during which the HMO offered new enrollees a $200 discount card for use at the local drugstore.
After Mrs. M signed up, her doctors told her that they did not accept that HMO. She subsequently disenrolled.

Part D and HMO Marketing

Confusion about Medicare HMO benefits and limitations increased amidst the anxiety surrounding Medicare Part D. Some people believed that they could only get Part D through an HMO. Others did not understand the difference between a stand-alone prescription drug plan (PDP) and a Medicare Advantage plan with prescription drug coverage (MA-PD), enrolling in the MA-PD by mistake and changing the way they access medical care. People will be able to disenroll from MA-PDs until June 30, after which the lock-in will begin.

True Story

In March 2006, Mr. L of New York went to a presentation given by an HMO. He invited a representative to his home, where he signed up for what he thought was a stand-alone prescription drug plan (PDP). Therefore, he was very surprised to hear from his doctor later that a claim had been rejected because he was no longer in Original Medicare. The HMO representative never explained to Mr. L that this would happen. Mr. L requested a retroactive disenrollment through the plan and his bills were paid through Original Medicare.

Cost-Sharing Surprises

Even when enrollees follow the requisite procedures and the services are approved by the HMO, they are often surprised at the amount of their copayments. They report that the information in their member's benefit manual does not correspond to what is given by sales or customer service representatives, or that HMOs do not send them a manual after multiple requests. When people sign up for an HMO, they often assume that they will save money because they will pay a copayment rather than the 20 percent coinsurance charge for most services under Original Medicare. This is not always true. Hidden higher costs become apparent when people need coverage most: when they fall ill.

True Stories

Mr. K., a Colorado resident and cancer patient, signed up for an HMO thinking he was signing up for a Medicare supplemental insurance plan and that his medical expenses would be covered in full. From April to December 2005, he filled his prescription for an injectable cancer medication. It wasn't until he received a $10,000 bill from the hospital that he realized he had not been covered by a supplemental and, under the terms of his HMO, he was responsible for 20 percent of the drug's cost.

Ms. S lives in Ohio. In December 2005 she was hospitalized twice in one month. Her member's manual stated that "if there were less than 60 days between two hospital admissions, they counted as a single benefit period." As a result, Ms. S assumed that she would have only one copayment for both admissions. However, the same page of her member's manual also stated that each hospital stay costs $750. Ms. S was actually responsible for $1,500 for the two admissions, even though they were within one single "benefit period"; which, in this context, meant little. If Ms. S had been with Original Medicare, she would have paid one $952 deductible for the two admissions. Payment would be based on the fact that the admissions had been within a single benefit period.

Browsing the web site of his preferred provider organization (PPO), Mr. P of Texas found an "in-network preferred provider" as his primary care physician (PCP). According to the site, he would pay a coinsurance of 30 percent for each visit to this PCP. After he visited the doctor in early 2006, his PPO informed him that the provider was actually a "nonpreferred" provider and, accordingly, Mr. P would be responsible for an 80 percent coinsurance for the visit. Mr. P is planning to appeal with a printout of the PPO's web page.

Network Restrictions

Unlike Original Medicare, Medicare HMOs restrict enrollees to a network of doctors. Not only does this limit consumer choice, but it also affects continuity of care. For example, while HMOs are required to cover out-of-network emergencies, they often deny immediate follow-up care at an out-of-network hospital. Similarly, people who need very specialized treatment are sometimes unable to find such specialists in the HMO's network. In such cases, they will be able to get care only if they disenroll from the HMO or successfully navigate an arduous appeals process.

True Stories

Ms. A, a New Jersey resident, had emergency appendix surgery at an out-of-network hospital in the spring of 2006. She remained in the hospital for three weeks, during which she developed an infection that was also treated in the same hospital. Her HMO paid for the initial emergency surgery but denied the follow-up care for the infection. The denial stated that she should have gone back to an in-network provider for the follow-up care. She is presently appealing the HMO's decision with a letter of support from the out-of-network surgeon.

In July 2005, as a member of a Medicare HMO in New York, Mr. C was diagnosed with acute lung cancer. His primary care physician thought that New York's premier cancer center would be the best place for him to receive treatment. However, Sloan-Kettering does not contract with any Medicare HMOs. Mr. C contacted MRC for help disenrolling from his Medicare HMO and was able to receive treatment through Original Medicare.

Experiences with Denials

Of the 4,325 Medicare HMO cases handled by MRC between January 2004 and June 2006, 1,069 (about 25 percent) involved denials of medical care by the HMO. In contrast, only 1,311 of the 15,079 callers with Original Medicare, or less than 9 percent, called about a denial in the same period. During this period, 208 out of the 4,325 HMO callers (nearly 5 percent) expressed an intention to disenroll.

Durable medical equipment, diagnostic services and emergencies comprise the majority of denials reported to MRC. While Original Medicare will pay for covered and medically necessary treatments, HMOs impose the additional requirement of prior authorization for certain services. When HMOs deny or delay prior authorization, patients are unable to get the care they need. They are disillusioned and frustrated because they feel that their health is not a priority for the HMO. As a result, they often disenroll.

After an HMO issues a denial, the enrollee needs to first appeal to the HMO for a redetermination. If the HMO refuses coverage or denies payment or care again, it is supposed to forward the case to an independent entity called the Center for Health Dispute Resolution (CHDR). In MRC's experience, HMOs have generally complied with this requirement. However, there have been cases when the HMO did not respond to an appeal in a timely fashion. Though the number is small, consumers in this situation do not know how to contact CHDR and can do little other than call the HMO's customer service representatives. The representatives often do not have access to specific appeals information, or they do not share it with the patient.

