

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE ADVANTAGE
MARKETING MATERIALS FOR
CALENDAR YEAR 2005**



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OBJECTIVE

To determine whether Medicare Advantage marketing materials for 2005 met the Centers for Medicare & Medicaid Services' (CMS) marketing requirements.

BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), referred to as the MMA, expands the availability of managed care options through a revised managed care program, Medicare Advantage (MA). MA organizations recruit beneficiaries using a variety of marketing materials. These materials can be grouped into two broad categories: advertising materials and enrollment materials (i.e., sales brochures, enrollment forms, summaries of benefits, and evidence of coverage documents). MA organizations generate sections of their plans' summaries of benefits using CMS's Health Plan Management System (HPMS), which CMS also uses to track marketing materials.

CMS's Managed Care Manual includes standards that MA marketing materials must meet to obtain CMS's approval. These requirements, last updated in August 2004, address such aspects of marketing materials as premium costs, required definitions, benefit descriptions, prescription drug benefit descriptions, and required contact information.

We reviewed marketing materials for January through December 2005 from a random sample of 36 MA plans. We did not review marketing materials for Medicare Part D plans because Part D did not begin until January 1, 2006. While our sample was randomly drawn, it was not large enough to produce reliable estimates of the population of plans. Using standard protocols that we developed based on CMS's Managed Care Manual, we reviewed advertisements, sales brochures, enrollment forms, summaries of benefits, and evidence of coverage documents from the 36 MA plans. We also interviewed staff at four CMS regional offices responsible for reviewing a large number of marketing materials from MA plans.

FINDINGS

Some marketing materials in our sample lacked CMS-required information concerning limitations to prescription drug benefits.

- Fifty-five percent of summaries of benefits did not state that formulary contents can change.
- Eighteen percent of evidence of coverage documents did not specify that beneficiaries can use the appeals process to have drugs added to the plan’s formulary or to appeal a decision not to cover a particular drug.
- Ten percent of advertisements did not identify coverage limitations when referring to prescription drug benefits.

Some marketing materials in our sample lacked elements required by CMS to ensure that beneficiaries can access plan information.

- Fifty-two percent of advertisements did not provide operating hours for their customer service numbers.
- Sixty-seven percent of summaries of benefits and 8 percent of evidence of coverage documents did not indicate that 1-800-MEDICARE operates 24 hours a day, 7 days a week. Moreover, this information was missing from the sections of the summaries of benefits that MA plans generate from HPMS.
- Ten percent of advertisements failed to present text telephone numbers for individuals with hearing impairments in the same font size and style as other phone numbers.
- Twenty-eight percent of advertisements inviting beneficiaries to sales presentations failed to indicate that special arrangements could be made at these events for persons with special needs.
- Thirty-nine percent of evidence of coverage documents did not indicate that individuals with special needs could obtain the document in alternative formats.

Some marketing materials in our sample did not clearly convey information concerning other aspects of MA plan coverage.

- Twenty-eight percent of summaries of benefits did not define the term “benefit period” when using the term to describe their plan.

- Thirty-six percent of summaries of benefits did not state that the plan’s contract with CMS is renewed annually and that nonrenewal could result in loss of coverage.
- Nineteen percent of enrollment forms and 14 percent of evidence of coverage documents contained technical language. Eleven percent of both enrollment forms and evidence of coverage documents contained unclear language.

CONCLUSION

Our review found that some Medicare Advantage marketing materials lacked CMS-required information essential for beneficiaries to make informed plan choices. Missing information concerned prescription drug benefit limitations and details that convey how beneficiaries can access plan information. Furthermore, some marketing materials used unclear and technical language.

CMS’s continued diligence in reviewing marketing materials is essential. CMS will also need to ensure consistency between its HPMS system and its requirements for marketing materials. We will continue to monitor marketing materials for Medicare Advantage plans and for Medicare Part D plans, as well as CMS’s oversight of the review process for these materials.

AGENCY COMMENTS

CMS concurred with our findings, stating that the report will help it improve its marketing review process. CMS also highlighted enhancements it made to the review process for Medicare Advantage and Medicare Part D plan marketing materials to improve their consistency. These include a consolidated review of Medicare Advantage and Medicare Part D plan marketing materials by CMS regional office staff, a contractor review of the consistency of marketing materials, and new features in its HPMS system to assist in monitoring the review process.

