



GAO

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United States Government Accountability Office
Washington, DC 20548

September 20, 2010

The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Michael C. Burgess
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

The Honorable Greg Walden
House of Representatives

Subject: *Medicare Advantage: CMS Actions Regarding Plans' Health Reform Communications*

In August and September 2009, Humana—a large private health insurer—sent a letter to the approximately 930,000 beneficiaries enrolled in its Medicare Advantage (MA) plans, advising that leading health reform proposals could adversely affect MA beneficiaries.¹ Signed by Humana's Chief Medical Officer, the letter stated that if proposed funding cuts became law, “millions of seniors and disabled individuals could lose many of the important benefits and services that make MA health plans so valuable,”² and encouraged beneficiaries to contact their members of Congress and ask them to protect MA funding.³ Once the Centers for Medicare & Medicaid Services (CMS) learned about the mailing,⁴ the agency directed Humana on September 18, 2009, and all other MA organizations on September 21, 2009,⁵ to

¹The MA program is an alternative to the original Medicare fee-for-service program. The MA program provides health care coverage to Medicare beneficiaries through private insurance plans, referred to as MA plans. MA plans must provide all Medicare-covered services (except hospice care) and may offer additional benefits and lower costs. As of December 2009, nearly 11 million—one in four—Medicare beneficiaries were enrolled in approximately 4,700 plans offered by 188 MA organizations.

²Specifically, the benefits and services cited in the Humana mailing were low premiums, low deductibles and copayments, wellness and enhanced preventive benefits, and coordinated care and disease assistance programs.

³The letter also invited beneficiaries and others to join a special Humana program—Partner—to receive information about proposed changes to Medicare and advocate for Medicare benefits and related issues.

⁴CMS is the agency within the Department of Health and Human Services (HHS) that administers the Medicare program.

⁵MA organizations may sponsor several MA plans with different benefits, cost-sharing requirements, and premiums.

immediately stop all communications to beneficiaries about the potential impact of health reform legislation while CMS investigated whether such communications violated federal laws, regulations, or MA program guidance. CMS issued clarifying guidance to all MA organizations on October 16, 2009, and took compliance action against some organizations, closing its investigation.

CMS is responsible for overseeing communications between MA organizations and beneficiaries enrolled in their plans. Because MA organizations are Medicare contractors, communications to beneficiaries must comply with various requirements, including marketing guidelines and restrictions on the use of beneficiary information obtained from CMS databases. CMS requires that MA organizations submit marketing materials—defined as materials targeted to beneficiaries that, among other things, provide information on plan benefits—to the agency for review and may impose penalties for distributing marketing material inappropriately.⁶

This report responds to your request that we review CMS’s actions in response to MA plan communications to beneficiaries about pending health reform legislation. We examined:

1. how CMS learned that Humana sent a mailing to beneficiaries on the impact of pending health reform legislation in 2009;
2. the concerns CMS officials cited regarding the Humana material and the reasons they gave for suspending all MA plan communications about pending health reform legislation;
3. how CMS learned whether any other MA organizations had communicated with enrolled beneficiaries about pending health reform legislation;
4. what criteria CMS used to evaluate whether MA communications on pending health reform legislation violated any laws, regulations, or agency guidance;
5. what CMS found in its investigation into MA communications on pending health reform legislation;
6. what specific actions CMS took after it investigated MA communications; and
7. the extent to which CMS’s actions were in accordance with agency policies and procedures, and consistent across MA organizations.

To address these issues, we interviewed officials from CMS’s central office and its Atlanta, Boston, Kansas City, New York, and San Francisco regional offices, as well as officials from the Department of Health and Human Services’ (HHS) Office for Civil Rights. We also interviewed representatives from six MA organizations, including Humana, which CMS found to be noncompliant with regard to materials provided to beneficiaries on pending health reform legislation in 2009. We reviewed relevant laws and regulations, CMS standard operating procedures, and other agency documentation related to its investigation into MA plans’ communications to beneficiaries about pending health reform legislation. We conducted our work from April 2010 through August 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our

⁶See CMS, *Medicare Managed Care Manual*, Chapter 3 (Revised Aug. 7, 2009).

findings based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings.

