

# HMO Marketing to Children: Important Questions, Risky Answers

## Summary

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## **Summary and Introduction**

To meet the ongoing challenge of enrolling uninsured children into Healthy Families and Medi-Cal, some health plans seek the ability to market directly to parents and sign up their uninsured children. Now before the Legislature in various forms, the proposal seems appealing at first blush. Why not turn health plans loose on the vexing problem of reaching uninsured children?

It is understandable why the state's policy makers are grappling for a solution. 1.5 million out of California's 2 million uninsured children qualify for but are not enrolled in one of two programs:

- Medi-Cal, California's health coverage program for low-income children and families; or
- Healthy Families, a new program for uninsured children with family incomes too high for Medi-Cal but too low to afford private health insurance.

This problem is serious – but are health plan sales the right solution? This report tries to answer that question by analyzing pending legislative proposals to cover uninsured children, including HMO marketing and enrollment legislation. It includes county-by-county breakdowns of the number of children potentially affected and the corresponding possible revenue for HMOs. It describes past HMO marketing in Medi-Cal, similar programs elsewhere in the country and Medicare. This report seeks to provide an historic and national context to the current legislative discussion about HMO marketing to children.

The most important context for this discussion, however, is that many other proposals squarely address the two major causes of children's lack of enrollment in California's health programs: the tremendous complexity of the application and retention process; and many parents' ignorance of available child health coverage. For example, the budget and other legislation proposes using the schools to reach out to the parents of uninsured children; simplifying the application and retention process for families by cutting paperwork and eliminating burdensome "assets tests" and quarterly status reports; expediting eligibility determinations for families who have already given government agencies information about family income; spending tens of millions of dollars on outreach via the media and trusted community organizations; exploring integration of Medi-Cal and Healthy Families into a single, family-friendly program for children; increasing coverage of low-income parents, which often reaches their children as well; and simplifying county procedures to retain Medi-Cal coverage for families who reject welfare in favor of low-wage jobs not offering health insurance. Other proposed legislation carves out a limited and appropriate role for HMOs: preserving current coverage by communicating with their enrollees to maintain contact information and encourage the timely completion of necessary eligibility forms.

The marketing and enrollment proposals advanced by the HMO industry are much less direct solutions and involve serious risks. HMOs have a long history of fraudulently recruiting vulnerable populations, including low-income families, to obtain monthly taxpayer payments, often without providing promised care. In Medi-Cal, that history began in the 1970s and continued until the mid-1990s, when Governor Pete Wilson finally signed into law a general ban on direct marketing to Medi-Cal beneficiaries. In 1995 and 1996, for example, there were widespread reports that Medi-Cal HMOs illegally bribed low-income enrollees with cash and drugs, lied about plan coverage and benefits, and signed up children for inappropriate plans and then refused them essential care. As recently as 1998, one HMO sent out letters over forged signatures of 22,000 beneficiaries' doctors, claiming falsely that HMO enrollment was needed to continue seeing those doctors. Administrative sanctions, criminal prosecutions and lawsuits followed.

Most current legislative proposals acknowledge the risk of fraudulent HMO marketing by curbing the scope of permitted marketing or at least applying some limited safeguards. But even broad safeguards like those in the Medicare program have not stopped fraudulent and abusive marketing. According to a formal review by the Office of Inspector General of the U.S. Department of Health and Human Services, more than three out of four Medicare (77%) marketing materials were incomplete or inaccurate. Another recent multi-state study found that more than 40% of Medicare HMOs failed to provide consumers essential information during the sales process. And here in California, Medicare HMOs still enroll seniors using false promises about comprehensive services and familiar doctors.

The stakes are enormous. Depending on whether HMO marketing legislation focuses on Medi-Cal along with Healthy Families, between 1.9 and 4.4 million children could be potential marketing targets for HMOs, and thus potential fraud victims. These children receive state health coverage currently or qualify but are not yet enrolled. This translates into between \$1.9 and \$4.4 billion a year in potential HMO revenue. It is not surprising that HMOs are pushing so hard for the right to market to these children.