▶ T A B L E O F C O N T E N T S

EXECUTIVE SUMMARY i

INTRODUCTION 1

FINDINGS 5

 Some materials lack prescription drug benefit limitations 5

 Some materials lack elements needed to access plan information . 6

 Some materials do not clearly convey coverage information. 8

CONCLUSION 12

 Agency Comments..... 12

ENDNOTES 13

APPENDIXES 15

 A: Methodology..... 15

 B: Agency Comments..... 18

ACKNOWLEDGMENTS 22

OBJECTIVE

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BACKGROUND

Medicare Managed Care

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), referred to as the MMA, revised the managed care program and expanded the availability of managed care options for Medicare beneficiaries. The MMA renamed the revised managed care program Medicare Advantage (MA). This program took effect March 22, 2005.¹

The MA encompasses multiple forms of Medicare managed care. As of January 2005, approximately 5.4 million Medicare beneficiaries were enrolled in managed care plans. Roughly 4.7 million, or 85 percent, of these beneficiaries received services through 143 health maintenance organizations, hereafter referred to as MA organizations.² Each MA organization may offer multiple plans.

We evaluated materials that MA organizations distributed to market their plans for calendar year 2005. These plans operated prior to implementation of the Medicare prescription drug benefit, hereafter referred to as Part D. We did not review marketing materials for the Part D plans, as Part D did not begin until January 1, 2006. Thus, any references to MA plan drug benefits exclude Part D drug benefits.

Medicare Advantage Marketing

MA organizations market their plans to differentiate them from both the original Medicare fee-for-service program and other MA plans. MA organizations employ a variety of marketing materials to inform and recruit beneficiaries. These materials can be grouped into two broad categories:

- Advertising materials, including newspapers, direct mail, television advertisements, and radio scripts.
- Enrollment materials, including the following:

- Sales brochures, which are product descriptions used in the sales/enrollment process that provide more details than advertisements;
- Enrollment forms/applications, which beneficiaries complete prior to enrolling in an MA plan;
- Evidence of coverage documents (also known as the member contract or subscriber agreement), which detail the benefits and restrictions of the MA plan; and
- Summary of benefits documents, which provide a synopsis of the MA plan's coverage.

To ensure consistency across summaries of benefits, CMS directs MA plans to generate sections of these documents directly from information the plans enter into the Health Plan Management System (HPMS).³ CMS maintains the HPMS to track marketing materials that plans submit to CMS for review. Plans also use the HPMS to submit marketing materials electronically to CMS for review.

Medicare Managed Care Marketing Oversight

Pursuant to section 1876 (c)(3)(C) of the Social Security Act and Federal regulations, CMS, on behalf of the Secretary of the Department of Health and Human Services, reviews the marketing materials that MA organizations use.⁴ Federal regulations set forth required elements of marketing materials. Pursuant to the regulations, MA organizations must provide beneficiaries with adequate written descriptions of rules, plan benefits, appeals and grievance processes, and the information necessary to make informed decisions about enrollment.⁵ Federal regulations also prohibit some marketing practices. For example, MA organizations must not discriminate against recruiting beneficiaries from low-income areas, mislead or confuse beneficiaries, misrepresent the health plan or CMS, or provide monetary rebates for enrollment.⁶

CMS's Medicare Managed Care Manual (hereafter, the manual) provides operational guidelines for meeting Federal marketing requirements and provides instructions regarding the review process. In addition, the manual instructs plans to make their marketing materials reader-friendly.⁷ In the manual, CMS also provides MA organizations with models of various marketing materials they can adapt for their own use. CMS drew heavily upon the manual when it created guidelines for marketing materials for the Medicare Part D benefit that began in January 2006.⁸

The manual specifies language that marketing materials must use, language plans can use, and language they cannot use. This guidance addresses such aspects of marketing materials as:

- descriptions of premium costs,
- required plan contact information,
- descriptions of prescription drug benefits, and
- definitions of coverage terms (e.g., benefit period).

For example, marketing materials that refer to prescription drug benefits must reference any limitations to these benefits to avoid misleading beneficiaries about the true level of coverage.⁹

Prior Work by the Office of Inspector General

Two Office of Inspector General (OIG) reviews of managed care marketing materials (OEI-03-98-00270 and OEI-03-98-00271) conducted in 2000 found that only 13 percent of a purposive sample of CMS-reviewed materials met all of CMS's marketing requirements.¹⁰ Furthermore, OIG found that 46 percent of the materials were confusing or contained jargon. OIG recommended that CMS standardize and mandate use of member materials, update its marketing guidelines, develop standard review instruments, and track marketing material reviews across regions.

