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Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

December 2009

MEDICARE ADVANTAGE

CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue

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GAO-10-36

December 2009

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Highlights

Highlights of GAO-10-36, a report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

MEDICARE ADVANTAGE

CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue

Why GAO Did This Study

Members of Congress and state agencies have raised questions about complaints that some Medicare Advantage (MA) organizations and their agents inappropriately marketed their health plans to Medicare beneficiaries. Inappropriate marketing may include activities such as providing inaccurate information about covered benefits and conducting prohibited marketing practices.

The Centers for Medicare & Medicaid Services (CMS) is responsible for oversight of MA organizations and their plans. GAO was asked to examine (1) the extent to which CMS has taken compliance and enforcement actions, (2) how CMS has helped beneficiaries affected by inappropriate marketing and the problems beneficiaries have encountered, and (3) information CMS has about the extent of inappropriate marketing. To do this work, GAO reviewed relevant laws and policies; analyzed Medicare data on beneficiary complaints, compliance actions and enforcement actions; and interviewed officials from CMS and selected state departments of insurance, state health insurance assistance programs, and MA organizations.

What GAO Recommends

GAO recommends that CMS gather more information on the extent of inappropriate marketing. CMS concurred with GAO's recommendation.

View GAO-10-36 or key components.
For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

CMS took compliance and enforcement actions for inappropriate marketing against at least 73 organizations that sponsored MA plans from January 2006 through February 2009. While the number of MA organizations varied during that time period, 192 MA organizations offered MA plans as of March 2009. Actions taken ranged from initial notices of noncompliance and warning letters to more punitive measures, such as civil money penalties and suspensions of marketing and enrollment. Nineteen of the 73 MA organizations had multiple types of actions taken against them.

CMS helped beneficiaries who experienced inappropriate marketing by providing special election periods (SEP) through which beneficiaries could disenroll from their MA plan and enroll in new coverage without waiting for the twice yearly regular enrollment periods. However, some beneficiaries experienced financial or access-to-care problems as a result of inappropriate marketing that could not be addressed by a SEP. Financial hardships occurred, for example, when beneficiaries disenrolled from their MA plans and the withholding of premiums from Social Security for their former MA plan was not stopped promptly. In other cases, beneficiaries did not realize they had been enrolled in an MA plan until they tried to access services. Some of these beneficiaries experienced disruption of their access to providers and medications because their providers did not participate in the MA plan.

CMS has limited information about the number of beneficiaries who experienced inappropriate marketing. Some beneficiaries who experienced inappropriate marketing may have exercised their option to disenroll from their MA plans during regular enrollment periods and might not have notified CMS of the marketing problems they encountered. For example, about 21 percent of beneficiaries disenrolled during the regular enrollment periods in 2007 from one type of MA plan that CMS officials acknowledged had a high incidence of inappropriate marketing. However, CMS discontinued a survey after 2005 that collected information on reasons for disenrollment and could have provided important information about the extent to which the disenrollments were the result of inappropriate marketing. CMS officials said that they plan to reinstitute a survey on disenrollment reasons in late summer 2010. CMS also has limited information about the number of beneficiaries who experienced inappropriate marketing because it did not directly track the number of SEP disenrollments. CMS did estimate the number of SEPs it provided for inappropriate marketing, but its estimates were based on data that were unreliable.

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Abbreviations

BBA	Balanced Budget Act of 1997
CAP	corrective action plan
CMS	Centers for Medicare & Medicaid Services
DOI	department of insurance
FFS	fee-for-service
HHS	Department of Health and Human Services
MA	Medicare Advantage
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug Improvement and Modernization Act of 2003
MOU	memorandum of understanding
NAIC	National Association of Insurance Commissioners
OIG	Office of Inspector General
PFFS	private fee-for-service
SEP	special election period
SHIP	state health insurance assistance program
SOP	standard operating procedure
SSA	Social Security Administration

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

December 17, 2009

The Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

Members of Congress and state agencies have raised questions about complaints that some Medicare Advantage (MA) organizations and their agents inappropriately marketed their health plans to Medicare beneficiaries.[1,2] Inappropriate marketing activities may include, for example, MA organizations and their agents misrepresenting plan benefits and conducting prohibited marketing practices, such as door-to-door marketing without appointments and providing potential beneficiaries with meals or gifts of more than a nominal value at marketing events to induce enrollment. In this report, the term inappropriate marketing also includes organizations' noncompliance with MA marketing requirements

[1]MA is Medicare's primary managed care program through which beneficiaries can join a private plan alternative to the original Medicare program, also known as Medicare fee-for-service (FFS). MA plans provide health insurance coverage for hospital, physician, and other services and are offered by private companies referred to as MA organizations. Generally, MA plans must offer the same benefits as Medicare FFS, but may offer additional benefits, reduced premiums, reduced cost-sharing, or a combination of the three. MA organizations may offer several plans with different combinations of benefits, cost-sharing, and premiums. Enrollment in Medicare's managed care program has more than doubled since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2067 (MMA), which established the MA program. MMA resulted in increased payments to private Medicare plans, which enabled them to enhance their benefit packages.

[2]In this report we use the term "agent" to refer to any person who markets a specific MA plan or limited number of MA plans and may receive compensation directly or indirectly from an MA organization for marketing activities. This includes independent agents, independent brokers, employees of businesses that have contracted with MA organizations to provide marketing services, and other similar types of marketing professionals. As of July 2008, about 21 percent or 9.7 million Medicare beneficiaries were enrolled in MA plans.

pertaining to proper training, compensation, and licensure of agents and registration of marketing events.[3]

Congress held several hearings on inappropriate marketing during 2007 and 2008.[4] In some of these hearings, officials of state departments of insurance (DOI) and MA beneficiaries and their advocates testified that as a result of inappropriate marketing, some beneficiaries were enrolled in MA plans in which they had not intended to enroll or that did not address their health care needs as well as their prior coverage. In June 2007, in response to increasing concerns that MA organizations were not adequately overseeing their marketing activities and that this could negatively impact beneficiaries, the Centers for Medicare & Medicaid Services (CMS), the agency responsible for administering Medicare and contracting with MA organizations to provide Medicare-covered services, took the unprecedented step of negotiating voluntary suspensions of marketing and enrollment activities of seven MA organizations' private fee-for-service (PFFS) plans.[5] CMS officials and others have acknowledged that inappropriate marketing has been particularly problematic in PFFS plans, in part because the structure of PFFS plans differs from other types of MA plans. For example, while other types of MA plans have provider networks, most PFFS plans do not. Instead, providers can choose to accept or not accept a PFFS beneficiary on a service-by-service basis, which may be confusing to beneficiaries.

[3]For example, MA organizations may employ as marketing representatives only those individuals licensed by the state in which they are marketing plans and who have been appointed by the organization consistent with that state's requirements. 42 C.F.R. § 422.2272.

[4]See House Committee on Ways and Means, Subcommittee on Health, *Hearing on Medicare Advantage Private-Fee-For-Service Plans*, 110th Cong., 1st sess., 2007; Senate Special Committee on Aging, *Medicare Advantage Marketing and Sales: Who Has the Advantage?* 110th Cong., 1st sess., 2007; House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Predatory Sales Practices in Medicare Advantage*, 110th Cong., 1st sess., 2007; Senate Committee on Finance, *Selling to Seniors: The Need for Accountability and Oversight of Marketing and Sales by Medicare Private Plans (Part 1)*, 110th Cong., 2nd sess., 2008; Senate Committee on Finance, *Selling to Seniors: The Need for Accountability and Oversight of Marketing and Sales by Medicare Private Plans (Part 2)*. 110th Cong., 2nd sess., 2008; Senate Special Committee on Aging, *What Seniors Don't Know Before They Enroll:—Aggressive Sales of MA Plans in Missouri*, 110th Cong., 2nd sess., 2008; House Committee on Ways and Means, Subcommittee on Health, *Hearing on Medicare Advantage*, 110th Cong., 2nd sess., 2008.

[5]PFFS plans are designed to offer an MA option that is more like Medicare FFS. Compared to other MA plans, PFFS plans generally offer a wider choice of providers and impose less plan management of health care services and providers.

The federal government and states each have responsibilities regarding the conduct of MA organizations and their agents. CMS is responsible for enforcing MA organizations' compliance with MA marketing requirements, including the requirements concerning agents acting on behalf of MA organizations.[6] Subject to certain exceptions, these requirements supersede state laws or regulations, and as a result, states generally do not have the authority to regulate MA organizations' marketing.[7] MA marketing requirements generally impose obligations upon MA organizations and not directly upon their agents. States retain oversight authority over the marketing activities of agents. According to state officials and the National Association of Insurance Commissioners (NAIC), holding MA organizations accountable for the actions of agents marketing their plans is an essential component of effective oversight of agents.[8] NAIC officials told us that placing responsibility for agent activity with MA organizations is important because organizations can implement systemic requirements, such as rigorous training programs, and can act faster than states to discipline agents.[9]

Marketing requirements for MA organizations are based, in part, on provisions in the Balanced Budget Act of 1997 (BBA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Under the BBA, Congress required that private plans offered through Medicare conform to fair marketing standards that, among other requirements, prohibit organizations from providing monetary inducements to

[6]The Secretary of Health and Human Services (HHS) has delegated oversight of the MA program to CMS.

[7]MA organizations are required to be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance in each state in which they offer an MA plan. MA organizations also must appoint agents who are licensed under state law. States, however, have oversight authority over MA organizations with respect to state laws and regulations related to licensure, plan solvency, and appointment of agents. 42 U.S.C. §§ 1395w-21(h)(4), (h)(7), 1395w-25(a), 1395w-26(b).

