

Health Maintenance Organization (HMO) Transfer Guidelines

A. Background:

Beginning in the late 1990s, the managed care industry began to feel the pressures of rising health insurance costs coupled with inadequate reimbursements. Medical groups experienced bankruptcies, mergers with larger medical groups, contract cancellations by Health Maintenance Organizations (HMOs) due to poor performance and unstable financial future, as well as the medical groups' own unwillingness to continue their HMO contracts at the negotiated reimbursement levels. Managed care plans themselves were under pressure to withdraw from the Medicare HMO market due to inadequate reimbursement rates in light of skyrocketing prescription drug prices and other increasing health care costs. Like other employers, the University of California experienced a series of major provider disruptions as medical groups and medical plans were no longer available in certain areas.

In response to the volatility of the health care market, the University implemented a HMO pilot program in 2001 to allow only California HMO participants the option to change their HMO medical plan throughout the year if/when medical plan providers terminated their contract with a medical group. However, this new option did not allow the participant to transfer outside of any California HMO plan. The intent of this pilot program was to protect participants from the threat of future provider disruptions. NOTE: Participants affected by total plan withdrawals from a service area were already provided an opportunity to transfer into another plan available in that area.

The effective date of the HMO pilot program was January 1, 2001. The program allowed HMO participants the option of transferring monthly among Health Net, Kaiser Permanente, PacifiCare and Western Health Advantage (WHA). The effective date of the transfer was the first day of the month following enrollment, subject to payroll processing deadlines. The University implemented this program to allow employees, annuitants and their enrolled family members continuity of care with their providers.

In 2003, the University discontinued the pilot program and changed its policy to allow monthly transfers between HMOs due to major provider disruptions as a standard practice.

The intent of these administrative guidelines is to clarify how a provider disruption is defined and the procedures which need to be followed when

considering an employee's or annuitant's request to transfer between the UC-sponsored HMO medical plans.

B. Eligibility:

If the Office of the President has made a systemwide announcement about a medical group disruption and identified it as qualifying under this policy, an employee or annuitant may be eligible to transfer between Health Net, PacifiCare, or WHA in order to remain with a specific medical plan provider. Health Net, PacifiCare or WHA members may also be allowed to transfer into Kaiser, even though it is highly unlikely their provider would be a Kaiser physician. An employee's or annuitant's request to transfer due to the termination of a single provider would not be considered a major provider disruption and generally will not be allowed.

The effective date of the transfer is the first day of the month following enrollment, subject to payroll processing deadlines.

The annual Open Enrollment Period is still available for members to transfer to any medical plan available in the participant's geographical area.

C. Employee/Annuitant Responsibilities:

Employees and annuitants enrolled in the affected HMO plan wishing to transfer plans may complete a UPAY 850 (for employees) or UBEN 100 (for retirees) and submit their form to the appropriate office within 31 days of the medical group disruption termination date. If the annuitant or family member is enrolled in a Medicare Advantage Plan, they will also need to complete a new Medicare Advantage form to assign their Medicare to the new HMO plan.

Employees: *Enrollment, Change, Cancellation or Opt Out form (UPAY 850).*

Annuitants: *Retiree Continuation, Enrollment, or Change form (UBEN 100).*

If an employee or an annuitant is requesting an HMO transfer and the Office of the President has **not** made a systemwide announcement, they must provide their local Benefits Office with a copy of the medical group termination letter. Upon receipt of the proper documentation, the local Benefits Office should ask the employee/annuitant to complete the appropriate forms.