The reports' recommendations spurred changes in CMS's handling of Medicare managed care marketing materials. Specifically, CMS established standard and model forms for member materials, formalized marketing guidelines into the manual, and developed the HPMS to track marketing materials.

METHODOLOGY

We reviewed a total of 415 marketing materials from a multistage random sample of 36 MA plans. While our sample was randomly drawn, it was not large enough to produce reliable estimates of the population of plans. The MA plans we examined met two criteria. First, these MA organizations were in operation prior to January 1, 2004. Second, these MA organizations enrolled new members in December 2004. These criteria ensured that we selected plans that had at least 1 year of experience and that participated in Medicare through January 2005.

I N T R O D U C T I O N

These criteria yielded a population of 130 MA organizations from CMS's HPMS. Some MA organizations offer more than one plan; however, we selected only one plan from each organization.¹¹ We sampled plans based on the number of plans offered by the MA organizations and the number of members in these plans. Appendix A contains a detailed description of our methodology.

After selecting our sample, we contacted the 36 MA plans and requested copies of any of the following materials the selected plan issued through March 1, 2005: advertising materials, sales brochures, enrollment forms/applications, summaries of benefits, and evidence of coverage documents. We received materials from all 36 plans for a total of 415 pieces of marketing materials. For each plan, we received one enrollment form, one summary of benefits, and one evidence of coverage document. We also received a total of 281 advertisements and 26 sales brochures from the 36 plans.

For our review, we created and used five review guides—one for each type of material. We based these review guides on requirements specified in the manual. We used five separate review guides because CMS marketing requirements vary depending on the type of marketing material. In addition to determining whether the marketing materials met CMS's requirements, we assessed whether the material was clear (i.e., obvious and not misleading) and free of technical language.

Additionally, we interviewed staff from four CMS regional offices that are responsible for overseeing large numbers of MA plans: Atlanta, Chicago, San Francisco, and Seattle. Our interviews focused on these offices' reviews of marketing materials and barriers to the review process.

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

► FINDINGS

Some marketing materials in our sample lacked CMS-required information concerning limitations to prescription drug benefits

Prior to January 1, 2006, MA plans offering prescription drug coverage provided a benefit

unavailable through traditional fee-for-service Medicare. To ensure that beneficiaries understand the true benefits and limitations of a plan's prescription drug benefit, CMS requires that plans include several types of information in their marketing materials when they refer to prescription drug coverage.¹²

Some marketing materials for MA plans offering drug coverage omitted required information concerning prescription drug benefit formularies (see Table 1). Specifically, in our sample, 55 percent of summaries of benefits for these plans did not state that the formulary contents are subject to change without advance notice. Because the formulary represents the list of drugs a plan covers, beneficiaries should understand these restrictions on their drug coverage. For this reason, CMS requires plans to inform beneficiaries that the plan uses a formulary, that formulary contents can change at any time, and that beneficiaries can appeal if they have complaints about the formulary.

Table 1. Missing Information Concerning Prescription Drug Formularies

| CMS Requirement | Materials Not Meeting This Requirement* |
|--|---|
| Summaries of benefits must state that formulary contents are subject to change without advance notice. | 55% (12 out of 22) |
| Evidence of coverage documents must specify that beneficiaries can use the appeals process to get drugs added to the formulary or to appeal a decision not to cover a particular drug. | 18% (4 out of 22) |

*Denominators equal the number of materials for plans that use a formulary for prescription drug benefits.

Source: Office of Inspector General analysis of MA plan marketing materials, 2005.

Additionally, to ensure that beneficiaries understand the full costs and restrictions of a prescription drug benefit, CMS requires that advertising materials identify any drug coverage limitations and the amount of any copayments, as well as inform beneficiaries if the benefit is restricted to a formulary.¹³ However, 10 percent of advertisements in our sample omitted required information concerning coverage limitations on prescription drug benefits (see Table 2).

| Table 2. Missing References to Coverage Limitations | |
|---|--|
| CMS Requirement | Materials Not Meeting This Requirement* |
| Advertisements must identify any coverage limitations when referring to prescription drug benefits. | 10% (18 out of 179) |
| Sales brochures for plans with prescription drug benefits must identify the amount of any copayments for prescription drugs. | 82% (9 out of 11) |
| Sales brochures for plans with prescription drug benefits must inform beneficiaries if the prescription drug benefit is limited to a formulary. | 70% (7 out of 10) |
| * Denominators equal the total number of marketing materials that require the respective information. | |

Source: Office of Inspector General analysis of MA plan marketing materials, 2005.

