Comments of the Health Care Financing Administration (HCFA)
on the General Accounting Office (GAO) Draft Report:
"Medicare+Choice: Revised Standards and Procedures
Could Improve Accuracy and Usefulness of Plan Information"

Overview

In order for beneficiaries to make the choice that is right for them with regard to their options for receiving their Medicare benefits, they need credible and unbiased information. With the Balanced Budget Act of 1997 (BBA), the Congress for the first time provided a stable funding source for a national information campaign that we have referred to as the National Medicare Education Program (NMEP). This effort includes the *Medicare & You* handbook, 1-800-MEDICARE, and a new beneficiary web site. While we hope that the NMEP will serve as a major source of accurate and unbiased information, we agree with the GAO that Medicare beneficiaries will continue to rely on information provided by Medicare+Choice (M+C) organizations.

We concur with the GAO's recommendations and agree that improved oversight of M+C organizations' marketing materials, as well as the use of standardized formats and language, will benefit the program. These changes are needed to help ensure that beneficiaries receive accurate and useful information. In fact, HCFA had previously identified many of these same issues and has already begun working to correct these problems and improve program oversight. For example, HCFA is already beginning efforts to require the use of standardized benefit information and to increase the consistency of marketing review for contract year 2000. We also have steps underway to assure the implementation of a more detailed and standardized reporting of benefit information -- the plan benefit package (PBP) by contract year 2001.

We were disturbed by the GAO's findings that all of the M+C organizations sampled in the report had distributed inaccurate or misleading information. This has occurred in part because not all final marketing material is reviewed by HCFA before use by M+C organizations. We will immediately implement the necessary policies to ensure that M+C organizations make required changes in marketing materials before they are used. Furthermore, HCFA will formally request that the GAO provide the names of the plans that are cited in the report as having violated HCFA policies. We will investigate and take appropriate action.

HCFA will continue to work closely with the Congress, GAO, beneficiary groups and other interested parties to assure that beneficiaries have complete, accurate and understandable information both to understand and compare their health plan options.

We will continue to examine instances where current marketing policies could be better implemented and areas where policies should be clarified or expanded.

GAO Recommendation

In October 1996, we recommended that the Secretary of HHS direct the HCFA Administrator to:

-- Require standard formats and terminology for important aspects of MCO's marketing materials, including benefit descriptions.

-- Direct the HCFA Administrator to require that all literature distributed by organizations follow these standards.

We recommend that the Administrator of HCFA:

-- Require each plan to produce one standard, FEHBP-like document that completely describes its benefit coverage and limitations and require organizations to distribute this document during sales presentations and upon request.

HCFA Comment

In principle, we concur with the GAO recommendations. HCFA has a two-phase standardization effort underway with the following goals and time lines.

Phase I: Standardize the Summary of Benefits document in time for use in the Fall 1999 HCFA beneficiary education campaign

Based on concerns raised at the Senate Aging Committee's hearing in May 1998, we have begun work to standardize the Summary of Benefits. This document is the key document used by health plans to inform potential members of a plan's benefit package. Similarly, Medicare beneficiaries have indicated the Summary of Benefits is the most important document provided by the M+C organization that they use in selecting a health plan.

The type of documents M+C organizations have used to describe their benefits varies widely. M+C organizations have used their own structure, format, and language in providing benefit information. But this flexibility has made it difficult for beneficiaries to make comparisons when choosing among Medicare+Choice organizations. Thus, beginning in contract year 2000, HCFA will require M+C organizations to use a

standardized Summary of Benefits and provide them to all prospective and current members, beginning with the November 1999 open enrollment period.

HCFA is currently producing the model template guide and instructions for the standardized Summary of Benefits. After consultation with beneficiary groups and plan representatives, the document will be distributed to M+C organizations by the end of May 1999. We anticipate a HCFA training session for all interested parties after the document is released.

Phase II: Standardize Remaining Documents

Again, after appropriate consultation with beneficiary groups and plan representatives, HCFA will require that remaining beneficiary notification (as opposed to advertising) materials (e.g., the Evidence of Coverage, enrollment application forms, appeals-related materials) be standardized. These materials will be in place for use in the Fall of 2000 HCFA beneficiary education campaign. It is critical to note that our standardization efforts will focus on the above materials and the important aspects of the marketing materials, such as benefits and appeal rights. M+C organizations should retain some flexibility in creating their advertising materials in order to differentiate their services from those provided by other M+C organizations. These advertising materials, however, should always accurately reflect the benefits offered, and HCFA will be diligent in its efforts to assure that advertising materials are not misleading.