The problem of HMO marketing fraud is not limited to a few bad California apples; it has afflicted the national predecessor program to Healthy Families; numerous Medicaid programs across the country; and even Medicare, as noted above. In formal testimony presented to Congress in November 1999, the National Association of State Medicaid Fraud Control Units described marketing abuses as among the most prevalent type of managed care fraud. According to one national survey, nearly 60% of the nation's Medicaid agencies now impose stringent restrictions on HMO marketing, most often in marketing and enrollment bans like California's. The lesson is clear: **whenever HMOs are paid based on the number of vulnerable people they enroll, fraudulent and abusive marketing is a serious risk.**

Some HMOs contend that enrollment fraud can be beneficial since it provides health coverage to uninsured children. However, enrollment fraud can also affect children who already have satisfactory coverage, steering them to inappropriate plans. The HMO industry's current legislation actually targets currently insured children much more than the uninsured. In Medi-Cal, fraudulent enrollment often caused dangerous delays in care, in part because parents did not realize they were limited to the HMO's network of physicians. When parents brought sick children to their former pediatrician for urgent care, or healthy children for immunizations, they often learned, for the first time, that they could no longer use those providers. As they scrambled to find care from a new and unfamiliar health system, their children often went unserved. Parents and children with limited English proficiency were shifted away from nearby health care providers who spoke their language to distant providers who did not, thereby cutting back access to care, sometimes leaving emergency rooms the only option for treatment. HMOs made it impossible to disenroll for months, while children went without both preventive care and treatment of illness and injury. And children shifted from doctor to doctor lost essential continuity of care.

Moreover, the taxpayers may suffer as well. If fraudulent or abusive marketing recruits children into inappropriate health plans, public dollars will be guaranteed every month to these fraudulent HMOs, even if they never provide the children they recruit with a single doctor visit or immunization. This danger is far from theoretical. In the average Medi-Cal HMO, 72% of all children ages 2 through 6 do not receive their annual well-child visit, and 53-57% of 2 year olds lack required immunizations, although such HMOs receive regular taxpayer payments every month to cover these children's care.

Even enrollment focused on Healthy Families inevitably will affect Medi-Cal children. Not only is the same application form used for both programs, they both reach indistinguishable families in the same low-income communities. In fact, some families have one child enrolled in Healthy Families and another in Medi-Cal, based simply on the children's age. If HMO enrollment practices affect Medi-Cal but do not meet federal Medicaid requirements, federal fiscal sanctions could result. One reason why: HMO marketing in the workplace could encourage employers to drop private coverage, violating federal rules.

It would be foolish to gamble again with such scandal. If more straightforward approaches are tried and fail, then the state's policy-makers could consider increased health plan marketing. Today, however, such a risky policy would be premature and unwise. Let's first give more direct approaches a chance to work.

<b>Summary Table A</b>		
Potential Child Market Under Two Legislative Scenarios		
Number of Children Potentially Targeted for HMO Marketing		
COUNTY	ALTERNATIVE LEGISLATIVE SCENARIOS	
	Extent of Marketing Permitted:	
	Maximum	Limited
STATEWIDE	4,396,419	1,340,823
Alameda	127,064	28,377
Alpine	125	16
Amador	1,542	368
Butte	34,334	10,019
Calaveras	2,668	359
Colusa	2,411	1,026
Contra Costa	65,964	16,527
Del Norte	3,369	302
El Dorado	15,879	7,388
Fresno	155,597	32,439
Glenn	3,464	936
Humboldt	11,366	1,391
Imperial	21,473	2,700
Inyo	1,312	123
Kern	112,839	27,871
Kings	13,919	1,989
Lake	6,583	857
Lassen	2,547	251
Los Angeles	1,700,835	537,407
Madera	16,087	1,973
Marin	9,600	3,922
Mariposa	1,317	349
Mendocino	8,991	1,340
Merced	42,555	10,386
Modoc	1,192	104
Mono	554	184
Monterey	41,802	13,236
Napa	7,838	2,822
Nevada	3,885	1,242
Orange	266,551	107,508
Placer	23,380	10,908
Plumas	1,335	210
Riverside	194,514	62,237
Sacramento	210,332	57,652
San Benito	3,479	828
San Bernardino	253,849	72,841
San Diego	292,877	100,675

<b>Summary Table A, cont.</b>		
Potential Child Market Under Two Legislative Scenarios		
Number of Children Potentially Targeted for HMO Marketing		
ALTERNATIVE LEGISLATIVE SCENARIOS		
COUNTY	Extent of Marketing Permitted:	
	Maximum	Limited
San Francisco	53,304	18,663
San Joaquin	91,283	24,597
San Luis Obispo	20,634	8,226
San Mateo	36,090	12,877
Santa Barbara	41,293	14,360
Santa Clara	114,444	34,263
Santa Cruz	12,764	3,072
Shasta	18,274	3,145
Sierra	154	15
Siskiyou	4,260	591
Solano	33,549	8,685
Sonoma	28,973	10,798
Stanislaus	66,387	17,318
Sutter	13,332	5,160
Tehama	6,299	937
Trinity	1,274	299
Tulare	77,728	17,885
Tuolumne	3,486	673
Ventura	72,422	28,604
Yolo	22,305	7,942
Yuba	14,736	3,953

Note: Maximum marketing scenario assumes HMOs can market to both Medi-Cal and Healthy Families children.