Finally, many sales brochures we reviewed also omitted required information about prescription drug benefit limitations. It is important that sales brochures include this information so that beneficiaries understand the amount of drug coverage they receive (see Table 2). One sales brochure noted only that “copayments may apply,” without explaining how beneficiaries incur these costs or providing copayment amounts. Moreover, 7 out of 10 sales brochures did not inform beneficiaries that the plan’s prescription drug benefit was limited to a formulary.

Some marketing materials in our sample lacked elements required by CMS to ensure that beneficiaries can access plan information

Some marketing materials omitted operating hours and contact information

CMS requires that each plan’s marketing materials include complete contact information, including operating hours for phone numbers.¹⁴ Listing this contact information ensures that beneficiaries know how to obtain any additional information they need to make informed plan selections. Yet, 52 percent of advertisements did not provide operating hours for their customer service numbers (see Table 3).

Additionally, 67 percent of summaries of benefits and 8 percent of evidence of coverage documents did not include the operating hours for 1-800-MEDICARE (see Table 3). Whenever enrollment materials list 1-800-MEDICARE, the manual directs materials to state that this phone number operates 24 hours a day, 7 days a week, because this represents an additional resource for beneficiary information.¹⁵ In contrast, many MA plans operate customer service phone numbers only

FINDINGS

on weekdays during business hours. Because 1-800-MEDICARE can provide beneficiaries with additional information on MA plans, CMS directs plans to include language identifying 1-800-MEDICARE and its operating hours in the template MA plans use to develop summaries of benefits. Because plans create sections of their summaries of benefits directly from CMS’s HPMS system, it is unclear why HPMS does not automatically include 1-800-MEDICARE’s operating hours in these sections.¹⁶

| Table 3. Missing Contact Information in MA Marketing Materials | |
|---|---|
| CMS Requirement | Materials Not Meeting This Requirement |
| Advertisements that provide customer service phone numbers must list operating hours for these services. | 52% (146 out of 279*) |
| Summaries of benefits must state that 1-800-MEDICARE operates 24 hours a day, 7 days a week if they provide this phone number. | 67% (24 out of 36) |
| Evidence of coverage documents must state that 1-800-MEDICARE operates 24 hours a day, 7 days a week if they provide this phone number. | 8% (3 out of 36) |
| *Denominator equals the number of advertisements that provide customer service phone numbers. | |

Source: Office of Inspector General analysis of MA plan marketing materials, 2005.

Some marketing materials lacked information for beneficiaries with special needs

CMS requires marketing materials to include language to ensure that beneficiaries with special needs have full access to plan information (see Table 4).¹⁷ CMS also requires MA plans to present the text telephone number for individuals with hearing impairments, known as a TTY phone number, in the same font size and style as other customer service numbers.¹⁸ Ten percent of advertisements did not present TTY phone numbers in the same font size and style as other phone numbers. Eight percent of advertisements failed to include this number at all.

CMS requires advertisements that invite beneficiaries to attend sales presentations to provide contact information for accommodating persons with special needs.¹⁹ Sales presentations offer beneficiaries more detailed plan information than advertisements provide. Twenty-eight percent of these advertisements failed to include information about special accommodations (see Table 4). For example, one advertisement simply invited “qualified Medicare beneficiaries” to attend a sales presentation—language that did not indicate how beneficiaries with

FINDINGS

special needs can access these opportunities for learning about plans and interacting with sales representatives.

| Table 4. Omitted Contact Information for Beneficiaries With Special Needs | |
|--|---|
| CMS Requirement | Materials Not Meeting This Requirement |
| Advertisements must provide TTY phone numbers whenever other customer service numbers are presented. | 8% (23 out of 275*) |
| Advertisements must present TTY phone numbers in the same font size and style as other phone numbers. | 10% (25 out of 252*) |
| Advertisements that invite beneficiaries to sales presentations must indicate how to make arrangements for individuals with special needs. | 28% (34 out of 120*) |
| Evidence of coverage documents must indicate that information in the document is available in other formats. | 39% (14 out of 36) |
| * Denominators equal the total number of marketing materials that require the respective information. | |

Source: Office of Inspector General analysis of MA plan marketing materials, 2005.