GAO Recommendation

-- Fully implement the agency's new contract form for describing plan benefit coverage, the PBP, for the 2001 contract submissions to facilitate the collection of comparable benefit information and help ensure full disclosure of plan benefits.

HCFA Comment

We concur with GAO. In fact, about 16 months ago, HCFA began revising the Benefit Information Form (the 1998 BIF) by developing the Plan Benefit Package (PBP). HCFA plans to fully implement the PBP as part of the 2001 Medicare managed care contract.

The description of plan benefits is the foundation of the marketing review process. For the 1998 and 1999 contract years, the BIF was used to approve benefits in the Adjusted

Community Rate (ACR) and to review M+C organization marketing material. Following a comprehensive review of the 1998 BIF, it became clear that a standard, more detailed reporting format system was needed. For 2000, the BIF has been modified as part of the transition to the PBP. The BIF 2000 reduces the need to have a separate data collection effort for Medicare Compare data for plan year 2000, thereby saving HCFA staff valuable time and effort and reducing the need for duplicative data validation. For 2001, the PBP will be used to perform these functions and will improve the reliability and accuracy of managed care organization contract documents.

The PBP focuses on creating a standard structure for the description of benefits in order to facilitate the review of marketing material. By establishing a standard benefit content structure, HCFA will ensure more reliable and accurate benefit information, in addition to creating standard reporting formats and terminology. The PBP more completely captures the different benefits M+C organizations offer, thus assisting HCFA in the approval of managed care organization marketing material. Below are two specific examples of how the Plan Benefit Package (PBP) will facilitate standardized review of marketing materials.

- **Screening Mammography**. GAO found that selected 1998 M+C organization marketing material on Medicare's screening mammography benefit was inconsistent with Agency stated policy (Page 8). The 1998 BIF would not have automatically identified such discrepancies because it did not address the issue of prior authorization, thereby allowing for error. The PBP will address this important issue by requiring all managed care organizations to identify the authorization rules for each service category. For the mammography service category, the PBP is predetermined by HCFA policy and is not an optional description by the M+C organization. As a result of this refinement, the PBP does not allow managed care organizations to enter any authorization rules for the Medicare screening mammography benefit.

- **Prescription Drug Benefit**. The GAO report identified inconsistent M+C organization information about prescription drug coverage from one marketing document to another. The report goes on to find instances of incorrect information on this benefit in marketing material (Page 9). While the 1998 BIF may have provided some drug benefit information, this information was not in sufficient detail to capture some of the key differences in the drug benefits offered. The PBP addresses this problem by requiring information on the rules for generic, preferred brand, brand, and mail order drugs, as well as the maximum plan benefit coverage amount (dollars), co-payments, and plan use of a drug formulary. This will allow for easier review and comparison of information.

In addition to our reliance on the PBP, HCFA will continue to improve staff training and marketing review efforts at the Regional level. As described in the last section of our response, HCFA will refer the mammography and drug benefit issues to our Marketing Product Consistency Team for further review and analysis.

The PBP will not only improve the HCFA review process and assist beneficiaries, but it will benefit the Center for Health Dispute Resolution (CHDR) as well. As mentioned in the GAO report, CHDR should have access to standardized benefit information as part of its adjudication of beneficiary appeal cases (Page 12). Implementation of the PBP will support the full disclosure of plan benefits, scope, exclusions, and fees thus expediting the adjudication of beneficiary appeals by CHDR.

GAO Recommendation

-- Develop standard forms for appeals and enrollment.

HCFA Comment

We concur with the GAO recommendation. HCFA recognizes the importance of establishing standard formats and common language for beneficiary appeal notices. We have undertaken several efforts to address some of these concerns. First, we recently issued an Operational Policy Letter (OPL) to M+C organizations transmitting model language for a Notice of Discharge and Appeal Rights. This notice advises Medicare beneficiaries in inpatient hospital settings of their appeal rights at the time of discharge. In addition, we are developing another OPL to transmit model denial notice language for service and payment denials for managed care enrollees. Both of these notices are scheduled to be consumer tested. Our goal is to require mandatory use of the final, standardized appeal notices by M+C organizations in 2000.