[8]NAIC is the association for insurance regulators in the U.S. and its territories. NAIC provides support and guidance to its members on federal policy issues related to insurance regulation.

[9]State DOIs investigate allegations of inappropriate marketing to compile evidence of agent misconduct, which according to officials from one state, can take months. MA organizations conduct their own investigations and can discipline agents or terminate them with or without cause.

beneficiaries for enrollment in a plan.[10] In 1998, CMS published implementing regulations that elaborated upon the BBA requirements, including prohibiting MA organizations from engaging in door-to-door solicitations and in activities that could mislead or confuse beneficiaries or misrepresent the MA organization.[11] CMS also provided guidelines to MA organizations on appropriate marketing practices, which organizations are required by regulation and under their contracts with CMS to follow.[12] The guidelines, among other things, require MA organizations to use state-licensed agents for marketing activities and set restrictions on these activities, such as a maximum value for give-away promotional items. MIPPA and its implementing regulations codified some of the requirements already established under CMS's marketing guidelines for MA organizations.[13] MIPPA and its implementing regulations also clarified existing marketing-related requirements and created new requirements for MA organizations such as limiting agent commissions and requiring MA organizations to comply with any request by a state for information related to agent performance when the state is investigating the conduct of an agent.[14]

CMS uses compliance and enforcement actions to bring noncompliant MA organizations into conformity with MA marketing requirements. Compliance actions include requiring MA organizations to develop corrective action plans (CAP) that specify actions the organization will

[10]Pub. L. No. 105-33, § 4001, 111 Stat. 251, 285-6 (1997) (codified, as amended, at 42 U.S.C. § 1395w-21(h)). Under the BBA, Medicare's private plan option was called Medicare+Choice. The program's name was changed to Medicare Advantage under the MMA. Regulations implementing the MMA made many of the requirements implementing the Medicare+Choice program, including those related to marketing, applicable to MA organizations. See 70 Fed. Reg. 4588 (2005).

[11]*Medicare Program: Establishment of the Medicare+Choice Program*, 63 Fed. Reg. 34,968 (June 26, 1998).

[12]*Medicare Marketing Guidelines for: Medicare Advantage Plans*, *Medicare Advantage Prescription Drug Plans*, *Prescription Drug Plan*, *1876 Cost Plans* (published Aug. 15, 2005, revised July 25, 2006).

[13]MIPPA, Pub. L. No. 110-275, § 103, 122 Stat. 2494, 2498-2501 (2008) (codified at 42 U.S.C. § 1395w-21(h)); *Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Benefit Programs; Final Rule*, 73 Fed. Reg. 54,220, as amended at 73 Fed. Reg. 54,250 (Sept. 18, 2008).

[14]In this report, unless otherwise specified, the term inappropriate marketing refers to noncompliance by MA organizations through the actions of their agents with marketing requirements established under federal law, regulations, and guidance.

take to address its noncompliance. Enforcement actions are more punitive than compliance actions and include imposition of civil money penalties, suspension of enrollment of Medicare beneficiaries, suspension of payment to an MA organization, suspension of marketing activities for an MA plan, and termination or non-renewal of the MA organizations' contract.[15] CMS has the authority to impose these sanctions for certain types of violations of marketing requirements by MA organizations, though the agency is not required to take such actions.[16]

Given concerns about inappropriate marketing and its effects on beneficiaries, you asked us to examine how CMS assists beneficiaries affected by inappropriate marketing, the extent of the noncompliance, and how CMS holds MA organizations accountable. Our report addresses the following questions: (1) To what extent has CMS taken compliance and enforcement actions against MA organizations for inappropriate marketing? (2) How has CMS helped MA beneficiaries affected by inappropriate marketing and what types of problems have they encountered? (3) What information does CMS have on the number of beneficiaries affected by inappropriate marketing?

To determine the extent to which CMS has taken compliance and enforcement actions against MA organizations for inappropriate marketing, we analyzed CMS data on compliance and enforcement actions

[15]42 U.S.C. § 1395w-27(g); 42 C.F.R. §§ 422.750-.764. Under federal law, HHS, through CMS and the Department of Health and Human Services' Office of Inspector General (HHS OIG), has the authority to impose sanctions on MA organizations for certain types of misconduct.

[16]CMS may suspend enrollment, payment, or marketing for specified categories of conduct by MA organizations, including (i) expelling or refusing to re-enroll a beneficiary who is eligible to enroll; (ii) conduct that may reasonably be expected to deny or discourage enrollment of individuals who may need future medical services; or (iii) misrepresenting or falsifying information provided to CMS, individuals or other entities. Separately, if CMS determines that an MA organization failed to substantially comply with the terms of its contract with CMS, which includes compliance with marketing requirements, CMS may terminate the contract and also suspend enrollment or suspend marketing. In addition to or in place of these sanctions, CMS may impose civil money penalties in certain instances. In order to impose civil money penalties, CMS must determine that the deficiency has directly adversely affected (or has the substantial likelihood of directly affecting) a Medicare beneficiary. 42 U.S.C. § 1395w-27(g); 42 C.F.R. § 422.752. The HHS OIG also has the authority to impose civil money penalties upon MA organizations.

CMS took against MA organizations for inappropriate marketing for the period January 2006 through February 2009.[17]

To determine how CMS helped beneficiaries affected by inappropriate marketing and the types of problems beneficiaries encountered, we interviewed officials from CMS's central office and all 10 regional offices, 6 state DOIs, and 6 state health insurance assistance programs (SHIP) and reviewed relevant documentation.[18] We also visited three CMS regional offices to conduct more detailed interviews.[19] We chose one of the regional offices because it had conducted detailed compilations of complaint data; another regional office because it housed the division that coordinated regional office oversight and monitoring activities; and a third regional office because it had responsibilities for MA organizations with a high concentration of PFFS plans. We interviewed DOI officials and SHIP officials in the three states where we conducted site visits. In addition, we interviewed DOI and SHIP officials from another three states because in one of the states, the DOI took an enforcement action against an MA organization for inappropriate marketing and in the other two states, DOI officials testified before NAIC on inappropriate MA marketing and sales practices.

To obtain information about the number of beneficiaries affected by inappropriate marketing, we used June 2007 through October 2008 data from CMS's complaint tracking module on the number of beneficiaries who claimed they were affected by inappropriate marketing and requested CMS assistance to disenroll from their MA plan.[20] We interviewed officials

[17]According to CMS officials and our review, CAPs for inappropriate marketing related to agent misconduct violations were primarily included under the category: "The MA organization does not engage in activities which materially mislead, confuse, or misrepresent the MA organization." This category can include deficiencies related to MA organizations' internal operations related to agent oversight, such as agent training programs and processes for monitoring agent behavior, and deficiencies related to agent-related noncompliance with marketing requirements. It is possible that some agent-related inappropriate marketing violations were included in other categories of the complaint tracking module; these complaints were not included in our analysis.

[18]SHIP is a national, federally funded program that uses grants directed to states to provide counseling, educational presentations, and other services to Medicare beneficiaries and their families. We interviewed DOI and SHIP officials in Florida, Missouri, New York, Ohio, Oklahoma, and Texas.

[19]We visited CMS regional offices in Missouri, New York, and Texas.

[20]The complaint tracking module is CMS's centralized database of complaints information.

in CMS's central office and all regional offices about their use of the complaint tracking module data. We also reviewed a February 2008 study conducted by one CMS regional office that analyzed CMS and MA organizations' resolution of cases entered into the complaint tracking module. In addition, we interviewed officials from CMS's central office about plans to collect information on beneficiaries' reasons for disenrollment from their MA plan.

To determine the reliability of the data we used, we reviewed documentation, examined the internal consistency and other aspects of the data, interviewed CMS officials about reliability issues, or some combination of the three. Based on our review, we determined that the CMS regional office study of complaint tracking and the compliance and enforcement data were sufficiently reliable for our purposes. We determined that the complaint tracking module data had significant limitations. As a result, we reported total complaints from the inappropriate marketing categories because this is an indicator that CMS uses, but did not include any additional analyses of the complaint tracking module data. Appendix I provides more detailed information on our methodology. We conducted this work from March 2008 through December 2009 in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CMS monitoring and oversight activities of MA organizations' compliance with marketing requirements, include maintaining regular communication with and providing technical assistance to MA organizations. In addition, CMS conducts surveillance activities and audits of MA organizations to collect information about potential problems and compliance with marketing requirements.

CMS's surveillance activities include tracking and analyzing complaint rates by MA organization and category of complaint. In 2007, CMS initiated a variety of new surveillance activities focused on monitoring MA organizations' marketing of PFFS plans. Among other activities, CMS implemented a secret shopper program that had CMS representatives, with

their identity concealed, attend PFFS marketing events and report on the accuracy of marketing presentations and agents' compliance with marketing requirements.[21] Other surveillance activities included monthly review of PFFS enrollment packages and review of agent training test results. CMS also tracks other indicators under certain circumstances, such as verifying that beneficiaries willingly and knowingly chose certain plans. For example, for 2008, CMS required MA organizations to call beneficiaries newly enrolled in PFFS plans to verify that beneficiaries wanted to enroll in the plan and understood plan features. CMS subsequently tracked the proportion of verified calls as one of its marketing performance indicators.

In conducting audits of MA organizations, CMS assesses whether organizations' operations are consistent with federal laws, regulations, and CMS policies and procedures in some or all of seven major categories, including marketing.[22] Audits typically involve a combination of desk reviews of documents submitted by MA organizations, and, at CMS's discretion, site visits. CMS uses a risk-based approach to identify MA organizations for audit.[23] While CMS may choose to audit only certain categories in any given year, since at least 2006, CMS has included marketing operations, and specifically those related to misleading marketing, in its audits. CMS also conducts focused, or out-of-cycle, audits of MA organizations to ensure that MA organizations implemented new processes for previously identified areas of noncompliance and to investigate potential noncompliance issues that CMS identified outside of the audit cycle.