Thirty-nine percent of evidence of coverage documents did not indicate that individuals could obtain the document in other formats (see Table 4). Moreover, simply including a statement about the availability of other formats does not ensure that beneficiaries will understand what options exist. For example, three of these documents noted only that the document was “available in other formats.” However, 19 evidence of coverage documents (53 percent) indicated which other formats were available—for example, large print, audio tape, and non-English language. Statements indicating exactly which formats are available are likely to be more useful to beneficiaries than statements that refer to other formats but do not identify them.

Some marketing materials in our sample did not clearly convey information concerning other aspects of MA plan coverage

When describing plan coverage, 28 percent of summaries of benefits did not define “benefit period” as CMS requires

CMS requires summaries of benefits to define the term “benefit period” in a footnote when using it to describe the plan (see Table 5).²⁰ A benefit period defines a specific period of health care and a beneficiary’s coverage during that period.²¹ To fully understand the details of a plan’s coverage, beneficiaries must understand such coverage terms.

F I N D I N G S

CMS's HPMS system generates a footnote for the summary of benefits that defines benefit period when describing original Medicare benefits. The manual specifies that plans must add this footnote when using the term to describe what the MA plan provides.

Thirty-six percent of summaries of benefits did not communicate the risk of nonrenewal as required by CMS

CMS reviews MA organizations annually and may choose not to renew an MA organization's contract for the following year. CMS requires MA organizations to include a statement in their summary of benefits informing beneficiaries of this annual review and renewal process to make beneficiaries aware that their plan may not be available in future years.²² Of the summaries of benefits we reviewed, 36 percent did not state that CMS renews MA organizations' contracts annually and that nonrenewal could result in the termination of the beneficiaries' enrollment in the plan (see Table 5). While CMS declined to renew only 3 plan contracts in January 2005, the number of plans participating in Medicare has fluctuated considerably, from a high of 346 plans in 1998 to a low of 151 plans in 2003.²³

| Table 5. Omitted Information About Plan Coverage | |
|--|---|
| CMS Requirement for Summaries of Benefits | Materials Not Meeting This Requirement |
| Include a footnote definition of the term "benefit period" when using this term to describe the health plan. | 28% (9 out of 32*) |
| State that the plan's contract is renewed annually and nonrenewal could result in loss of coverage. | 36% (13 out of 36) |
| *Denominator equals the number of summaries of benefits that use this term. | |

Source: Office of Inspector General analysis of MA Plan Marketing Materials, 2005.

Enrollment forms and evidence of coverage documents were not reader-friendly

The manual encourages MA organizations to develop reader-friendly marketing materials so that beneficiaries are able to fully understand plans' benefits and conditions.²⁴ For this study, we defined reader-friendly materials as those that use clear language and avoid technical language (see Text Box 1). Eleven percent of enrollment forms and evidence of coverage documents contained unclear language. Additionally, 19 percent of enrollment forms and 14 percent of evidence of coverage documents included technical language. We found unclear

and technical language most often in enrollment forms and evidence of coverage documents (see Table 6 on page 11).

Text Box 1. Examples of Unclear and Technical Language

Unclear language

“Services rendered without prior authorization of my Plan contracting primary care physician (PCP), except for emergency services anywhere in the world or urgently needed services outside the Plan service area (or under unusual and extraordinary circumstances, provided when I am in the service area, but my contracting medical group is temporarily unavailable or inaccessible), will not be reimbursed by Plan or Medicare.” (Evidence of coverage)

“I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and HMO, or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings.” (Enrollment Form)

Technical language

“Termination of Coverage will not terminate coverage of Medicare Part A inpatient Covered Health Services under the Plan if, on the date of termination, you are Confined as an inpatient in a Hospital, a rehabilitation Hospital, a distinct part of a Hospital used as an inpatient rehabilitation unit, or a long-term care facility or Hospital as covered under Section 6.B.2 of this EOC, and your place of Confinement is paid by CMS on a prospective payment system basis (per stay basis.)” (Evidence of coverage)

Source: Office of Inspector General analysis of MA Plan Marketing Materials, 2005.

F I N D I N G S

| Table 6. Unclear and Technical Language in Marketing Materials | | |
|---|-------------------------|---------------------------|
| Type of Material | Unclear Language | Technical Language |
| Enrollment Form | 11% (4 out of 36) | 19% (7 out of 36) |
| Evidence of Coverage | 11% (4 out of 36) | 14% (5 out of 36) |
| Summary of Benefits | 3% (1 out of 36) | 0% (0 out of 36) |
| Advertisement | 0% (0 out of 281) | 1% (3 out of 281) |
| Sales Brochure | 0% (0 out of 26) | 0% (0 out of 26) |

Source: Office of Inspector General analysis of MA Plan Marketing Materials, 2005.