Second, we have developed model language for letters and forms that all M+C organizations could use for enrollment notification. In the near future, after consultation with outside groups, we intend to mandate the use of the enrollment notification language. Finally, HCFA is currently piloting a disenrollment process with 1-800-MEDICARE. The purpose of this pilot is to (1) establish an alternative neutral mechanism other than the Social Security Administration in which a beneficiary can disenroll from the M+C plan to original Medicare; and (2) develop a standard tool in which useful disenrollment reason information can be collected from beneficiaries.

GAO Recommendations

-- Take steps to ensure consistent application of the agency's marketing review policy.

HCFA Comment

We concur with the GAO recommendation. HCFA is aware of the issues regarding uniform application of marketing review regulations and guidelines across the 10 HCFA Regional Offices. HCFA will continue and expand its existing effort to address the complex issue of uniformity of review. This effort includes the following activities:

(a) Final Verification of all Marketing Materials. HCFA central office will issue a directive that all final marketing documents must be reviewed before they are used to ensure that HCFA's required changes are incorporated.

(b) HCFA is pursuing options regarding the feasibility of centralized marketing review. We will initiate a nationally representative, 6-month pilot study on the efficacy of a private sector contractor performing the review of marketing materials. We will compare the effectiveness of a centralized review system with the current system.

(c) The "Medicare Managed Care Marketing Product Consistency Team (PCT)." This group is comprised of representatives from all 10 HCFA Regional Offices and HCFA Central Office policy and operational staff. The group meets monthly to update the National Marketing Guide and to address any marketing issues that have arisen regarding operational or policy interpretations. The PCT will further review the GAO's findings and determine additional changes that need to be made to our marketing review practices and training of HCFA staff.

(d) Development of a single source of information on marketing. HCFA is currently working on issuance of the M+C Manual as the definitive operational document for participation in the Medicare managed care program. Chapter 5 of this manual will incorporate the National Marketing Guide and all marketing related Operational Policy Letters. It is an effort to bring into a single source document all available operational information related to participation in marketing activities in the Medicare managed care program.

MARKETING AND APPEALS FOR MEDICARE BENEFICIARIES
April 12, 1999

Background: The New York Times and other newspapers are expected to run stories Tuesday morning in advance of the Senate Aging Committee hearing on Medicare+Choice marketing and appeals. Two GAO reports are being released at the hearing. The first, "Medicare+Choice: Revised Standards and Procedures Could Improve Accuracy and Usefulness of Plan Information," looks at the materials that managed care plans use to market themselves to Medicare beneficiaries and HCFA's review processes. The second report, "Medicare Managed Care: Greater Oversight Needed to Protect Beneficiaries' Rights," reviews appeals processes available to Medicare beneficiaries, their use of the appeals process and HCFA's oversight. The reports criticize HCFA for inadequate oversight of the marketing materials and information about rights of appeal that managed care plans provide to beneficiaries.

Q. The GAO says HCFA needs to improve its review processes for marketing materials that plans distribute to beneficiaries. What is HCFA doing to improve its oversight of these materials?

A. Medicare beneficiaries must have accurate, credible information, whether it's provided by managed care companies or by Medicare.

In 1997 and 1998, HCFA issued managed care marketing guidelines and established the strongest appeal rights for any managed care enrollees anywhere in the country. But HCFA is taking additional steps to make sure that beneficiaries receive accurate information from managed care plans about their rights and options -- sending a loud and clear message to the managed care industry that these guidelines will be strictly enforced. HCFA will investigate the guideline violations cited by GAO and impose any appropriate sanctions.

Medicare serves as an unbiased source of information for beneficiaries to learn about their health plan options, whether or not they are enrolled in managed care plans. As part of HCFA's National Medicare Education Program, Medicare beneficiaries now have 1-800-MEDICARE (1-800-633-4227) which is now available nationwide, a consumer-friendly Internet site (www.medicare.gov) and the expanded *Medicare&You 2000* handbook which will be mailed to Medicare beneficiaries this fall. (Copies of the 1999 handbook are available on the Internet and can be requested on the toll-free line).

This fall, managed care plans must standard formats and language in the summary of benefits materials they provide to beneficiaries to help them make apples-to-apples comparisons between plans. Other materials will be standardized for use this fall, including application forms for enrolling in an HMO, appeals information, and the information about benefits, premiums and cost-sharing used in reviewing the accuracy of marketing materials and the ability of plan to serve beneficiaries.

Q. The GAO says that Medicare beneficiaries don't know that they have the right to appeal and when they do appeal, they are not treated well. How are beneficiaries notified of their right to appeal?