1. How did CMS learn that Humana sent a mailing to beneficiaries about the impact of pending health reform legislation in 2009?

According to CMS, during the third week of September 2009, officials from its Office of Legislation were on a phone call with a number of Senate staff discussing unrelated Medicare Advantage issues. At the end of that call, staff indicated they had reports from beneficiaries who had received mailings from their MA plan urging them to contact their members of Congress. Staff asked whether it was permissible for an MA organization to lobby the beneficiaries enrolled in their plans or ask beneficiaries to lobby Congress on the plan's behalf. The Office of Legislation referred the question to CMS's Center for Drug and Health Plan Choice, which is now the Center for Medicare. Subsequently, the Office of Legislation received and forwarded a number of additional inquiries from other congressional offices. Agency officials could not say with certainty which particular congressional office made the first inquiry.⁷

2. What concerns did CMS officials cite regarding the Humana material and what reasons did they give for suspending all MA plan communications about pending health reform legislation?

On September 18, 2009, CMS instructed Humana to discontinue mailings containing its views on pending health reform legislation and to remove any related materials from its Web site while the agency investigated whether any federal laws, regulations, or MA program guidance had been violated. CMS's letter to Humana stated that

- the information contained in the mailing could mislead and confuse beneficiaries;
- the mailing represented information to beneficiaries as official communications about the MA program; and
- the mailing potentially contravened federal laws, regulations, and guidance, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).⁸

Of particular concern to CMS was the statement on the mailing's envelope—"Important information about your Medicare Advantage plan – open today!" Agency officials noted in correspondence to members of Congress that such labeling on the envelope implied that the information provided in the Humana mailing was about the benefits offered under a particular plan.⁹

⁷On September 21, 2009, the Senate Committee on Finance issued a press release stating that the Committee Chairman had requested that CMS investigate the Humana mailing.

⁸The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of HHS to issue regulations governing individually identifiable health information if Congress did not enact privacy legislation within 3 years of HIPAA's enactment. A final regulation implementing standards for the use and disclosure of certain health information, the "Privacy Rule," was published December 28, 2000. Modifications to the Privacy Rule were published in final form August 14, 2002. *See* Pub. L. No. 104-191, §§ 261-264, and 45 CFR Parts 160 and 164, Subparts A and E.

⁹According to CMS, between September 24, 2009, and October 13, 2009, HHS and the agency received several inquiries signed by members of Congress.

CMS cited similar concerns in its September 21, 2009, memorandum directing all MA organizations to immediately discontinue all communications on pending health reform legislation.¹⁰ The subject line for the September 21 memorandum read, “Misleading and Confusing Plan Communication to Enrollees.” In it, CMS expressed concern that recent mailings by MA organizations claimed to convey legitimate program information about an individual’s specific benefits, but instead offered opinion and conjecture about the effect of health reform legislation. Although they were aware only of the Humana mailing when they issued the September 21, 2009, memorandum, CMS officials told us they took this preemptive action to protect beneficiaries and avoid confusion while the agency investigated whether violations of federal laws, regulations, or MA program guidance had occurred.

Furthermore, as CMS stated in its correspondence to members of Congress, the timing of the Humana mailing also raised concerns. Officials stated that beneficiaries could misconstrue it for their plan’s annual notice of change—a letter describing any changes in coverage and costs for the upcoming year that MA organizations must send to beneficiaries by October 31 each year—rather than Humana’s views on the implications of pending legislation.¹¹ However, neither the September 18, 2009, letter to Humana nor the September 21, 2009, memorandum to all MA organizations expressed concern that the timing of these materials could cause them to be misconstrued with beneficiaries’ annual notices of change.

3. How did CMS learn whether any other MA organizations had communicated with enrolled beneficiaries about pending health reform legislation?