In June 2008, CMS reorganized its internal structure for overseeing MA plans and established standard operating procedures (SOP) for the oversight of MA organizations. The 2008 SOPs outlined the agency's oversight approach and clarified, among other things, what actions CMS may take when MA organizations were found to be out of compliance with marketing and other requirements. According to CMS officials, the SOPs

[21]In 2008, CMS's secret shopper program was expanded to include all plan types.

[22]CMS considers for inclusion in its audits the following broad categories: enrollment and disenrollment; benefits and beneficiary protections; quality assurance; provider relations; contracts; claims, organizations' determinations, appeals and grievances; and marketing.

[23]According to CMS officials, they consider various factors when selecting MA organizations for audit, including performance, enrollment, date of last audit, contract effective date, and plan type.

formalized many procedures that CMS was already using to oversee MA organizations and were intended to ensure that these procedures were being applied in a uniform manner nationwide.

CMS's SOPs state that CMS is to consider the nature of each violation in determining the appropriate compliance or enforcement action. The 2008 SOPs include the following actions from least to most severe:

- **Informal contact**: phone call, e-mail, or meetings with MA organization officials to provide technical assistance.
- **Compliance**: initial notice of noncompliance—e-mail to the MA organization, usually through the MA organization's compliance officer. An initial notice of noncompliance is generally issued at the first finding of relatively minor noncompliance with federal laws, regulations, or CMS guidance, such as a single instance of inappropriate marketing activities. The notice informs an MA organization that it is out of compliance and directs MA organizations to reply to the email to indicate how it will address the noncompliance.
- **Compliance**: warning letter—formal letter to the MA organization's compliance officer stating the concern or area of noncompliance that requires immediate remedy for a limited and quickly fixable situation. CMS also notifies MA organizations that continued noncompliance will lead to stricter actions by CMS, such as requiring the MA organization to develop a CAP.
- **Compliance**: CAP request letter—formal letter to the MA organization's chief executive officer stating the concern(s) and requiring the organization to develop and implement a CAP for the specific violation(s). CMS can require CAPs from MA organizations when the agency identifies noncompliance that generally affects multiple beneficiaries and represents an ongoing or systemic inability to adhere to Medicare requirements.[24] CMS's SOPs provide time frames for CMS and MA organizations to

[24]The CAP details the steps agreed upon by CMS and the MA organization that the MA organization will take to address the concern(s) raised by CMS. CMS audit SOPs state that in order for CMS to accept the CAP, MA organizations should, among other things, address deficiencies identified by CMS; provide an attainable time frame for implementing corrective actions; and devise a process for the MA organization to validate that corrective actions were taken, including conducting ongoing monitoring to ensure the organization maintains compliance. CMS audit SOPs also include instructions and time frames for resubmitting CAPs if CMS officials determine that an MA organization's first CAP is unacceptable.

respond, accept, and implement CAPs. CAPs are reported publicly on the CMS Web site.

- **Enforcement**: sanctions provided for under federal law that CMS may impose on MA organizations for what CMS considers egregious or sustained noncompliance and for specific violations, including misrepresenting or falsifying information to CMS, beneficiaries, or potential beneficiaries, or substantially failing to carry out the terms of their contracts with CMS.[25] Sanctions may include civil money penalties; the suspension of plans' marketing activities, enrollment, or Medicare payment; or termination or nonrenewal of organizations' contracts with CMS.[26] Suspensions of plans' marketing activities, enrollment, or Medicare payment are to remain in place until CMS is satisfied that the noncompliance that served as the basis for the suspension has been corrected and is not likely to recur.

For more serious violations, CMS may choose to forgo initial, less formal actions against an MA organization in favor of stricter actions, including later-stage compliance or enforcement actions. However, the SOPs indicate that compliance matters will generally escalate through the compliance process in a step-by-step manner, starting with the initial notice of noncompliance up through the CAP stage. CMS has also chosen to negotiate voluntary suspensions with MA organizations rather than go through formal processes to impose involuntary sanctions. According to CMS officials, voluntary suspensions can result in a faster intervention. If CMS makes the determination that the MA organization has engaged in certain fraudulent activity, the agency is to refer the violation to the Department of Health and Human Services Office of Inspector General (HHS OIG) for review.[27]

[25]As described earlier in this report, CMS has the authority to take enforcement actions as defined under federal law and regulations. 42 U.S.C. § 1395w-27(g); 42 C.F.R. § 422.752.

[26]MA organizations in most instances must be provided the opportunity to develop a CAP to resolve issues before CMS terminates or does not renew contracts. 42 C.F.R. § 422.510(c).

[27]Under federal regulations, if CMS determines that an MA organization has failed to comply with certain requirements, including misrepresenting or falsifying information to CMS, individuals or entities, CMS must notify HHS OIG, which may independently impose a civil money penalty upon the organization for this conduct. 42 C.F.R. § 422.756.

CMS Took Compliance and Enforcement Actions against at Least 73 MA Organizations for Inappropriate Marketing

From January 2006 through February 2009 CMS took a range of compliance and enforcement actions against at least 73 MA organizations for inappropriate marketing. While the number of MA organizations varied during the approximately 3-year period, 192 MA organizations offered MA plans as of March 2009. The exact number of MA organizations that were subject to an action could be higher. According to CMS, the agency did not begin tracking two types of action—initial notices of noncompliance and warning letters—until June 2008. From June 2008 through February 2009, CMS sent one initial notice of noncompliance and 76 warning letters to MA organizations.[28] (See app. II for more information about the types of inappropriate marketing that resulted in initial notices of noncompliance and warning letters.) From January 2006 through February 2009, CMS required 37 CAPs from MA organizations and also took 5 enforcement actions for inappropriate marketing—3 marketing and enrollment suspensions and 2 civil money penalties. The 73 MA organizations against which CMS took compliance or enforcement actions enrolled approximately 7.4 million beneficiaries through February 2009. (See table 1.) These beneficiaries represented about 71 percent of all MA beneficiaries.[29] CMS also negotiated voluntary suspensions of marketing and enrollment activities for PFFS plans with seven of these MA organizations effective June 2007.[30]

[28]From June 2008 through February 2009, CMS issued "outlier letters" to some MA organizations that the agency deemed to be outliers in complaint rates identified through agency surveillance activities. We included outlier letters in our count of warning letters.

[29]CMS's enrollment data do not include enrollment for contracts that had fewer than 10 beneficiaries, and thus beneficiaries enrolled under these contracts are not included in our total of beneficiaries enrolled in MA organizations subject to at least one compliance action or in the total number of beneficiaries enrolled in the MA program.

[30]According to CMS officials, the agency negotiated the voluntary suspension based on findings from its secret shopper activities and on general concerns of inappropriate marketing practices by agents selling PFFS plans. CMS officials told us that by asking the MA organizations to voluntarily suspend their marketing and enrollment activities, the agency was able to avoid some of the procedural requirements that are part of the process of imposing sanctions, such as undergoing a 15-day waiting period during which MA organizations have the opportunity to provide evidence that they did not commit the violation they were being sanctioned for and providing the MA organizations the opportunity to appeal.

Table 1: CMS Compliance and Enforcement Actions Taken for Inappropriate Marketing, January 2006 through February 2009

	Number of actions[a]	Number of MA organizations[a]	Number of MA beneficiaries enrolled (in millions)[b]
Compliance action			
Initial notices of noncompliance[c]	1	1	0.3
Warning letters[c]	76	57	7.1
Corrective action plans (CAP)	37[d]	32	4.9
Subtotal[e]	114	72[e]	7.4
Enforcement action			
Civil money penalties	2	2	1.9
Suspensions of marketing and enrollment	3	3	0.3
Contract terminations	0	0	0
Subtotal[e]	5	5[e]	2.2
Total, all actions	**119**	**73[e]**	**7.4**

Source: GAO analysis of CMS data.

Note: Inappropriate marketing includes misrepresenting plan benefits and conducting prohibited marketing practices, such as door-to-door marketing without appointments or providing potential enrollees with gifts of more than a nominal value as an inducement for beneficiaries to enroll. Inappropriate marketing also includes organizations' noncompliance with federal marketing requirements pertaining to proper training, compensation, and licensure of MA agents and registration of marketing events.

[a]The total number of compliance and enforcement actions exceeds the total number of MA organizations because CMS took more than one action against some MA organizations. For example, between January 2006 and February 2009, CMS required one MA organization to submit two CAPs and the agency suspended the MA organization's marketing and enrollment.

[b]MA enrollment data exclude MA organizations' contracts with fewer than 10 beneficiaries. MA enrollment data are current as of March 2009. Some MA organizations that received compliance and enforcement actions no longer offered MA plans as of March 2009; enrollment for these MA organizations was zero.

[c]The count of initial notices of noncompliance and warning letters includes only those notices and letters sent from June 2008 through February 2009. CMS did not track the number of initial notices of noncompliance and warning letters in a central location prior to June 2008.

[d]When MA organizations requested CAPs from multiple contracts under the same audit ID, we counted these as one CAP. Similarly, when there were multiple audits for the same parent organization that had the same date for the CAP request, we counted these as one CAP.

[e]The number of MA organizations with specific actions does not always equal the subtotal or total because CMS took more than one action against some MA organizations.