A. The Clinton Administration has made appeal rights for Medicare+Choice among the strongest for any managed care enrollees in the country, and Medicare is taking additional steps to strengthen the appeals process and make sure these rights are enforced.

The right to appeal a decision by a managed care plan is just as important as having the right information when choosing a health plan. Right now, Medicare beneficiaries receive information about appeals rights in the Medicare Handbook and in the summary of benefits, rights and protections that managed care plans provide beneficiaries; when they are admitted or discharged from a hospital; and whenever payment or service is denied by a managed care plan.

In the coming months, Medicare will issue model language that plans must use when they deny a request for payment or service. This notice must be understandable and provide detailed reasons -- not just say, "care was no longer necessary." The notice must also tell about the right to a reconsideration, and describe the expedited and standard appeal procedures and the place and length of time for an appeal.

Congress of the United States

House of Representatives

Washington, DC 20515

February 1, 1999

President William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President,

Continuing media reports and an initial HHS analysis of state data on TANF work participation rates show that there has been a significant drop in the number of families nationwide receiving cash assistance. While some attribute the decline to implementation of the Temporary Assistance to Needy Families (TANF) program, there is strong evidence that our healthy economy is playing a large role.

In our view, the jury is still out on whether TANF will prove to be a success in helping to meet the needs of vulnerable, low-income people. But there are worrisome signs that some TANF applicants, recipients and leavers are not always receiving vital support services that can help ensure the transition to work is a permanent one.

For example, average monthly food stamp participation fell by 4.4 million between 1995 and 1997, or five times more than the decline in poverty during that period, according to the Center on Budget and Policy Priorities. This means that millions living in poverty, although eligible, are not receiving food stamps. In another analysis, a 1998 study prepared for the Commonwealth Fund estimates that five million uninsured children – out of a total of 11 million – are potentially eligible for health benefits under Medicaid.

We believe it is important to look at the story behind these numbers. An October 1998 report published by the Kaiser Family Foundation suggests that some states are failing to inform TANF recipients and applicants about their potential eligibility for Medicaid — despite a letter sent out by the Health Care Financing Administration that directs states to coordinate their TANF and Medicaid eligibility. And until a Federal judge intervened in New York City last week, eligible families were being denied the

opportunity to apply for food stamp and Medicaid assistance *to which they are legally entitled.*

The Kaiser report suggests that "those who administer the work programs were believed to know little of Medicaid or health programs and to be focused solely on the objective of getting people into the first possible job." Based on interviews with welfare and Medicaid program administrators and researchers, the Kaiser report also finds that "people do not know they are eligible for Medicaid because both they and state workers lack information or are confused about eligibility rules, given all the recent policy changes."

The fact that Americans are being denied access to food stamps and Medicaid because of the implementation of the TANF program is clearly in violation of federal law. The 1996 welfare law (section 835) reiterated a long-standing food stamp rule that "a state agency...shall permit an applicant household to apply to participate in the program on the same day the household first contacts a food stamp office in person."

Medicaid law is equally clear. The Medicaid statute and subsequent regulations refer to the right of an individual to receive benefits on a timely and fair basis. Furthermore, the welfare reform law took specific precautions to ensure that changes in cash welfare eligibility did not affect a family's right to medical assistance under the Medicaid program. Under the Personal Responsibility and Work Opportunity Reconciliation Act, states are required to provide coverage to families that would have been eligible under program income and resource standards in effect on July 16, 1996.

We believe the Administration must not stand by and watch as these practices to delay or deny health benefits and food stamps become more widespread. Overt actions to deprive people of the health benefits or food assistance for which they are eligible simply must not be tolerated. Likewise, operational practices that have a similar, albeit inadvertent, effect must be corrected immediately. Otherwise, welfare "reform" will wind up wrongly depriving many Americans who are struggling to make a living in low-wage jobs of the critical support services that they need to keep working and on the road to self-sufficiency.

We hope you will agree that states and local jurisdictions cannot be allowed to ignore federal Medicaid and food stamp laws. The well-being of millions of low-income TANF families demands that state rules and practices *support* families as they transition from welfare to work. In addition, we

hope that the Administration will play a more active role in promoting the value of both these programs to low-income families.

We thank you for your attention to these important issues, and we look forward to hearing about the actions your Administration is taking to address alarming declines in Medicaid and food stamp participation.

Sincerely,

Pete Stark
Member of Congress

Robert Matsui
Member of Congress

William J. Coyne
Member of Congress