To identify whether any other MA organizations communicated with beneficiaries on pending health reform legislation, CMS relied primarily on its regional offices. On September 21, 2009, CMS’s central office provided the regional offices with information about the Humana mailing and told them to “be on the lookout” for similar communications from other MA organizations.¹² Then, on September 24, 2009, CMS’s central office directed the regional offices to examine plan marketing materials that had been submitted for CMS review in order to identify any health reform communication.¹³ Also, some regional office staff contacted MA organizations to inquire whether they had disseminated materials on pending health reform legislation. Relevant materials were collected and preliminarily reviewed by regional office staff and then forwarded to CMS’s central office for a final evaluation. Subsequently, CMS regional office staff learned of additional MA organizations’ communications on pending health reform legislation during the normal course of business. For example, according to an MA organization we spoke with, CMS staff conducting a routine on-site audit noticed a newsletter in the company’s reception area that contained information on health reform, which they forwarded to the central office.

¹⁰The Senate Finance Committee began public debate of its health reform bill on September 22, 2009.

¹¹See Social Security Act § 1851(d)(2).

¹²CMS requires MA organizations to submit all plan marketing materials to CMS prior to use. MA organizations can submit materials for CMS review under (1) the 45-day standard review process for material that does not contain, or contains modified, CMS model language; (2) the 10-day model review process for materials that use CMS model language without modification; or (3) the “file and use” process for marketing materials that have unmodified CMS model language and are submitted to CMS at least 5 days before distribution. MA organizations must certify that all plan materials submitted under file and use are in compliance with MA marketing requirements.

¹³CMS conducts quarterly retrospective reviews of a sample of marketing materials submitted under the file and use process to ensure compliance with CMS marketing guidelines. This examination of marketing materials was not a part of a formal retrospective review that CMS conducts quarterly.

To supplement the regional office review, CMS engaged existing program management contractors to examine publicly available information to identify MA organizations' communications on health reform. The contractors looked at Web sites and placed telephone calls to customer call centers. They found several instances of organizations warning that health reform proposals threatened beneficiaries' coverage under the MA program. In their October 9, 2009, final report to CMS, the contractors indicated which MA organizations had used these outlets to encourage beneficiaries to contact members of Congress and object to program cuts.

In addition, in October 2009, the Connecticut Attorney General, in conjunction with Connecticut's Office of the Healthcare Advocate, asked the state's five largest health insurers to submit any materials they disseminated on the impact of proposed reforms to the MA program.¹⁴ Three of the five organizations provided Connecticut officials with copies of information on pending health reform legislation either sent to beneficiaries or posted to their Web site. On October 29, 2009, Connecticut officials forwarded the replies to CMS and the congressional delegation from Connecticut.

4. What criteria did CMS use to evaluate whether MA communications on pending health reform legislation violated any laws, regulations, or agency guidance?

In responses to congressional correspondence following CMS's September 21, 2009, memorandum, the agency reported that it is required by law and conforming regulations to ensure that (1) MA beneficiary communications are accurate and not confusing or misleading, (2) MA organizations do not use beneficiary information for purposes other than those agreed to under CMS's data use agreement that all MA organizations sign, and (3) federal funds are not used for impermissible activities, such as lobbying. Therefore, CMS explained, in its examination of MA organizations' documents, the agency sought to determine whether the MA organization had violated any of the following:

- CMS's Medicare Marketing Guidelines prohibit MA organizations from disseminating misleading or confusing information.¹⁵ CMS explained that this covers instances where MA organizations inappropriately commingle plan and nonplan information in a single document, such as a member newsletter. In addition, the Medicare Marketing Guidelines require MA organizations to submit plan marketing materials—defined as “any informational materials targeted to Medicare beneficiaries that, among other things, provide information on plan benefits,”¹⁶—to CMS for review prior to their distribution.¹⁷
- CMS's Data Use Agreement and related policies, which according to the agency, bar MA organizations from using Medicare beneficiary information obtained from CMS's databases for purposes other than the administration of plan benefits. MA organizations' use of beneficiary information for health-related communications, such as information on separate dental and vision policies,¹⁸ is consistent with the Data Use Agreement. However,

¹⁴The five companies were Aetna, ConnectiCare, Anthem Health Plans of Connecticut, HealthNet of Connecticut, and UnitedHealth Group.