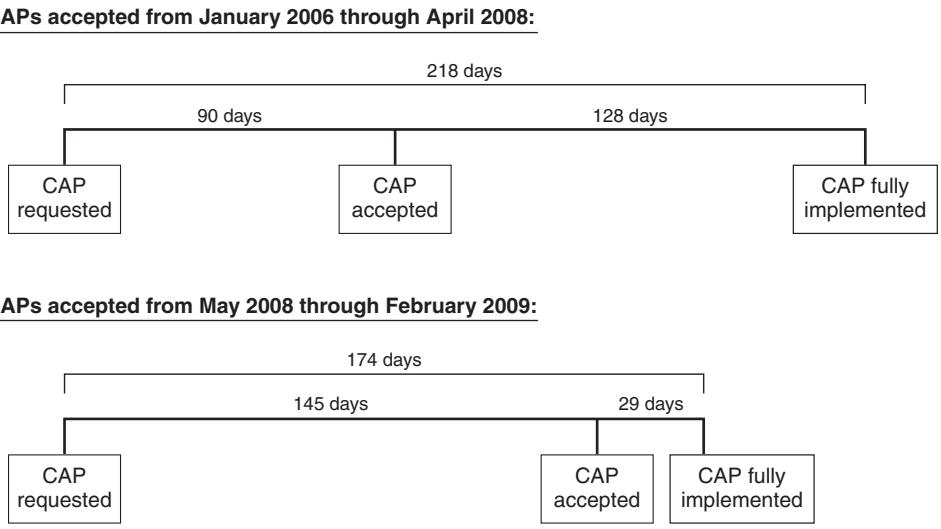
In some cases, during the period from January 2006 through February 2009, CMS took multiple types of actions against the same MA organizations because it determined that these organizations had more than one inappropriate marketing violation. (See app. III for information about the criteria CMS uses to make compliance and enforcement decisions.) Nineteen of the 73 MA organizations subject to compliance or enforcement actions had multiple types of actions taken against them. Fifteen of the 19 organizations received at least one warning letter or notice of noncompliance and a CAP. Two MA organizations received at least one warning letter or notice of noncompliance, were required to submit at least one CAP, and were subject to an enforcement action. One organization received at least one warning letter or notice of noncompliance and was subject to an enforcement action and another was required to submit at least one CAP and was subject to an enforcement action.

The time it took for MA plans to implement CAPs varied widely and changed over time. In May 2008, CMS revised its audit SOPs to generally require MA organizations to fully implement CAPs within 90 days from CMS's acceptance.[31] Consequently, the average time from when CAPs were requested to when corrective actions were fully implemented decreased for CAPs accepted after May 2008. Specifically, corrective actions for inappropriate marketing deficiencies were fully implemented an average of 218 days after CAPs were requested for the 22 CAPs accepted from January 2006 through April 2008 and an average of 174 days for the 13 CAPs accepted from May 2008 through February 2009. The period of time from when CMS requested the CAP to when CMS accepted the CAP increased, on average, from 90 days for CAPs accepted prior to May 2008 to 145 days for CAPs accepted May 2008 through February 2009. However, the average time from CMS acceptance of the CAP to when corrective actions were fully implemented decreased from 128 days for CAPs accepted from January 2006 through April 2008 to 29 days for CAPs

[31]CMS's audit SOPs state that the agency has discretion to extend the time frame for full implementation of a CAP beyond 90 days if the MA organization provides a credible explanation as to why it can not implement a CAP within 90 days. Prior to the May 2008 revision, CMS's audit procedures stated that the agency should provide an attainable timetable for CAP implementation but which generally should not exceed 6 months. In addition, CMS officials told us that prior to May 2008, the agency would keep some CAPs open after they had been fully implemented in order to monitor the MA organization's performance to ensure that the corrective actions had the desired effect. After May 2008, agency officials said they closed CAPs once the corrective action was implemented but might continue to monitor performance if necessary.

accepted from May 2008 through February 2009. (See fig. 1.) Overall, the period of time from when CMS requested CAPs to when MA organizations fully implemented them varied widely for CAPs accepted both for the period from January 2006 through April 2008 (from 61 to 410 days) and from May 2008 through February 2009 (from 68 to 345 days).

Figure 1: Average Time Frames of CAPs for Inappropriate Marketing, January 2006 through February 2009



Source: GAO analysis of CMS data.

Notes: CMS requests CAPs from MA organizations when the agency identifies noncompliance related to inappropriate marketing that generally affects multiple beneficiaries and represents an ongoing or systemic inability to adhere to Medicare requirements. In response, the MA organization is required to develop a plan on how it will correct the identified deficiencies. When CMS agrees with the MA organization's proposed corrective actions, the agency accepts the CAP. CMS then monitors the MA organization's progress in implementing the agreed upon corrective actions. We considered a CAP to be fully implemented when CMS determined that the agreed upon corrective actions to address the noncompliance related to inappropriate marketing had been taken.

Inappropriate marketing includes misrepresenting plan benefits and conducting prohibited marketing practices, such as door-to-door marketing without appointments or providing potential enrollees with gifts of more than a nominal value as an inducement for beneficiaries to enroll. Inappropriate marketing also includes organizations' noncompliance with federal marketing requirements pertaining to proper training, compensation, and licensure of MA agents and registration of marketing events.

While CMS required 37 CAPs for inappropriate marketing from January 2006 through February 2009, this figure contains averages that reflect CAPs that were fully implemented as of July 2009. Of the 37 CAPs, 35 were implemented as of July 2009—22 from January 2006 through April 2008 and 13 from May 2008 through February 2009.

For enforcement actions, the implementation time periods varied widely as well—from approximately 2 weeks to 2 years before CMS took an enforcement action after first identifying what it considered to be inappropriate marketing. For example, CMS suspended the marketing and enrollment activities of one MA organization based on results of CMS's secret shopper activities that showed what CMS considered egregious inappropriate marketing approximately 2 weeks after the MA organization began marketing its MA plans.[32] In contrast, in February 2009, CMS suspended the marketing and enrollment activities for another MA organization after 2 years of sustained noncompliance with marketing requirements. During the 2-year period, CMS determined that this MA organization employed agents who had engaged in activities that misled, confused, or misrepresented the organization or its MA plans to beneficiaries during three audits conducted between March 2007 and July 2008, for which CMS required CAPs. In addition, in July 2008, CMS sent the MA organization a notice of noncompliance based on beneficiary allegations of inappropriate marketing by agents selling its MA plans. (See table 2 for a summary of the five cases for which CMS took enforcement actions.)

[32]CMS withdrew the formal suspension in favor of a voluntary suspension agreed to by the MA organization.

Table 2: CMS Enforcement Actions Taken against MA Organizations for Inappropriate Marketing, January 2006 through February 2009

Date action taken	Basis for enforcement action	Enforcement action
09/18/2007	Based on the results of an MA organization's investigation into agent marketing violations in spring 2007, CMS determined that agents employed by the MA organization had engaged in activities that misled and confused beneficiaries, which ultimately resulted in 352 beneficiaries requesting disenrollment from the PFFS plan. A majority of these individuals said they did not fully understand aspects of the plan and/or the provider would not accept the plan at the time of their visit.	$264,000 civil money penalty[a]
09/18/2007	CMS discovered that the MA organization employed more than 60 unlicensed agents, based on the results of a September 2006 state market conduct examination provided to the agency. CMS determined that because the agents were unlicensed they did not meet minimum Medicare requirements for agent training to market MA plans responsibly. In addition, CMS determined that agents marketed and sold inappropriate MA plans to some beneficiaries who then faced increased out-of-pocket costs and disruptions in access to health care.	$75,000 civil money penalty
10/19/2007	During its fall 2007 Secret Shopper program, CMS found that agents selling the organization's MA plans made a large number of inaccurate statements about plan benefits and coverage to potential beneficiaries.	Suspension of marketing and enrollment[b]
9/15/2008	CMS received complaints in June 2008 that the MA organization was not paying provider claims in a timely manner. CMS conducted an audit in June 2008 and found that the MA organization had failed to meet requirements in a number of areas, including marketing. Specifically, CMS determined that the MA organization failed to ensure that its agents met state licensure and appointment requirements. In addition, CMS was notified by a DOI in August 2008 that the MA organization failed to meet that state's financial solvency standards.	Suspension of marketing and enrollment
02/19/2009	Based on long-standing and persistent noncompliance with CMS requirements identified during surveillance and audit activities conducted in 2007 and 2008, CMS determined that the MA organization and agents employed by the organization had engaged in sustained noncompliance and in activities that misled and confused beneficiaries and misrepresented the organization, engaged in unauthorized door-to-door solicitations, and failed to establish a system for confirming that beneficiaries had enrolled in one of the organization's plans and understood applicable plan rules.	Suspension of marketing and enrollment

Source: GAO analysis of CMS data.

Note: Inappropriate marketing includes misrepresenting plan benefits and conducting prohibited marketing practices, such as door-to-door marketing without appointments or providing potential enrollees with gifts of more than a nominal value as an inducement for beneficiaries to enroll. Inappropriate marketing also includes organizations' noncompliance with federal marketing requirements pertaining to proper training, compensation, and licensure of MA agents and registration of marketing events.

[a]CMS and the MA organization settled the penalty for $190,000.

[b]CMS lifted the sanction in favor of a voluntary suspension of marketing and enrollment activities agreed to by the MA organization. However, according to agency officials, CMS includes the suspension on its list of enforcement actions because the agency had begun the process to formally sanction the MA organization at the time that it agreed to voluntarily suspend its marketing activities.

CMS Helped Beneficiaries Who Experienced Inappropriate Marketing to Disenroll from Their MA Plans, but Some Faced Adverse Consequences

CMS assisted beneficiaries who experienced inappropriate marketing by helping them restore their previous health insurance coverage or enrolling them in another option. Some beneficiaries experienced financial liability or access-to-care problems as a result of being enrolled in an MA plan or stemming from their disenrollment and enrollment in prior or different coverage.