Medical Coverage Denials That Delayed or Prevented Treatment

True Stories

In mid-December of 2003, Mrs. D of Florida had two strokes and urgently needed several lab tests. Her doctor faxed in an expedited prior authorization request to a number provided by Mrs. D's HMO. However, Mrs. D's HMO did not respond to the doctor's request within the expedited time frame. When Mrs. D's daughter contacted the HMO, she was informed that the doctor had faxed his request to the wrong number and that as a result, the HMO would not make a decision until the end of January. Mrs. D's daughter managed to obtain the correct fax number from the representative and asked the doctor to make another expedited request. The lab tests were finally authorized in the middle of January. At this point, however, the hospital was worried that it would not be paid and demanded prior authorization in writing before it would administer the tests to Mrs. D. With the help of an MRC caseworker, the HMO faxed a letter granting authorization to the hospital and Mrs. D received care.

In June 2006, Mr. P of New York called MRC about his wife. Mrs. P is paralyzed from polio and had recently suffered a stroke. She went into a rehab facility upon her discharge from the hospital. Mr. P was very dissatisfied with the quality of care she received there and asked her doctor whether she could receive skilled therapy at home instead. Her doctor forwarded the plan of care to her HMO and told Mr. P that the HMO would send a nurse to their home for the required medical evaluation. However, citing lack of medical necessity, the HMO denied coverage for the skilled therapy and refused to send a nurse. Mrs. P's doctor said that he had provided all the help he could. Furthermore, Mr. P reported that the Island Peer Review Organization (IPRO) quality improvement organization had been of no help.

Mr. D of Florida is a cancer patient. In January 2006, he needed an injection of medication in preparation for his radiation treatments. However, his HMO required prior authorization for the injection. His doctor had called his HMO to request prior authorization but had still not received a response two weeks later. Since his cancer needed to be treated as soon as possible, Mr. D decided to get the injection and worry about appealing later.

Medical Coverage Denials That Block Payment

True Stories

Mr. P is a 77-year-old New York resident. In February 2005, while vacationing in Florida, he was injured in a car accident and was rushed to the hospital. Mr. P was unconscious for a week and received a large number of services. His HMO denied payment for the services because he did not request prior authorization.

Mr. S of California has a history of heart disease and underwent open heart surgery. When he felt severe chest pain and shortness of breath in March 2003, he went to the hospital closest to his home for emergency care. His HMO denied payment because the hospital was not in its network. With the help of an MRC caseworker, Mr. S appealed, pointing out that HMOs are required to cover out-of-network emergency services and the closest in-network hospital was 45 minutes away from his home. The HMO overturned its decision and paid for the treatment.

Part D Coverage Denials

Like stand-alone drug plans, Medicare Advantage plans with Part D drug coverage (MA-PDs) deny or restrict drug coverage benefits. As a result, people with Medicare have to resort to exception requests and appeals procedures in order to obtain the medicines they need. In a previous brief, MRC reported on problems with this process (see "Medicare Part D Appeals System Breaks Down," May 2006). Since the plan is in control of the coverage determinations and the first stage of the appeals process, it can deny coverage at these levels although it may be overruled at a higher level of appeal. Meanwhile, the patient goes without medication and sometimes becomes too discouraged to proceed.

People in MA-PDs are in an especially vulnerable situation because their drug coverage is linked to their medical coverage. They cannot change one without changing the other. If a doctor accepts a limited number of Medicare Advantage plans but none of them offers a drug benefit that meets a patient's needs, then the patient faces a choice between the doctor and the drug coverage. Conversely, someone who finally finds a drug plan that meets his or her needs will discover that the plan forces them to take on the plan's medical coverage as well, regardless of whether that medical coverage meets his or her needs.

We note, in particular, that several Medicare Advantage plans that previously offered limited drug coverage have raised their copayments since the onset of Part D.

True Stories

Mrs. S of New York has taken Isoptin for a heart condition for 18 years. In January 2006, her HMO told her that she needed to try other less expensive medications before it would cover Isoptin. In the past, Mrs. S has had bad reactions to generics and had even been admitted to the hospital as a result. But because she doesn't speak English well and does not want to go through the appeals process, Mrs. S decided to try the generics again and cross her fingers that "it might not happen this time."

Ms. C from Arizona called MRC in February 2006 on behalf of her daughter, who was born with an underdeveloped digestive system. Her daughter's doctor had tried many prescription laxatives and finally found one that worked for her. Her HMO denied it, citing a lack of medical necessity. Ms. C is appealing with the help of the doctor.

Conclusion

Disenrollment has been an important option for people who are dissatisfied with their HMOs and, as we stories above illustrate, there have been many reasons to be dissatisfied.

If people cannot go back to Original Medicare or at least change HMOs, they will be locked in to unexpectedly high cost-sharing, forced to fight frequent and often unreasonable denials, and trapped by network restrictions that bar access to longtime doctors or high quality specialists.

People who have been subject to high-pressure or deceptive marketing practices especially should retain the protection of timely disenrollment. If they never truly intended to enroll, they must be allowed to correct the mistake as soon as possible.

We urge Congress to lift lock-in and allow people to change their MA or drug plan anytime during the course of the year.

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[1] Dallek, G., Biles, B., and Dennington, A: *The 2002 Medicare+Choice Plan Lock-In: Should It Be Delayed?,* 2001.
[2] Laschober, M.: *Estimating Medicare Advantage Lock-In Provisions Impact on Vulnerable Medicare Beneficiaries*, 2005.
[3] Fireman, B, Bartlett, J, and Selby, J.: *Can Disease Management Reduce Health Care Costs By Improving Quality?,* 2004.