¹⁵CMS, *Medicare Managed Care Manual*, Chapter 3, Section 40.5 (Revised Aug. 7, 2009).

¹⁶42 CFR 422.2260; 423.2260.

¹⁷CMS, *Medicare Managed Care Manual*, Chapter 3, Section 90 (Revised Aug. 7, 2009).

¹⁸CMS, *Medicare Managed Care Manual*, Chapter 3, Section 40.14.1 (Revised Aug. 7, 2009).

MA organizations must obtain permission before using CMS's beneficiary information to send nonhealth-related information, such as information on life insurance policies and annuities.¹⁹

- Federal law prohibits the use of federal funds for certain activities designed to influence legislation or appropriations.²⁰ Among the activities that cannot be paid for with federal funds are “grassroots” lobbying efforts aimed at defeating or supporting pending legislation that expressly urge the public to contact Congress. Contractors and grantees funded by annual HHS appropriations acts cannot use federal funds to pay for certain activities designed to influence legislation or appropriations pending before Congress.

CMS's September 18, 2009, letter to Humana and September 21, 2009, memorandum to all MA organizations stated that some MA organizations' communications on pending health reform legislation had potentially violated HIPAA. However, the HHS Office for Civil Rights—the office responsible for enforcing the HIPAA Privacy Rule, which governs the use of individuals' protected information by health insurers and others—did not investigate whether MA organizations had violated HIPAA. According to an official in the Office for Civil Rights, because CMS was investigating whether MA organizations' communications violated the agency's Data Use Agreement, which the official stated is more restrictive than HIPAA on the use of beneficiary information, it was not necessary for the Office for Civil Rights to explore a potential HIPAA violation.

5. What did CMS find in its investigation into MA communications on pending health reform legislation?

CMS's investigation into MA communications found violations by 6 of the 189 MA organizations under contract with CMS in September 2009.²¹ These organizations used various means to communicate with about 3 million beneficiaries on pending health reform legislation. The agency concluded that four violated CMS's Medicare Marketing Guidelines, all six violated CMS's Data Use Agreement, and three violated the prohibition on using federal funds to lobby members of Congress on pending legislation.²² (See table 1.)

¹⁹CMS, *Medicare Managed Care Manual*, Chapter 3, Section 40.14.5 (Revised Aug. 7, 2009).

²⁰See, e.g., 18 U.S.C. § 1913; Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Act, 2009, Pub. L. 111-8, 123, div. F, title V, § 503.

²¹CMS identified an additional four organizations that had potentially violated federal laws, regulations, or MA program guidance on communications on pending health reform legislation. Agency officials told us that, prior to its investigation into MA communications, two organizations had asked regional office staff to review their materials and were advised not to disseminate the materials. During CMS's investigation, regional office staff determined that one MA organization developed newsletters that contained an article on health reform, and submitted them under the file and use process, but the organization told CMS it did not distribute them to beneficiaries; and another MA organization posted information on pending health reform legislation on a company Web site but not on its Medicare-specific Web site, and thus the communication was not deemed to be in violation of any federal laws, regulations, or MA program guidance.

²²CMS identified one of the six MA organizations from materials received from the Connecticut Attorney General's Office. CMS did not identify this organization during its own review because the organization did not submit its marketing material for CMS review.

Table 1: Results of CMS’s Investigation of MA Organizations’ Communications with Beneficiaries on Pending Health Reform Legislation, 2009

MA organization	Type of communication	Month of communication	Type of violation		
			CMS’s Medicare Marketing Guidelines	CMS’s Data Use Agreement	Legal prohibition on using federal funds for lobbying
A	Stand-alone mailing and article in newsletters	January, June, and September	X	X	
B	Flyer in plan “Welcome Kit”	February through September		X	
C	Article in newsletters	March and June		X	X
D	Article in newsletter	September	X	X	X
E	Article in newsletters	July and August	X	X	X
F	Stand-alone mailing	August and September	X	X	

Source: CMS and MA organizations.

Note: According to CMS, notices of noncompliance are considered confidential and are maintained in CMS’s internal compliance tracking system, but not posted publicly.