CMS Uses Special Election Periods to Help Beneficiaries Who Experienced Inappropriate Marketing

CMS assisted MA beneficiaries who experienced inappropriate marketing by MA organizations by providing special election periods (SEP), which enable beneficiaries to disenroll from their MA plan outside of the regular enrollment periods and to enroll in prior coverage or another option, such as another MA plan, Medicare FFS, or a stand-alone Medicare prescription drug plan.[33] CMS announced that it had established a special SEP for inappropriate marketing in a July 2007 memo to MA organizations.[34,35] CMS officials described these SEPs as their primary attempt to make beneficiaries who experienced inappropriate marketing "whole."

[33]The annual coordinated election period runs from November 15th through December 31st. During this time, beneficiaries may change MA plans, change prescription drug plans, return to Medicare FFS, or enroll in an MA plan for the first time. The open enrollment period runs from January 1st through March 31st and provides beneficiaries with one opportunity to enroll in, disenroll from, or change an MA plan. MA organizations are not required to open their MA plans for enrollment during the open enrollment period, but all MA organizations are required to provide disenrollments during this period.

[34]Under federal law, CMS has the authority to specify conditions for SEPs, including if the beneficiary meets exceptional conditions as defined by CMS. 42 U.S.C. § 1395w-21(e)(4). CMS uses these exceptional conditions SEPs for beneficiaries who had enrolled in MA plans based on alleged misleading or incorrect information by plan employees or agents. In this report, we refer to these exceptional condition SEPs as inappropriate marketing SEPs.

[35]While CMS officials confirmed that the inappropriate marketing SEP officially went into effect in July 2007, the agency established SOPs for processing the SEPs in June 2007, and CMS data show that some beneficiaries were provided an inappropriate marketing SEP in June 2007.

According to CMS's SOPs, MA beneficiaries qualify for the SEP if they call 1-800-Medicare or contact a CMS regional office and give reasonable assurance that they were subject to inappropriate marketing; CMS does not require the beneficiaries to provide evidence. According to CMS officials, they decide whether to provide SEPs before investigations into inappropriate marketing allegations are complete to ensure that beneficiaries who did experience misleading marketing can disenroll from the MA plan and enroll in other health coverage as quickly as possible. Consequently, some of the beneficiaries who were provided a SEP might not have been subject to inappropriate marketing.

CMS offered MA beneficiaries either a prospective or retroactive SEP. Under a prospective SEP, beneficiaries could disenroll from the MA plan and return to their previous coverage or enroll in another option effective the first day of the next month. CMS officials told us that the customer service representatives at 1-800-Medicare generally processed prospective disenrollments and enrollment in other MA plans or Medicare FFS. Under the retroactive SEP, beneficiaries could disenroll from the MA plan and return to their previous coverage or enroll in other coverage effective as early as the date of their enrollment in the MA plan. Retroactive SEPs are more complicated because they require payment adjustments for any premiums paid and medical services received while the beneficiary was enrolled in the plan. Retroactive SEPs are processed by regional office staff.

According to CMS's SEP SOPs, 1-800-Medicare customer service representatives should ask beneficiaries who provide reasonable assurance that they were subject to inappropriate marketing whether they would like to prospectively disenroll from their plan and enroll in new coverage. If the beneficiary agrees, the disenrollment from the MA plan and enrollment in new coverage is handled by the customer service representative. If the beneficiary requests a retroactive SEP, the case is forwarded to a regional office. CMS's SEP SOPs state that regional office officials are required to explain the consequences of a retroactive disenrollment or enrollment to the beneficiary before such a disenrollment is processed. If a beneficiary directly contacts a regional office with a complaint of inappropriate marketing, officials should offer beneficiaries a prospective SEP, although they may offer a retroactive SEP if the beneficiary insists. While CMS's SOPs indicate a preference for offering beneficiaries a prospective SEP, CMS officials we interviewed said that whether CMS offers a prospective or retroactive SEP to a beneficiary depends on what would be in the beneficiary's best interest.

The most suitable SEP for a MA beneficiary depended on the beneficiary's circumstances. For example, if beneficiaries used services while enrolled in an MA plan, they could benefit from a prospective SEP if their cost sharing—the amount they paid out-of-pocket for a covered service—under the MA plan was lower than it would be under their restored or other coverage. If these beneficiaries chose a retroactive SEP, they would have to make up the difference between the lower cost sharing amount under the MA plan and the higher amount under their restored or other coverage. Conversely, beneficiaries who chose restored or other coverage with cost sharing that was lower than the MA plan could benefit from disenrolling retroactively because they would be reimbursed for the difference between the out-of-pocket costs they incurred for services received under the MA plan and the lower costs under the restored or other coverage.

Some Beneficiaries Experienced Problems Associated with Retroactive Disenrollments, While Others Experienced Problems That Could Not be Fixed by a SEP

Some DOI and SHIP officials we interviewed told us that MA disenrollments and enrollments resulting from inappropriate marketing generally appeared to go smoothly, but that some beneficiaries experienced problems.[36] Officials from some DOIs and a SHIP we interviewed said some beneficiaries' retroactive disenrollments took several months to process. Officials from one DOI said that some beneficiaries received bills from collection agencies because provider reimbursements associated with retroactive disenrollments were not timely. An official from another DOI said that it could take from 10 to 30 days to receive enrollment material, including a plan identification card, and this could cause access-to-care problems if beneficiaries needed health care services before the material arrived. To help mitigate any access-to-care problems, CMS officials said that they instructed 1-800-Medicare customer service representatives to give beneficiaries their MA plans' contact information when they enrolled so that beneficiaries could contact the plans directly for information about accessing services. Additionally, CMS officials stated that CMS regional office employees routinely worked with MA organizations to ensure that beneficiaries who received a retroactive SEP could access services prior to receiving plan identification cards.

[36]We did not ask the DOI and SHIP officials whether these problems—or the specific cases they cited to illustrate them—involved use of the inappropriate marketing SEP because CMS, not state officials, administers it.

CMS officials told us that some of the problems encountered by MA beneficiaries receiving a retroactive inappropriate marketing SEP were unavoidable and inherent to the processing of a retroactive disenrollment. They noted that under a retroactive SEP, different premium amounts needed to be collected, provider bills and payments might need to be retracted and reprocessed by the new insurer, and different cost-sharing amounts applied. Therefore, a SEP could take time to be fully processed. These officials stated that the administrative actions and associated problems that beneficiaries may experience are preferable to keeping beneficiaries in an MA plan after they have stated that they experienced inappropriate marketing.

Beneficiaries who stated they experienced inappropriate marketing may also have experienced problems that the SEP could not address. For example, these beneficiaries could have experienced financial or access-to-care issues prior to receiving the SEP. CMS, DOI, and SHIP officials described cases in which beneficiaries did not realize they had been switched to an MA plan until they tried to access services. These officials said some of the beneficiaries experienced disruption of their access to providers and medications because their providers did not participate in the MA plan. DOIs and SHIPs also cited several other problems the inappropriate marketing SEP could not resolve because the problems were associated with private or state employee insurance plan provisions or involved other government agencies, and hence were outside CMS's jurisdiction. DOIs and SHIPs provided information about specific types of cases that a SEP could not resolve:

- A beneficiary had to pay higher premiums to obtain the same Medigap polices that she had dropped when she was enrolled in a MA plan.[37]

- Beneficiaries could not have coverage restored by their prior employer's retiree health plan. DOI and SHIP officials said that employer retiree health plans are generally not required to restore coverage to MA beneficiaries who stated they experienced inappropriate marketing. CMS officials said that they were able to get retiree health coverage restored for some beneficiaries, but not for others.

[37]Medigap refers to individually purchased private insurance policies that provide additional supplemental coverage to help fill Medicare FFS's coverage gaps and pay some out-of-pocket expenses.

- Beneficiaries who had premiums withheld from their Social Security checks experienced delays in ending the withholding after they were disenrolled from their MA plan, which could have caused financial hardships.[38]

CMS Has Limited Information on the Number of Beneficiaries Affected by Inappropriate Marketing

The information CMS has on the number of beneficiaries affected by inappropriate marketing is limited for two reasons. First, some beneficiaries who experienced inappropriate marketing may have exercised their option—available during certain times of the year—to disenroll from their MA plan and might not have notified CMS of the marketing problems they encountered. Second, CMS did not directly track the number of beneficiaries who contacted the agency and were provided a SEP. CMS did estimate the number of SEPs it provided for inappropriate marketing, but its estimates were based on data that were unreliable.

All MA beneficiaries, including those who had been affected by inappropriate marketing, may have elected to change their health plans during the annual coordinated election period or the annual open enrollment period. CMS had the information to determine the number of beneficiaries who disenrolled during these regular enrollment periods, but during the time of our study, the agency did not collect information that would have allowed it to determine the extent to which beneficiaries disenrolled from health plans as a result of inappropriate marketing.

Disenrollment rates varied considerably among plans and types of plans. For example, we previously reported on disenrollment rates in PFFS plans occurring during the regular enrollment periods for 2007.[39] PFFS plans were considered by CMS and others to have high rates of inappropriate

[38]MA beneficiaries have the option of having their MA premiums withheld from their Social Security payments. We recently reported that schedule and timing issues have complicated this process for some MA beneficiaries. Among the issues cited in the report was that beneficiaries could request changes to their premium withholding early in a month and SSA would not be able to process that change in time for the next month's payment. As a result, premium withholding would not be accurate for at least 1 month, and once processed, retroactive adjustments would be required for the months when the withholding was not accurate. In some cases, beneficiaries did not receive refunds for overpayments of premiums paid in 2006 until July 2007 or later. See GAO, *Schedule and Timing Issues Complicate Withholding Premiums for Medicare Parts C and D from Social Security Payments*, GAO-08-816R (Washington, D.C.: July 15, 2008).