Limited marketing scenario assumes HMOs market to Healthy Families children only, with some Medi-Cal "spillover."

Sources: Department of Finance, Legislative Analyst's Office, MRMIB, UCLA Center for Health Policy Research

Calculations by Health Consumer Alliance, 6/00

<b>Summary Table B</b>			
Potential Child Market Under Two Legislative Scenarios			
Millions of Dollars in Annual HMO Revenue			
ALTERNATIVE LEGISLATIVE SCENARIOS			
COUNTY	Extent of Marketing Permitted:		
	Maximum	Limited	
STATEWIDE	\$ 4,379.5	\$ 1,331.9	
Alameda	\$ 139.2	\$ 29.2	
Alpine	\$ 0.1	\$ 0.0	
Amador	\$ 1.6	\$ 0.4	
Butte	\$ 35.8	\$ 10.1	
Calaveras	\$ 2.8	\$ 0.4	
Colusa	\$ 2.5	\$ 1.0	
Contra Costa	\$ 68.8	\$ 16.7	
Del Norte	\$ 3.5	\$ 0.3	
El Dorado	\$ 16.4	\$ 7.5	
Fresno	\$ 153.5	\$ 32.1	
Glenn	\$ 3.6	\$ 0.9	
Humboldt	\$ 11.9	\$ 1.4	
Imperial	\$ 22.5	\$ 2.7	
Inyo	\$ 1.4	\$ 0.1	
Kern	\$ 119.5	\$ 28.4	
Kings	\$ 14.6	\$ 2.0	
Lake	\$ 6.9	\$ 0.9	
Lassen	\$ 2.7	\$ 0.3	
Los Angeles	\$ 1,596.6	\$ 521.7	
Madera	\$ 16.9	\$ 2.0	
Marin	\$ 9.9	\$ 4.0	
Mariposa	\$ 1.4	\$ 0.4	
Mendocino	\$ 9.4	\$ 1.4	
Merced	\$ 44.4	\$ 10.5	
Modoc	\$ 1.3	\$ 0.1	
Mono	\$ 0.6	\$ 0.2	
Monterey	\$ 43.5	\$ 13.4	
Napa	\$ 8.1	\$ 2.9	
Nevada	\$ 4.0	\$ 1.3	
Orange	\$ 276.3	\$ 108.8	
Placer	\$ 24.2	\$ 11.0	
Plumas	\$ 1.4	\$ 0.2	
Riverside	\$ 187.4	\$ 61.0	
Sacramento	\$ 219.2	\$ 58.3	
San Benito	\$ 3.6	\$ 0.8	

<b>Summary Table B, cont.</b>			
Potential Child Market Under Two Legislative Scenarios			
Millions of Dollars in Annual HMO Revenue			
ALTERNATIVE LEGISLATIVE SCENARIOS			
COUNTY	Extent of Marketing Permitted:		
	Maximum	Limited	
San Bernardino	\$ 255.3	\$ 72.7	
San Diego	\$ 304.3	\$ 101.8	
San Francisco	\$ 56.5	\$ 19.0	
San Joaquin	\$ 87.8	\$ 24.1	
San Luis Obispo	\$ 21.4	\$ 8.3	
San Mateo	\$ 37.5	\$ 13.0	
Santa Barbara	\$ 42.9	\$ 14.5	
Santa Clara	\$ 128.8	\$ 35.8	
Santa Cruz	\$ 13.3	\$ 3.1	
Shasta	\$ 19.1	\$ 3.2	
Sierra	\$ 0.2	\$ 0.0	
Siskiyou	\$ 4.5	\$ 0.6	
Solano	\$ 35.0	\$ 8.8	
Sonoma	\$ 30.1	\$ 10.9	
Stanislaus	\$ 69.1	\$ 17.5	
Sutter	\$ 13.8	\$ 5.2	
Tehama	\$ 6.6	\$ 0.9	
Trinity	\$ 1.3	\$ 0.3	
Tulare	\$ 79.2	\$ 17.9	
Tuolumne	\$ 3.6	\$ 0.7	
Ventura	\$ 75.1	\$ 28.9	
Yolo	\$ 23.2	\$ 8.0	
Yuba	\$ 15.4	\$ 4.0	

Note: Maximum marketing scenario assumes HMOs can market to both Medi-Cal and Healthy Families children.

Limited marketing scenario assumes HMOs market to Healthy Families children only, with some Medi-Cal "spillover."

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