All of the organizations cited by CMS had urged beneficiaries to contact members of Congress about pending health reform legislation directly or by referring them to the Coalition for Medicare Choices,²³ an organization created by the industry trade association America’s Health Insurance Plans. Four of the six MA organizations’ materials directly stated that if health reform legislation was enacted, MA beneficiaries could experience reductions in their benefits. The other two MA organizations’ materials did not directly mention the potential impact of pending health reform on plan benefits, but referred beneficiaries to the Coalition for Medicare Choices Web site, which stated that if Congress were to cut MA funding, “millions of seniors could see their benefits reduced, face higher out-of-pocket costs, or lose their MA coverage entirely.”

In addition, CMS found that three of the six MA organizations had not submitted their materials for agency review, as required by the Medicare marketing guidelines. These organizations told us that based on their interpretation of the guidelines, their communications did not meet the definition of marketing materials and were therefore exempt from the review requirement. For example, member newsletters are typically not subject to CMS review prior to use unless they convey information on enrollment, disenrollment, benefits or coverage, operational policies, rules, or procedures.²⁴ One of the three MA organizations that had submitted their materials for CMS review told us they did so only as a precaution even though they did not consider them marketing materials.

²³The Coalition for Medicare Choices’ Web site is available at: www.medicarechoices.org.

²⁴CMS, *Medicare Managed Care Manual*, Chapter 3, Section 90.20 (Revised Aug. 7, 2009).

6. What specific actions did CMS take after it investigated MA communications?

After determining that some MA organizations violated federal law, regulations, or MA program guidance, CMS took several actions. In a memorandum issued October 16, 2009, CMS provided clarifying guidance to amplify previous MA guidance on allowable uses of Medicare beneficiary information obtained from CMS. This guidance reiterated that the CMS Data Use Agreement—which all MA organizations must sign—bars organizations from using CMS data for purposes other than the administration of plan benefits. In addition, the guidance clarified requirements in CMS’s Medicare Marketing Guidelines pertaining to the use of beneficiary information for health care-related and nonhealth-care related lines of business. Specifically, the memorandum clarified that MA organizations are required to obtain prior authorization from beneficiaries in order to send them materials that are not health related. The October 16, 2009, guidance also stated that before distributing materials on pending state or federal legislation or about joining grassroots advocacy organizations, plans must ensure that beneficiaries have opted-in to receive such communications.

Also on October 16, 2009, CMS issued another memorandum reiterating the prohibition on using federal funds for nonplan-related activities designed to influence legislation.²⁵ The memorandum stated that MA and other organizations under contract with CMS may not include the cost of lobbying activities in their bid or cost reports. Furthermore, beginning with bids submitted for contract year 2011, if an agency audit were to determine that lobbying expenses had been paid with federal funds, the organizations would be required to return those expenditures to the federal government.

Representatives from the MA organizations that we interviewed stated that, prior to the October 16, 2009, memoranda, in 1997 CMS issued a letter responding to an inquiry about a Medicare health maintenance organization’s communications to beneficiaries on pending legislation. This letter, signed by the Director of the agency’s Center for Health Plans and Providers,²⁶ was, according to CMS, the most recent guidance issued by the agency on this issue and stated that a federal prohibition on such communication would violate the basic freedom of speech or other constitutional rights of Medicare beneficiaries. In responses to congressional correspondence, the CMS Acting Administrator noted that since 1997 many new laws and regulations have taken effect—including those related to data use, marketing, and health information privacy—that have implications for MA plans’ communications on pending legislation. She pointed out that MA plans may communicate their views on pending legislation with no interference from CMS or others in HHS, provided it is done in accordance with CMS’s current guidance.

In addition, the agency issued letters of noncompliance—their lowest level of compliance action that carries no penalty—to five MA organizations in October 2009 and a sixth MA organization in June 2010. CMS officials told us they decided to take this action in light of the somewhat vague guidance on this issue. At the time of CMS’s review, the Marketing Guidelines did not explicitly address plan-to-beneficiary political communications. Four of these MA organizations received noncompliance letters for violating both CMS’s data use

²⁵The clarifying information in the October 16, 2009, memoranda was subsequently incorporated into CMS’s Medicare Marketing Guidelines. See CMS, *Medicare Managed Care Manual*, Chapter 3, Sections 160 and 170 (Revised June 4, 2010).