D. Location Responsibilities:

1. Counsel the employee or annuitant on the HMO transfer eligibility requirements, appropriate forms to complete and processing deadlines.
2. Obtain from the employee or annuitant documentation (e.g. letter from medical group) which states that they have terminated or will be terminating their contract with the medical plan and the effective date of the termination. If an employee or annuitant is making the request to transfer due to a major provider disruption (e.g. medical group termination) and official notice was sent from the Health and Welfare Administration Unit at Office of the President, documentation of the termination is not required.
3. Have employee or annuitant complete a UPAY 850 or UBEN 100 and Medicare Advantage form, if appropriate, and submit it for processing. For employees, keep a copy of the UPAY 850 and the letter for your records. For annuitants, mail the original UBEN 100 and any documentation to Retirement Insurance Program, University of California, P.O. Box 24570, Oakland, CA 94623-1570 for processing.
4. A new EDB System Code Value has been created for HMO Provider Disruptions (DR). The department responsible for EDB transactions will enter the new EDB System Code Value "DR" (HMO Provider Disruption) in EDB. This will identify the change as an eligible change and allow the TIP deductions to adjust.

E. Impact to Tax Savings on Insurance Premiums (TIP)

The Tax Savings on Insurance Premiums (TIP) program is established under Internal Revenue Code, Section 125. This section limits changes of the TIP deductions to only situations involving an "eligible change in status." Loss of an individual provider is not an eligible change in status, but a "significant coverage curtailment" (an entire medical group) does qualify. If an employee switches health plan coverage mid-year because of an eligible change in status, the TIP deduction amount will adjust automatically. If, however, an employee is allowed to change health plans for any other reason, the employee may be subject to imputed income.

Examples – HMO Transfers

Example # 1

UCLA Medical Group is canceling its contract with Health Net Seniority Plus. Over 250 UC members are affected.

Yes, request will be approved. The 250 UC members will be given an opportunity to transfer into another HMO plan (e.g. PacifiCare Secure Horizons) to maintain continuity of care with the UCLA Medical Group.

Example # 2

PacifiCare informs a participant that she must be transitioned to a skilled nursing facility and provides the spouse with a list of skilled nursing facilities that have an opening. The spouse visits each facility and does not find any of the facilities acceptable. During this process, the spouse visits a skilled nursing facility that he likes, but it is not contracted with PacifiCare. The spouse is requesting that the member be transferred to another medical HMO so that the member can access this particular “out of network” facility.

Request should be denied. The request to change plans because the spouse does not find the facilities acceptable does not meet the criteria of major provider disruption.

Example # 3

Retiree has been seeing Dr. Smith for years through Kaiser. During the last visit, Dr. Smith informs him that he is retiring next month and provides a referral to another Kaiser doctor. Retiree decides this would be good time to switch to Western Health Advantage (WHA).

Request should be denied. Not only is this a situation involving an individual provider, but since the doctor is retiring, changing plans will not prevent the disruption.

Example # 4

Employee is enrolled in Blue Cross PLUS and informed by their cardiologist's office that Dr. Brown is terminating his Blue Cross PLUS contract. Dr. Brown's office, however, informs the employee that Dr. Brown is still contracted with PacifiCare. The employee submits a form to change to PacifiCare.

Request should be denied. This option only applies to CA HMO plans and Blue Cross PLUS is not an HMO plan. In addition, Blue Cross PLUS allows continuity of care through out-of-network benefits.

Example # 5

Retiree ages into Medicare and loses access to his primary care physician (PCP) because the provider is not contracted with the medical carrier's Medicare Advantage Plan. Can the retiree use the HMO transfer program to retain his provider?

No. Under the HMO Transfer Guidelines, a disruption of a single provider does not qualify as a major provider disruption. However, if the medical group is not contracted with the medical carrier's Medicare Advantage plan, the retiree would be transferred to another medical group in the service area that is contracted with the medical carrier's Medicare Advantage plan.

Example # 6

Health Net retiree ages into Medicare but Health Net Seniority Plus is not offered in the area. Can the retiree transfer into another plan?

Yes (this situation is not subject to the HMO Transfer Guidelines). The retiree is given an opportunity in which to transfer into any plan available in the area (e.g., Blue Cross PPO, High Option Supplement to Medicare, etc.).