► C O N C L U S I O N

Our review found that some Medicare Advantage marketing materials lacked CMS-required information essential for beneficiaries to make informed plan choices. Missing information concerned prescription drug benefit limitations and details that convey how beneficiaries can access plan information. Furthermore, some marketing materials described aspects of plan coverage using unclear and technical language.

CMS's continued diligence in reviewing marketing materials is essential. CMS will also need to ensure consistency between its HPMS system and its requirements for marketing materials. We will continue to monitor marketing materials for Medicare Advantage plans and for Medicare Part D plans, as well as CMS's oversight of the review process for these materials.

AGENCY COMMENTS

CMS concurred with our findings, stating that the report will help it improve its marketing review process. CMS also highlighted enhancements it made to the review process for Medicare Advantage and Medicare Part D plan marketing materials to improve their consistency. These include a consolidated review of Medicare Advantage and Medicare Part D plan marketing materials by CMS regional office staff, a contractor review of the consistency of marketing materials, and new features in its HPMS system to assist in monitoring the review process. For the full text of CMS's comments, see Appendix B.

▶ E N D N O T E S

¹ 70 Federal Register 4588, 4591 (January 28, 2005).

² The remaining 15 percent of Medicare beneficiaries are enrolled in a variety of Medicare programs, such as cost-based plans, demonstration projects, preferred provider organizations, private fee-for-service plans, and provider-sponsored organizations. In addition, the Program of All-Inclusive Care for the Elderly is a capitated managed care model that is not part of the MA program.

³ CMS. “Medicare Managed Care Manual,” Chapter 3, “Marketing,” p. 61.

⁴ 42 C.F.R. § 422.80.

⁵ 42 C.F.R. § 422.80(c)(1).

⁶ 42 C.F.R. § 422.80(e)(1).

⁷ CMS. “Medicare Managed Care Manual,” Chapter 3, “Marketing,” p. 3.

⁸ CMS. “Medicare Part D Plan Marketing Guidelines,” August 15, 2005.

⁹ CMS. “Medicare Managed Care Manual,” Chapter 3, “Marketing,” pp. 47-48.

¹⁰ Department of Health and Human Services, OIG, Office of Evaluation and Inspections (OEI), Final Reports, “Medicare Managed Care: Goals of National Marketing Guide,” OEI-03-98-00270; and “Medicare Managed Care: 1998 Marketing Materials,” OEI-03-98-00271, February 2000.

¹¹ The MA organization carries the actual contract with CMS; in CMS’s system this is referred to as the “H#,” which is analogous to a provider number for a hospital. Within that H#, an MA organization may offer plans for different geographic areas (typically counties), different benefit packages, or different premium arrangements.

¹² CMS. “Medicare Managed Care Manual,” Chapter 3, “Marketing,” pp. 22, 32, and 47-48.

¹³ Ibid., pp. 47-48.

¹⁴ Ibid., pp. 16-17, 20, 38, and 45.

¹⁵ Ibid., pp. 16-17, 20, and 38.

¹⁶ Ibid., p. 62.

¹⁷ Ibid., pp. 16 and 61.

¹⁸ Ibid., pp. 17, 21, 34, and 38.

¹⁹ Ibid., p. 16.

²⁰ Ibid., p. 63.

²¹ Ibid., p. 63. CMS requires plans to include the following definition for a benefit period:

A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing facility care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

²² Ibid., p. 23.

²³ Medicare Health Plan Tracker; Medicare Advantage Fact Sheet. Henry J. Kaiser Family Foundation. September 2005, available online at www.kff.org.

²⁴ CMS. “Medicare Managed Care Manual,” Chapter 3, p. 3.

METHODOLOGY

We obtained marketing materials from a random sample of 36 MA plans that CMS classifies as health maintenance organizations (HMOs) and HMO point of service (HMOPOS) plans.¹ We selected these organizations in an unbiased random sample that is representative of organizations that vary by their number of plans and of plans that vary by enrollment size. While our sample was randomly drawn, it was not large enough to produce reliable estimates of the population of plans.

Selection of MA plans. The MA plans we examined were from MA organizations that met two criteria. First, the MA organizations must have been in operation prior to January 1, 2004. We used that date to ensure that the MA organization had at least 1 year of operational experience prior to the timeframe for which we requested materials. Second, the MA organization must have enrolled new members in December 2004. This criterion ensured that the plan continued to be an active contractor in the MA program at the time we sampled.