²⁶In 1997, CMS was referred to as the Health Care Financing Administration. The Center for Health Plans and Providers is now referred to as the Medicare Drug and Health Plan Contract Administration Group.

agreement and marketing guidelines and two organizations received noncompliance letters for violating CMS's Data Use Agreement.

Finally, CMS stated in correspondence to members of Congress that the agency had asked several MA organizations that inappropriately used federal funds to reimburse Medicare for those funds. However, officials from the three MA organizations that used federal funds to communicate with beneficiaries on pending health reform legislation reported that they have not been asked to reimburse Medicare for federal funds used for such communications. CMS officials confirmed that, as of June 2010, they have not asked for reimbursement.

7. To what extent were CMS's actions in accordance with agency policies and procedures, and consistent across MA organizations?

In general, CMS's handling of MA communications on pending health reform legislation appeared to adhere to the agency's policies and procedures. For example, consistent with its operating procedures, CMS handled the inquiry about the Humana mailing in a manner and time frame typically used for congressional inquiries. CMS standard operating procedures state that all congressional inquiries are considered urgent and must be resolved within 10 days. Within a week of learning of the Humana mailing, CMS took action to address the matter.

Some members of Congress expressed concern that the lobbying activities of AARP—an advocacy organization for people age 50 and older—were overlooked in the CMS investigation because it favored health reform legislation. However, we found that CMS reviewed all applicable MA organizations' communications in a consistent manner. While AARP receives royalties from UnitedHealthcare in exchange for the use of the AARP brand on some of its MA plans, it is not a Medicare contractor and maintains its own membership records. UnitedHealthcare, which offered an MA product co-branded under AARP, was included in CMS's investigation of health reform communications.

Although CMS's actions generally conformed to its policies and procedures, the September 21, 2009, memorandum instructing all MA organizations to discontinue communications on pending legislation while CMS conducted its investigation was unusual. Officials from the MA organizations and CMS regional offices that we interviewed told us they were unaware of CMS ever directing all MA organizations to immediately stop an activity before CMS had determined whether that activity violated federal laws, regulations, or MA program guidance. When asked about this directive, officials from CMS's central office stated that, given the degree of potential harm to beneficiaries, the action was appropriate for the circumstances.

Agency Comments and Our Evaluation

We obtained written comments on our draft report from HHS, the agency under which CMS operates, which are reprinted in enclosure I. HHS also provided technical comments, which we incorporated as appropriate.

Regarding the Medicare Marketing Guidelines, HHS stated that not all instances of combining plan and nonplan information into a single document, such as a member newsletter, violate Medicare rules. In general, newsletters that contain information that qualifies as marketing material—such as information on benefits and coverage—are subject to Medicare review. HHS stated that although newsletters that contain marketing materials would not necessarily be disapproved, in certain instances CMS requires the separation of plan and nonplan

information in mailings that might otherwise mislead beneficiaries. We modified language in the report to reflect this clarification.

In addition, HHS expressed concern that our description of the September 21, 2009, memorandum as “unusual” makes it appear as though their suspension of all MA organizations’ communications on pending health reform legislation was inappropriate. It noted that directing an MA organization to immediately stop an activity while the agency determined whether violations had occurred was infrequent but not unprecedented. It cited a previous instance where it suspended an MA reporting requirement while it reassessed its interpretation of regulations. We believe that the example provided—wherein CMS put its data collection activities on hold until the agency resolved concerns with interpretation of its own regulations—is not comparable to CMS instructing all MA organizations to stop sending information about health reform proposals to beneficiaries while it investigated potential violations. Moreover, our characterization of CMS’s action as unusual is based on discussions with MA organizations and CMS staff. They told us that they could not recall a previous example where CMS told all plans to stop an activity after a potential violation was discovered and prior to the completion of an agency investigation.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report for 30 days. At that time, we will send copies to the CMS Administrator and interested congressional committees. The report will also be available at no charge on the GAO Web site at <http://www.gao.gov>. Should you or your staff have any questions on matters discussed in 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. Other key contributors to this report were Rosamond Katz, Assistant Director; Hillary Loeffler; Kevin Milne; Elizabeth Morrison; and Kathryn Richter.