[39]See GAO, *Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans*, GAO-09-25 (Washington, D.C.: Dec. 15, 2008).

marketing. From January through April 2007, when the disenrollments took effect, about 169,000 beneficiaries in PFFS plans, or 21 percent of the total number of PFFS beneficiaries, disenrolled from the plan that they were enrolled in. This 4-month total was more than double the disenrollments from other plan types during that same time period. However, the number of these beneficiaries who changed plans because they were affected by inappropriate marketing was unknown because CMS did not have data on why these beneficiaries disenrolled.

After 2005, CMS discontinued a survey on disenrollment reasons that provided information on the frequency of certain problems leading to disenrollment. From 2000 to 2005, CMS conducted an annual survey asking MA beneficiaries who disenrolled why they left their plan. Among the disenrollment reasons that beneficiaries could have chosen was: "Given incorrect or incomplete information at the time you joined the plan." A 2005 analysis prepared by CMS contractors of survey results from 2000 through 2003 found that over this time period, the percent of beneficiaries who said they disenrolled because they were given incorrect or incomplete information at the time they joined their plan ranged from about 9 to about 11 percent. However, in each of the 3 years, less than one percent of beneficiaries who responded to the survey stated that this was the most important reason for their disenrollment. The survey did not collect information on the problems beneficiaries experienced as a result of the reasons that led to their disenrollment or the disenrollment itself. The analysis prepared by CMS contractors noted that the survey's primary goals were to enhance CMS's ability to monitor MA plan performance and assist plans in identifying areas where they might focus their quality improvement efforts.

CMS officials said that they plan to reinstitute a survey on disenrollment reasons in late summer 2010. CMS officials plan to collect data over a 9- to 12-month period, so final results should be available sometime in 2011. After the survey ends and results are analyzed, CMS will determine whether to conduct additional surveys on disenrollment reasons.

CMS did not directly track the number of SEPs it provided, but instead estimated the number based on information collected in its complaint tracking module. Complaints from beneficiaries who stated they experienced inappropriate marketing and wanted to disenroll from their MA plans were classified into one of two categories in CMS's complaint

tracking module.[40] One category was for inappropriate marketing cases that required regional office action to complete beneficiaries' disenrollment and enrollment in another plan. According to complaint tracking module data provided by CMS, during the 17-month period from June 2007 through October 2008, CMS received 18,331 such complaints. CMS officials said that most of these cases were retroactive SEP requests.[41] The second category was for inappropriate marketing cases that did not require regional office action to complete beneficiaries' disenrollment and enrollment in another plan. During the 7-month period from April 2008 through October 2008, CMS received 1,689 inappropriate marketing complaints that the agency determined did not need regional office action. According to CMS officials, cases included in the second category were primarily prospective SEP requests. CMS officials told us that most of the complaints in these two categories resulted in an inappropriate marketing SEP but that the total included some beneficiaries who made such statements but did not disenroll.[42]

However, the complaint data were not a reliable source of information on the number of beneficiaries who received the SEP. A study conducted by a CMS regional office of a sample of about 170 complaints lodged between August 2007 and January 2008 highlighted inaccurate and incomplete documentation as well as a portion of inappropriate marketing complaints that had been miscategorized:

- About 33 percent of cases were resolved or closed inappropriately or involved duplicate cases. For example, some cases were closed prior to final resolution. In one of these cases, the MA organization indicated in

[40]The inappropriate marketing complaint categories in the complaint tracking module, which CMS calls misleading marketing complaint categories, include agent-related complaints as well as complaints pertaining to the accuracy of marketing materials distributed to beneficiaries.

[41]There are some cases that a 1-800-Medicare customer service representative would forward to a regional office for a retroactive SEP, but after regional office officials consult with the beneficiary, a prospective SEP is provided instead. Also, 1-800-Medicare customer service representatives may send a complaint to a regional office for a secondary review, at which point a prospective SEP is provided. Both situations would result in the complaints being filed in the category requiring regional office action even though a prospective SEP was provided.

[42]The CMS officials also said that the total includes beneficiaries enrolled in stand-alone prescription drug plans, which provide only prescription drug coverage and are not considered MA plans. The officials stated that the number of these beneficiaries is likely very low.

case notes that a beneficiary was experiencing a problem with reimbursement and that it was doing additional research on the issue.[43] However, the MA organization closed the case prior to completing its research on whether the beneficiary was due reimbursement and, if so, whether the beneficiary received it. Four of the 54 cases in this category were for instances in which multiple cases were open for the same member and issue.

- About 28 percent of case resolutions were poorly documented. Most frequently these cases contained notes in the complaint tracking module that did not indicate when disenrollments took effect or addressed part of the complaint but notes did not reflect that all aspects of the complaint had been resolved.

- About 20 percent of cases were incorrectly categorized. The majority of miscategorized cases were inappropriate marketing complaints that were coded in categories other than inappropriate marketing.

- About 12 percent of cases lacked specific information about at least one issue involved in the complaint, such as details about refunds or payments owed to the beneficiary.

Officials from another CMS regional office conducted a more informal examination of complaint tracking module cases in 2008 and found similar problems. The officials told us that the regional office did a spot check of 50 inappropriate MA marketing complaints by calling the beneficiaries and determined that the notes in the complaint tracking module often did not match the description of the complaint that the beneficiary provided during the follow-up call. The officials also said that CMS staff examined complaints against one MA organization and found cases of alleged inappropriate marketing that were not categorized as such. The officials from this regional office estimated that they had recategorized 60 percent of all complaint tracking module cases within this region. However, other CMS regional offices said the percentage of cases that needed to be recategorized was small. The reason for this disparity is unclear, but it may be due to how regional offices determined whether cases needed to be recategorized.

[43]MA organizations generally have access to the complaint tracking module so that they can investigate complaints and coordinate with CMS on addressing problems.

CMS officials told us that they used the results of internal studies of the complaint tracking module to improve their ability to categorize complaints. However, it was beyond the scope of our study to determine the effectiveness of these changes.[44]

Conclusions

Inappropriate marketing can adversely affect MA beneficiaries, causing financial hardship and difficulty in accessing needed care. While CMS has used SEPs to assist beneficiaries, the agency was unable to prevent some of them from experiencing negative consequences. Currently, CMS has limited information on the extent of inappropriate marketing and the number of beneficiaries affected. The agency intends to conduct a survey of beneficiaries who disenrolled from MA plans and ask about their reasons for disenrollment. Depending on the specific questions included, such a survey could provide information about the number of beneficiaries who experience inappropriate marketing and identify plans, plan types, and geographic locations where inappropriate marketing problems are most prevalent. CMS's information about the extent of inappropriate marketing is also limited because the agency has not gathered reliable information about the number of prospective and retroactive SEPs provided for this reason. Without an investigation into individual cases, CMS cannot determine whether all of the problems reported by beneficiaries represent inappropriate marketing. Nonetheless, gathering information on the reasons beneficiaries disenroll from their MA plans and tracking the number of the SEPs that the agency provides would enable the construction of useful indicators of the potential scope and location of the marketing problems. Because of the potentially serious implications for beneficiaries as a result of inappropriate marketing, it is important for CMS to have information that can inform the agency's oversight efforts and help it to appropriately target interventions when necessary.

Recommendation for Executive Action

To improve CMS's oversight of MA organizations and its ability to appropriately target interventions, we recommend that the Administrator of CMS gather more information on the extent of inappropriate marketing and the types of problems beneficiaries experienced as a result of

[44]We examined aspects of the complaint tracking module in our 2008 report, GAO, *Medicare Part D: Complaint Rates Are Declining, but Operational and Oversight Challenges Remain*. GAO-08-719 (Washington, D.C.: June 27, 2008).

inappropriate marketing. As part of this effort, CMS should directly track retroactive and prospective SEPs provided for inappropriate marketing.

Agency Comments and Our Evaluation

We provided a draft of this report for comment to HHS, the department under which CMS resides. Responding for HHS, CMS stated that it concurred with our recommendation and that it would assess the costs and benefits of alternative systems that could be used to collect information on the extent of inappropriate marketing and the types of problems beneficiaries experience as a result. CMS also stated that while it did not directly track the number of retroactive and prospective SEPs provided for inappropriate marketing, it used data from its complaint tracking module and considered that data a reasonable proxy of the total number of SEPs requested for inappropriate marketing. As our report notes, findings from a formal and informal study conducted by two CMS regional offices demonstrated that data from the complaint tracking module were not a reliable source of information on the number of beneficiaries who received a SEP. However, CMS officials told us in an interview that they used the results of these studies to improve their ability to categorize complaints. It was beyond the scope of our study to determine the effectiveness of these changes. CMS also stated in its comments that it had taken additional steps in 2009 to protect beneficiaries from deceptive marketing practices conducted by agents, including establishing stronger rules for governing the commissions that can be paid to independent sales agents, disseminating new marketing guidelines about how MA plans identify themselves to beneficiaries, and expanding its secret shopper program. (CMS's comments are reprinted in app. IV.) CMS provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies to the Administrator and interested congressional committees. We will also make copies available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix V.

Sincerely yours,

James Cosgrove
Director, Health Care

Appendix I: Scope and Methodology

This appendix describes in detail the scope and methodology we used to address the report objectives. We briefly summarize the methodologies by objective and then discuss for all objectives (1) our review of relevant federal laws, regulations, and guidance from the Centers for Medicare & Medicaid Services (CMS), including policies and procedures; (2) interviews with CMS officials and other stakeholders; and (3) CMS data.