From these criteria, we obtained a population of 132 MA organizations from CMS's Health Plan Management System. After consulting with other branches of OIG, we reduced the number under consideration to 130 MA organizations.

Each MA organization may offer more than one plan.² Our starting population of 130 MA organizations included 659 plans. Some organizations have 20 or more plans, while others have only one. We selected only one plan from each organization because organizations may use similar marketing materials for all their MA plans.

Due to sample size limitations, the variability in the number of plans offered by MA organizations, the variability in the enrollment size among plans within MA organizations, and our desire to have a sample that was representative of the population, we used the following sampling strategy. First, we eliminated from our population 146 plans

¹ The HMOPOS plans are point-of-service plans. HMOs make up about 94 percent of enrollees and plans, and the eight HMOPOS plans make up the remaining 6 percent of each.

² The MA organization carries the actual contract with CMS; in CMS's system this is referred to as the "H#," which is analogous to a provider number for a hospital. Within that H#, an MA organization may offer plans for different geographic areas (typically counties), different benefit packages, or different premium arrangements.

that enrolled fewer than 100 beneficiaries. This left a population of 513 plans in the 130 MA organizations.

We grouped the 130 MA organizations into 8 strata by first forming 4 primary groups based on the number of plans that the MA organizations offer. We then subdivided each primary group into two subgroups based on enrollment size within the organizations.

In the first stage of sampling, we randomly selected MA organizations within each stratum. In the second stage of sampling, we randomly selected one plan from each MA organization selected in the first stage of sampling, yielding individual plans with a relatively high enrollment and plans with a relatively low enrollment.

Marketing materials reviewed. We contacted the selected MA organizations and asked them to send us the following materials issued for the selected plan for the 2005 marketing period, through March 1, 2005:

- Advertising materials
 - Print advertisements published in newspapers
 - Direct mail advertisements
 - Scripts for radio and television advertisements
- Enrollment materials
 - Sales brochures/kits
 - Enrollment forms/applications
 - Summary of benefits
 - Evidence of coverage

We received materials from all 36 plans, for a total of 415 pieces. For each plan, we received one enrollment form, one summary of benefits, and one evidence of coverage document. We also received a total of 281 advertisements and 26 sales brochures from the 36 plans.

Review guides. We developed and used five review guides, one for each type of material. Multiple guides were necessary because requirements governing what must appear in the different types of materials vary.

We based these review guides on requirements specified in CMS's Medicare Managed Care Manual, Chapter 3, "Marketing."

In addition to determining whether the marketing materials met CMS's requirements, we included two additional questions on each review instrument to assess whether the material was reader-friendly:

- Is this piece clear or confusing?
- Does this piece contain technical language or jargon?

For our purposes we defined a clear piece as one in which the meaning of all the text is obvious and not misleading. We define jargon as:

- Technical language (i.e., words, terms, phrases, and acronyms specific to a certain field) and
- Sentences with strings of big words, overblown phrases, “-izing” words (e.g., finalizing, utilizing), invented words (e.g., signage), legalese, or bureaucratic language.



We recognize that determining whether marketing materials are reader-friendly is a subjective process. These criteria provided a way of looking at the materials systematically.

CMS Regional Office Interviews

To learn more about the marketing material review process, we interviewed staff from four CMS regional offices that are responsible for overseeing large numbers of MA plans: Atlanta, Chicago, San Francisco, and Seattle. Our interviews focused on the offices' reviews of marketing materials and barriers to the review process.

▶ A P P E N D I X B

Agency comments

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|  | DEPARTMENT OF HEALTH & HUMAN SERVICES | Centers for Medicare & Medicaid Services |
| | | <i>Administrator</i> Washington, DC 20201 |
| DATE: | JUL -7 2006 | |
| TO: | Daniel R. Levinson Inspector General Office of Inspector General | |
| FROM: | Mark B. McClellan, M.D., Ph.D.  Administrator Centers for Medicare & Medicaid Services | |
| SUBJECT: | Office of Inspector General Draft Report, "Medicare Advantage Marketing Materials for Calendar Year 2005" (OEI-01-05-00130) | |

The Centers for Medicare & Medicaid Services (CMS) is pleased that the findings in your report were limited in number and coincided with areas we targeted for improvement in conjunction with the overall implementation of the Medicare Prescription Drug Benefit. Our response to the Office of the Inspector General's (OIG) report indicates that our 2006 marketing material review is improved over the limited issues noted in the report.