James C. Cosgrove
Director, Health Care

Enclosure – 1

Enclosure

Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

AUG 30 2010

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

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled: "Medicare Advantage: CMS Actions Regarding Plans' Health Reform Communications" (GAO-10-953R).

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

Sincerely,

A handwritten signature in cursive script that reads "Jim Esquea".

Jim Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE ADVANTAGE: CMS ACTIONS REGARDING PLANS' HEALTH REFORM COMMUNICATIONS" (GAO-10-953R)

The Department appreciates the opportunity to comment on this draft report. The report provides a summary of the Centers for Medicare and Medicaid Services (CMS) actions in response to Medicare Advantage (MA) organization communications to beneficiaries about pending health reform legislation in the fall of 2009.

CMS took the actions described in this draft report under clear statutory and regulatory authority based on three underlying concerns regarding what CMS saw as potentially misleading or confusing plan mailings. First, under the statute and implementing regulations, CMS is required to ensure that communications from MA organizations to their MA plan enrollees about the MA plan are submitted to CMS for approval, and are accurate, and not confusing or misleading. Second, CMS must ensure that plans do not misuse beneficiary information for purposes inconsistent with the contractual and legal restrictions they have agreed to that pertain to the use of such information. Finally, CMS is required to ensure that Federal funds paid to contracting entities, including MA plans, are not used for impermissible purposes such as lobbying. Contracted organizations that sponsor Medicare Advantage and Part D plans may communicate their views on pending legislation without interference from CMS, but they must also comply with all relevant statutory, regulatory, and subregulatory requirements.

While we agree that CMS' authority to prohibit plan sponsors from disseminating misleading or confusing information extends to instances in which MA organizations inappropriately co-mingle plan and non-plan information, we wish to clarify that MA organizations are not necessarily prohibited in all cases from combining plan and non-plan information in a single document, for example, a newsletter. Newsletters are not subject to Medicare review unless they contain information that meets the definition of marketing material (e.g., information on enrollment, disenrollment, benefits or coverage). While inclusion of benefit-specific information would subject a newsletter to our marketing material review requirements, this does not necessarily mean the newsletter would be disapproved. However, there are various instances in the Medicare Marketing Guidelines where we require the separation of plan and non-plan information in mailings, including newsletters; on websites; and in advertisements with the express purpose of not misleading beneficiaries. In addition, our Guidelines require plan sponsors to pro-rate mailing costs when plan and non-plan information are co-mingled in a mailing to ensure the costs of non-Medicare materials were not included as "plan-related" costs in the plan sponsor's bid to CMS.

In addition, we are concerned that the GAO's finding that our September 21, 2009 memorandum instructing all MA organizations to discontinue communications on pending legislation while CMS conducted its investigation was "unusual" makes it appear as though our actions were inappropriate. Given the potential for beneficiary confusion, we believed it was imperative to act quickly to avoid beneficiary confusion, particularly with the annual coordinated open enrollment period approaching. While infrequent, it is not unprecedented that CMS would direct MA organizations and Part D sponsors to immediately stop an activity while we determined whether actions were in violation of regulations or program guidance. For example, in July 2009, we

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE ADVANTAGE: CMS ACTIONS REGARDING PLANS' HEALTH REFORM COMMUNICATIONS" (GAO-10-953R)

asked MA organizations and Part D sponsors to suspend their submission of updated agent and broker commission fee information for contract year 2010 enrollments (per a June 2009 instruction) while we considered whether we had appropriately interpreted our regulations with respect to compensation for initial enrollments. We subsequently (in August 2009) reissued our policy and our request for resubmission of compensation amounts consistent with our regulatory authority.

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