Methodology by Objective

To determine the extent to which CMS has taken compliance and enforcement actions against Medicare Advantage (MA) organizations for inappropriate marketing, we analyzed CMS data on the number and types of corrective and enforcement actions taken against MA organizations for inappropriate marketing. We conducted an analysis of noncompliance and warning letters from CMS notifying MA organizations about marketing violations, such as providing inappropriate information to beneficiaries at marketing events, or agent-related operational violations, such as those related to agent compensation. We excluded from our analysis letters for non-agent-related violations such as incorrect information on an MA organization's Web site. We analyzed corrective action plans (CAP) that CMS required if the agency determined that the MA organization had engaged in activities that materially misled, confused, or misrepresented the MA organization to beneficiaries.

To determine how CMS helped MA beneficiaries affected by inappropriate marketing and the types of problems beneficiaries encountered, we reviewed relevant agency documentation for the period January 2006 through February 2009 and interviewed officials at CMS's central office and all 10 regional offices, 6 state departments of insurance (DOI), and 6 state health insurance assistance programs (SHIP).[1] We also conducted site visits at the Dallas, Kansas City, and New York City CMS regional offices to interview officials from these regions more extensively.

To determine what information CMS had on the number of beneficiaries affected by inappropriate marketing, we analyzed CMS's complaint data to quantify the number of beneficiaries who complained about inappropriate marketing and requested to disenroll from their plan outside of the annual

[1]SHIP is a national, federally-funded program that uses grants directed to states to provide counseling, educational presentations, and other services to Medicare beneficiaries and their families.

coordinated election and open enrollment periods, when beneficiaries can join, switch, or drop MA plans.[2] We reviewed one CMS regional office's study of CMS's complaint tracking module conducted in February 2008. We also interviewed CMS officials about the agency's plan to obtain information about reasons for disenrollment during the annual coordinated election and open enrollment periods. Unless otherwise noted, we limited our analysis of inappropriate marketing in this report to instances of agent-related noncompliance with marketing requirements.

Review of Relevant Federal Laws, Regulations, and CMS Guidance

We reviewed relevant federal laws, regulations, and CMS guidance for the provisions related to inappropriate marketing, compliance and enforcement actions, and the time frames for which the provisions were in effect. We interviewed CMS officials about agency guidance related to oversight of the MA program, including policies and procedures, for the period of January 2006 through February 2009.

Interviews with CMS Officials and Other Stakeholders

We interviewed officials from CMS, state DOIs, SHIPs, and MA organizations and reviewed any documentation referenced during our interviews. In our interviews with state DOIs and SHIPs, we asked both specific and open-ended questions about the problems beneficiaries encountered and, on some occasions, interviewed officials from a state's DOI and SHIP concurrently. Because of this, the frequency of our interviewees' responses is not comparable. Therefore, we report these responses without reporting the total number of state DOIs or SHIPs associated with each response. In addition, state DOIs, SHIPs, and MA organizations we interviewed may not be representative of all state DOIs, SHIPs, and MA organizations, and thus the information is not generalizable to these entities.

[2]The annual coordinated election period runs from November 15th through December 31st. During this time, beneficiaries may change MA plans, change Medicare prescription drug plans, return to Medicare FFS, or enroll in an MA plan for the first time. The open enrollment period runs from January 1st through March 31st and provides beneficiaries with one opportunity to enroll in, disenroll from, or change an MA plan. MA organizations are not required to open their MA plans for enrollment during the open enrollment period, but all MA organizations are required to grant disenrollments during this period.

CMS

We interviewed officials from CMS's central office and its 10 regional offices. For three regional offices (Dallas, Kansas City, New York City), we conducted our interviews during site visits. We chose the Dallas regional office because it has a high concentration of enrollment in private fee-for-service plans, a type of MA plan for which there has been a high percentage of allegations of inappropriate marketing. We chose the Kansas City regional office because it conducts detailed analyses of complaint data for the other regional offices. We chose the New York City regional office because it houses the division that coordinates CMS's regional office MA monitoring and oversight activities.

State DOIs

We interviewed officials from six state DOIs. We chose the Texas, Missouri, and New York DOIs because they were located in the states where we conducted site visits to CMS regional offices. We chose the Oklahoma DOI because it took enforcement action against at least one MA organization that was related to inappropriate marketing by agents. In addition, we interviewed officials from the Florida and Ohio DOIs because officials from these DOIs have testified before the National Association of Insurance Commissioners (NAIC) on inappropriate MA marketing and sales practices.

SHIPs

We interviewed officials from 6 SHIPs, which we chose because they were located in the same states as the DOIs whose officials we interviewed.

MA Organizations

We interviewed officials from five MA organizations that CMS regional officials we spoke with identified as having had major performance problems and that had been subject to one or more CMS compliance and enforcement actions, or that had voluntarily suspended marketing and enrollment for inappropriate marketing and noncompliance with agent-related marketing requirements. The five MA organizations varied in enrollment size, ranging from fewer than 230,000 beneficiaries to more than 1 million beneficiaries.[3] As of March 1, 2009, these MA organizations provided Medicare coverage for approximately 26 percent of all MA beneficiaries.

[3]One of the MA organizations we interviewed no longer offered MA plans as of March 1, 2009. Enrollment for this MA organization was zero as of March 1, 2009, and was not included in our range.

CMS Data

We reported on results from a February 2008 study performed by one CMS regional office and analyzed data from CMS's complaint tracking module and on the compliance and enforcement actions taken by the agency.

CMS Regional Office Study of Complaint Tracking

We reviewed a study conducted in February 2008 by one CMS regional office that examined how complaint cases entered into the complaint tracking module were resolved by current staff in the regional office and MA organizations, and whether staff followed agency guidelines when resolving cases. The study findings were based on a content analysis performed by CMS officials of about 170 randomly selected cases that were closed in the region between August 2007 and January 2008. Because the study only reviewed complaints received by the one regional office, the results of this study are not generalizable to other CMS regional offices. In addition, we did not independently assess the accuracy of study results. Based on our review of the study's methodology, we concluded that the study results were sufficiently reliable for our purposes.

Complaint Data

We reviewed data from the complaint tracking module that serves as CMS's best estimate of the number of beneficiaries who received a SEP. The SEP estimates come from two categories in the complaint tracking module: inappropriate marketing complaints that required regional office action and inappropriate marketing complaints that did not require regional office action. We analyzed data on complaints that required regional office action from June 2007 through October 2008 and complaints that did not require regional office action from April 2008 through October 2008.[4] During our interviews with CMS officials, we identified several limitations associated with the complaint tracking module data. While CMS officials told us that the agency had made improvements to its complaint tracking module, it was beyond the scope of our report to evaluate the effectiveness of these changes. On the basis of our review of the data and interviews with CMS officials, we determined that the complaint tracking module data had significant limitations. As a result, we include totals for the two complaint categories in our finding, but do not provide any additional analyses of the data. We also include a discussion of the data limitations in our finding.

[4]CMS has assisted beneficiaries who allege they have been affected by inappropriate marketing, including agent misconduct, by providing SEPs, through which CMS disenrolls them from their MA plan and attempts to restore their previous coverage.

Compliance and Enforcement Action Data

We analyzed data for the number and type of compliance and enforcement actions that CMS took against MA organizations from January 2006 through February 2009 for violations related to inappropriate marketing. CMS provided us with marketing-related notices of noncompliance and warning letters issued during the agency's review of compliance letters issued from June 2008 through February 2009.[5] We conducted a content analysis of CMS's marketing-related compliance letters to identify those related to inappropriate marketing and noncompliance with agent-related marketing requirements. We included in our count letters that CMS sent to MA organizations for agents providing inappropriate information to beneficiaries at marketing events, engaging in prohibited activities such as providing meals to beneficiaries, and for high rates of beneficiary complaints of inappropriate marketing for which CMS considered the organizations to be outliers. We also included compliance letters for operational violations that are related to agent oversight. We excluded compliance letters for operational violations that were not agent-related such as incorrect information on MA organizations' web sites, security breaches, and failure to issue beneficiary notices about plan changes in a timely manner.

For our CAP analysis, we included those CAPs that CMS required if the agency determined that the MA organization engaged in activities that materially misled, confused, or misrepresented the MA organization to beneficiaries. We confirmed with CMS officials that violations in this category were related to inappropriate marketing by agents and that most deficiencies associated with inappropriate marketing that CMS identified fell under this audit category. This category can include deficiencies related to MA organizations' internal operations related to agent oversight, such as agent training programs and processes for monitoring agent behavior, and deficiencies related to agent-related noncompliance with marketing requirements. However, it is possible that some instances of inappropriate marketing may have been included in violations identified in other categories. We note this limitation in the report. When MA organizations requested CAPs from multiple contracts under the same audit ID, we counted these as one CAP. Similarly, when there were multiple audits for the same parent organization that had the same date for the CAP request, we counted these as one CAP. In calculating the length of

[5]Prior to June 2008, CMS did not track the number of noncompliance and warning letters it issued in a centralized location; as a result, any letter sent prior to June 2008 was not included in our analysis.

time CAPs remained open, we used the dates for when CMS accepted and closed the corrective action element for the specific inappropriate marketing deficiency, rather than the dates for which the entire CAP was accepted and closed. CMS requests CAPs to address multiple violations of agency requirements in addition to marketing; CMS may accept and close individual corrective actions for specific deficiencies under a CAP at different times.

We identified enforcement actions related to inappropriate marketing and noncompliance with agent-related marketing requirements by performing a content analysis of the enforcement actions listed on CMS's Web site. We reviewed the sanction letters CMS sent to these organizations or interviewed agency officials to determine that the enforcement actions we had identified were related to inappropriate marketing. Based on our review of the data and interviews with CMS officials, we concluded that the compliance and enforcement action data were sufficiently reliable for our purposes.