We appreciate the opportunity to provide the following comments on this report. We concur with the findings presented in this report but we do ask that, due to the major changes that were made with the implementation of the Medicare Prescription Drug Benefit in 2006, the report be very clear that it covers calendar year 2005; that is, *prior* to marketing review improvements planned as part of the implementation of the Medicare Prescription Drug Benefit. The report was limited to 36 Medicare Advantage (MA) plans. This small sample cannot be used to determine the reliability of the review processes or directly lead to changes in procedures. Nevertheless your report will help CMS improve its marketing reviews just as your earlier reviews did in areas of clarity, standardization, and tracking. For example, our tracking system in Health Plan Management System (HPMS) is now used to monitor the status and volume of marketing materials submitted to CMS for a wide variety of productive purposes.

The review and approval of marketing materials is a highly decentralized function. The 10 Regional Offices (ROs) are responsible for the review of the vast majority of marketing materials. In order to enhance the effectiveness of the process, CMS Central Office and the ROs have developed an interdependent and collaborative relationship. There are regular conferences and training sessions to ensure compliance with current policies, consistency across regions, sharing best practices, and even resources. The volume of marketing materials with the expansion the MA program and the Part D program required us to use new and innovative methods for our reviews. The new file and use with certification relies on the market to help us monitor certain materials such as advertising. This leveraging of our resources is essential in our current environment.

Page 2 – Daniel R. Levinson

For 2006, CMS used a contractor for a large portion of the initial reviews of stand-alone prescription drug plan (PDP) marketing materials. This helped ensure a national consistency for many Part D marketing materials. Through this experience, and along with the consistency protocols used this year, CMS will be able to increase the accuracy, consistency, and clarity of the Part D marketing materials, especially as these reviews are being moved in-house for 2007.

We are working with the systems staff to enhance the HPMS marketing module for 2007. This will integrate administrative and reporting data into one module for both MA and PDP, making it possible for CMS Central Office and the ROs to track and monitor key information, including reviewers' corrections or comments in order to help improve the quality of the marketing products for the beneficiaries.

We take our role as the overseer of marketing seriously and expect that your support will help ensure that Medicare beneficiaries will continue to get fair and accurate information from plans.

We look forward to improving the quality of those marketing materials. We believe that the insights we gain from your report and future reports will help us and the MA organizations improve our service to beneficiaries.

Attachment

**Centers for Medicare & Medicaid Services' Comments to the Office of Inspector General (OIG)
Draft Report Entitled: Medicare Advantage Marketing Materials for 2005
OEI-01-05-00130**

OIG Findings

The 2005 Medicare Advantage marketing materials lacked CMS-required information concerning limitations to prescription drug benefits.

CMS Response

The CMS is addressing this issue and is striving to make continuous improvements in this area. CMS has also awarded a contract to determine the consistency between the reviews of marketing materials conducted by reviewers, as well as consistency with the CMS marketing guidelines dated August 15, 2005. The consistency reviews will serve as a formal mechanism for national quality assurance. We hope to use those results and the findings in this report to improve our procedures. Further, as part of our planning and execution of the 2006 marketing process we developed consistent procedures across both Part D and Part C. We hope this will help ensure close adherence to the marketing guidelines by the Part D and C contractors and help the CMS reviewers ensure accuracy and uniformity. We will use your findings in our 2006 quality assurance process.

OIG Findings

Marketing materials did not clearly convey information concerning other aspects of MA plan coverage for 2005.

CMS Response

We expect our procedures for 2006 have reduced the types of problems you identified. In addition, we have tried to focus our procedures and reviews on areas that have the greatest impact on beneficiaries. For example, we have linked the Summary of Benefits and the Evidence of Coverage information to ensure accuracy and timeliness of these key items of beneficiary information, and we have revised model materials to ensure that standard requirements are included. This last step will also help meet the marketing needs of plans.

OIG Findings

Marketing materials for 2005 used unclear and technical language

CMS Response

The CMS is aware of these issues and is committed to making significant improvements in marketing policy and the procedures used to review the marketing materials. As noted above, we are improving our entire marketing approach, to include combining Medicare Advantage (MA) and PDP marketing guidelines and review approaches, so that guidance for MA Organizations is simplified and streamlined, and therefore less likely to lead to unclear or deficient information for beneficiaries. The

Page 2 – Comments

Personal Plan Finder has revised some of its beneficiary information for 2007. We will be incorporating language improvements into our 2008 model language documents to help reduce unclear and technical language.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Joyce M. Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office, and Russell W. Hereford, Deputy Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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