Appendix II: Inappropriate Marketing Violations for Which CMS Sent Compliance Letters to MA Organizations, June 2008

In June 2008 CMS began tracking the number of compliance letters—initial notices of noncompliance and warning letters sent to MA organizations. For the period of study, CMS issued one initial notice of noncompliance and 76 warning letters for various instances or areas of noncompliance. (See table 3.) During the 2008 annual election period, CMS conducted multiple surveillance activities: analyzing rates of beneficiary allegations of agent-related noncompliance in the agency's complaint tracking module, and secret shopping of MA organizations marketing events and customer call centers. CMS also reviewed MA organizations' compliance with required agent commission limits. CMS then sent the letters as a result of its findings from its surveillance activities and its review of compliance with required agent commission limits.

Table 3: Inappropriate Marketing Violations for Which CMS Sent Initial Notice of Noncompliance or Warning Letter, June 2008 through February 2009

Specific area of noncompliance	Number of MA organizations
MA organization developed and distributed unapproved marketing materials that included persuasive language and incomplete information	1
MA organization distributed unapproved and misleading marketing materials	1
CMS received reports from SHIPs of aggressive PFFS marketing to dual-eligibles	1
MA organization was outlier in observations of violations in secret shopping of MA call centers	14
MA organization was outlier in marketing complaint rates received by CMS	12
MA organization was out of compliance with agent commission rates established by CMS regulation	37
MA organization failed to submit a unique record identification for each agent commission schedule to CMS	7
MA organization failed to report advertised marketing events to CMS	1
Secret shopper violations	
Presenter provided meals to enrollees	2
Presenter did not read PFFS disclaimer	6
Presenter required signatures on forms other than enrollment forms	1
Presenter did not provide information on where to find drugs in plan formulary	2
Presenter provided gifts without appropriate disclaimer	1
Presenter misrepresented plan	2
Presenter did not tell attendees that sign-in sheet authorized contact with enrollee	1
Presenter misrepresented CMS requirements for enrollment	1
Presenter provided limited information in order to schedule home appointment	2
Presenter provided gifts only to enrollees who filled out scope of appointment forms	3
MA organization did not respond to CMS request for investigation into secret shopper violation	2
Presenter conducted marketing presentation at plan district manager's office with no other attendees present	1
Presenter provided limited information to get enrollee to sign scope of appointment form	1
Marketing materials lacked appropriate CMS-required disclaimers	1
Presenter gave prizes without providing disclaimer that attendees were not obligated to enroll in plan	2
Presenter compared plan to other health plans using information not created by CMS	2

Source: GAO analysis of CMS data.

Note: The number of violations exceeds the number of notices of noncompliance and warning letters CMS sent to plans because the agency sent notices and warning letters to some MA organizations that contained more than one violation. For example, CMS sent some MA organizations warning letters to notify them that the agency had observed violations at secret shopping events and that the MA organization was an outlier in complaint rates.

Appendix III: CMS Criteria for Taking Compliance and Enforcement Actions

CMS's MA organization account management SOPs provide general guidelines for when a compliance action may be appropriate:

- the MA organization has engaged in an activity that is egregious in nature,
- the MA organization has demonstrated sustained poor performance over a period of time,
- the issue involves a large number of MA beneficiaries, or
- the issue raises significant compliance concerns, such as the MA organization not meeting certain contractual requirements.

CMS has implemented its general guidelines for compliance actions such that the agency has taken such actions based on specific oversight activities for which it has explicit criteria. Specifically, the agency issued the majority of notices of noncompliance and warning letters based on MA organizations' noncompliance with required agent commission limits or the results of surveillance activities (such as analysis of inappropriate marketing complaints and secret shopper activities). CMS required the majority of CAPs based on the results of audits of MA organizations. Required agent commission limits, surveillance activities, and audits all have explicit criteria for assessing compliance with agency requirements. For example, of the 76 warning letters CMS sent to MA organizations for inappropriate marketing practices, 44 were based on noncompliance with required agent commission limits and 30 were based on the results of surveillance activities. CMS regulations published in September 2008 require MA organizations to establish reasonable agent commission limits; CMS sent warning letters to those MA organizations that had commission limits that the agency determined were unreasonable. As part of the surveillance activities, during the 2008 annual election period, CMS analyzed the rates of inappropriate marketing complaints and sent warning letters to those MA organizations that met the criteria of having more than 15 complaints per 1,000 beneficiaries. During the same period, CMS sent warning letters to those MA organizations that met the criteria of committing one or more violations at secret shopper events, based on specific marketing guidelines that the agency developed. Similarly, 36 of 37 CAPs for deficiencies associated with inappropriate marketing were required by CMS based on audit findings. For its audit activities, CMS's audit SOPs contain specific criteria for assessing compliance with requirements in defined areas that trigger the agency to require MA organizations to develop and implement CAPs for identified deficiencies.

CMS's MA organization account management SOPs and its audit SOPs provide guidelines for when an enforcement action may be appropriate:

- all compliance actions have been exhausted,
- the MA organization has a repeat deficiency,[1]
- an area of noncompliance could result in harm to one or more Medicare beneficiaries, or
- an area of noncompliance is deemed as a "substantial failure" of Medicare requirements.

Unlike compliance actions, criteria for enforcement actions are derived from federal statute and regulations. Enforcement actions are expressly provided for in federal statute as a remedy for certain violations. CMS officials told us that the agency initiates enforcement decisions when particular instances of non-compliance or failures to correct deficiencies warrant a higher level of intervention. According to CMS officials, they review various sources of evidence in determining whether to initiate an enforcement action, including: beneficiary complaints; results of surveillance activities, such as secret shopper observations; problems self-reported by the MA organization; data from audits; reporting requirements; and information from DOIs and SHIPs. In addition, when making enforcement decisions, CMS officials said that they consider the nature, scope, and severity of the particular non-compliance, how many beneficiaries have been or potentially could be adversely affected by the noncompliance, whether the MA organization has failed to address a serious compliance deficiency for which it has received prior notice and opportunity to correct, whether the compliance deficiency has been previously corrected but recurred, and CMS precedent in taking enforcement actions in similar circumstances. However, CMS officials said they prefer to resolve cases through lower levels of intervention given the resources required to investigate cases and the potential disruption to beneficiaries.

[1]According to CMS's audit procedures, when the same deficiency is identified in two consecutive audits, it is considered a repeat deficiency. CMS's guidance on repeat deficiencies was in place as of January 1, 2006, the beginning of our study period.

Appendix IV: Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 3 2009

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Cosgrove:

Enclosed are the Departments comments on the U.S. Government Accountability Office's (GAO) draft report entitled: "MEDICARE ADVANTAGE: CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue" (GAO-10-36).

The Department appreciates the opportunity to comment on this report before its publication.

Sincerely,

Andrea Palm
Acting Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC 03 2009

TO: Andrea Palm
Acting Assistant Secretary for Legislation

FROM: Charlene M. Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: "MEDICARE ADVANTAGE: CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue" (GAO-10-36)

Thank you for the opportunity to review and comment on GAO's draft report titled, "MEDICARE ADVANTAGE: CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue (GAO-10-36)." As the GAO has found, the Centers for Medicare & Medicaid Services (CMS) has continued to address complaints raised by beneficiaries and others about violations of the Agency's marketing requirements, and has taken action against Medicare Advantage (MA) organizations that violate those guidelines.

In addition to the efforts GAO has identified, CMS has taken steps within the past year to protect beneficiaries from deceptive marketing practices conducted by sales agents and brokers who sell MA and MA Prescription Drug plans, or, when necessary, the plans themselves. CMS has strengthened oversight of plan marketing activities by establishing stronger rules for governing the commissions that can be paid to independent sales agents, and disseminating new marketing guidelines around how MA plans identify themselves to beneficiaries. In addition, CMS is expanding its current surveillance efforts by conducting a greater variety of secret shopping activities, including one-on-one marketing sessions.

Furthermore, CMS takes immediate action when marketing violations are identified. These actions range from issuing notices of noncompliance, to the imposition of more severe sanctions such as suspension of marketing and enrollment. All of these actions require MA organizations to immediately implement corrective measures.

GAO Recommendation

To improve CMS' oversight of MA organizations and its ability to appropriately target interventions, we recommend that the Administrator of CMS gather more information on the extent of inappropriate marketing and the types of problems beneficiaries experienced as a result

of inappropriate marketing. As part of this effort, CMS should directly track retroactive and prospective special election periods (SEPs) provided for inappropriate marketing.

CMS Response

The CMS concurs with this recommendation, and is looking into the cost/benefits of possible alternative systems changes required to effectuate such a change. It is important to note that although our systems do not directly track retroactive and prospective SEPs provided for inappropriate marketing, we use data in our Complaint Tracking Module that serves as a reasonable proxy of the total SEP requests received.

Moreover, we have effectuated a comprehensive marketing surveillance initiative designed to detect and respond to incidents of inappropriate marketing. This includes secret shopping of public sales events and individual sales appointments conducted by MA and prescription drug plan (PDP) sponsors, review of marketing advertisements for inappropriate content, as well as other various surveillance activities.

We appreciate GAO's effort in researching this report and will continue to gather more information regarding inappropriate marketing activities being conducted by plan sponsors and their agents. Again, thank you for the opportunity to comment on this report.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Staff Acknowledgments

Other contributors to this report include Christine Brudevold, Assistant Director; Shana Deitch; Gregory Giusto; Kevin Milne; Elizabeth T. Morrison; Michael Rose; and Hemi Tewarson.

Related GAO Products

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