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BENEFICIARY BEWARE: INADEQUATE REVIEW OF MEDICARE MANAGED CARE PLANS RESULTS IN INCOMPLETE INFORMATION FOR CONSUMERS

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UNITED STATES SENATE

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BENEFICIARY BEWARE: INADEQUATE REVIEW OF MEDICARE MANAGED CARE PLANS RESULTS IN INCOMPLETE INFORMATION FOR CONSUMERS

TUESDAY, APRIL 13, 1999

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice at 2:33 p.m., in room SD–628, Dirksen Senate Office Building, Hon. Charles E. Grassley (Chairman of the Committee) presiding.

Present: Senators Grassley, Collins, Breaux, Reed, Bayh, and Lincoln.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

Chairman GRASSLEY. Once again, Senator Breaux and I are pleased to welcome everybody to this hearing, particularly those who have gone out of their way to come here to testify. We owe a great deal of gratitude to not only this group of panelists but also to previous witnesses who have appeared before our committee, bringing real life testimony, which is very important to us.

This represents the third in a series of hearings that this committee has held to examine how Medicare enrollees are educated about the Medicare program. In the last Congress, this committee held two hearings, one prior to the passage of the Balanced Budget Act of 1997, which resulted in legislation that we introduced and subsequently passed to establish the National Medicare Beneficiary Education Campaign. We held another hearing after the Balanced Budget Act became law to examine how beneficiaries were navigating this new world of Medicare+Choice and how to improve the information that we provided them.

Today's hearing results from extensive work that the General Accounting Office has done for this committee on this topic. Consequently, today we are pleased to announce that this committee is releasing two General Accounting Office reports. The reports address two important components of the Medicare Managed Care Program. They are, first, the Health Care Financing Administration's review process for approving managed care plan materials, and second, a General Accounting Office report looking at and critiquing the Medicare appeals process. Both reports are interrelated in a very important way and are the subject of this hearing that we are having today.

The point of entry for the Medicare beneficiaries into the Medicare+Choice Program is through the marketing process conducted by plans. We often hear from the plans that their marketing materials are "approved by HCFA," but exactly what does approval by HCFA mean?

We asked the General Accounting Office to take a look at what the review process entails and how well it is working.

One of the key components of the marketing process is the document beneficiaries receive describing their benefits as well as their rights as enrollees into the plan. It may come as a surprise to you, and it has come as a surprise to me as well, that HCFA does not require any standard type of document that contains a full disclosure of benefit coverage. Plans send an array of materials, with no one identifying piece of information designated as the beneficiary's contract of benefits with the plan.

The plans must simply provide a summary of benefits, and this can vary greatly across plans in format and content. Some plans choose to disclose the benefits in greater detail, but some plans merely provide a brief summary with a disclaimer telling the beneficiaries that they must request full disclosure. Many beneficiaries rely on verbal assurances that they receive from marketing representatives that a benefit is covered. Summaries are useful, and assistance from plan representatives is essential, but this should not be the only way that beneficiaries are told about these benefits.

When information is inadequate or misleading, this leads to confusion, and in some instances, an appeal by the beneficiary over what is covered or not covered by the plan. To further add to their confusion, enrollees are not given a clear or consistent description of the appeals process, leaving them feeling helpless and alone. Many beneficiaries believe their only alternative is to disenroll from the plan. Of course, this is very costly and time-consuming for everyone involved, and as our witnesses will tell us, is not always their preferred choice.

It is often the case that when seniors leave traditional Medicare for a managed care plan, they believe they are no longer in Medicare. Their inability to identify their Medicare+Choice plan as being part of Medicare can often lead to confusion and misunderstanding of what they are entitled to under the program.

We will hear from two Medicare enrollees this afternoon who will describe how their difficulties in obtaining the kind of useful and reliable information and assistance they needed wreaked havoc on their lives. We will also hear from a representative of the State Health Insurance Program, which I will refer to as SHIP, who will testify about her experiences assisting Medicare beneficiaries through the maze and confusion of understanding their benefits and their rights to appeal when problems arise. The SHIPs are to many beneficiaries the ombudsmen of Medicare. These programs provide a tremendous amount of support and counseling to Medicare enrollees across the country and trained volunteers in local communities to assist with their mission.

We will also hear from a former HCFA regional director who ran the managed care division in the Atlanta region during a time of high growth in managed care, about the problems he saw with the review process and program operations. We will also hear from

HCFA about what they are doing to improve program operations. And finally, the GAO will testify about their findings and recommendations on the two reports that I have referred to.

Our goal at this hearing is to offer constructive insight and recommendations on ways to improve the HCFA review process and the means by which seniors get information about their benefits and rights under Medicare+Choice. I do not want folks leaving this hearing with the impression that we want to restrict plans from marketing to Medicare beneficiaries or from running their business the way they see fit. That is not my objective.

Rather, our focus and attention should be and is on the beneficiary, because that is what this program is all about. Medicare is a Federal program, and Congress has the responsibility of making sure beneficiaries are receiving the kind of high-quality care and assistance they deserve.

My primary interest and the interest of this committee is to learn how we can improve the operations of the program to simplify the information seniors are provided when they enter a managed care plan. Beneficiaries are bombarded with information daily from many different sources, but it is our job in Congress and at the Health Care Financing Administration to make sure we provide them with the tools they need to understand the program, to know what their benefits are regardless of their choice of how to receive those benefits, and to be able to successfully navigate the appeals process when problems arise.

So I expect this hearing will shed some light on these issues, and I look forward to hearing from all of our distinguished witnesses who are here today.

Before we go to the first panel, I am going to ask my colleagues to speak, starting with Senator Breaux.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

I am pleased to hold this hearing today, and I want to extend my gratitude to the witnesses who will testify before this committee. This hearing represents a third in a series of hearings this committee has held to examine how Medicare enrollees are educated about the Medicare program. Last Congress, Senator Breaux and I held two hearings, one prior to the passage of the Balanced Budget Act (BBA) of 1997, which resulted in legislation we introduced and subsequently passed to establish the National Medicare Beneficiary Education Campaign. We held another hearing after BBA became law to examine how beneficiaries were navigating this new world of Medicare+Choice and how to improve the information we provide them. Today's hearing results from extensive work the General Accounting Office has done for this committee on this topic. I am pleased to announce that we are releasing two GAO reports at today's hearing. The reports address two important components of the Medicare managed care program. They are: (1) the Health Care Financing Administration's (HCFA) review process for approving managed care plan materials, and (2) the Medicare appeals process.Both reports are interrelated in a very important way and are the subject of today's hearing. The point of entry for Medicare beneficiaries into the Medicare+Choice program is through the marketing process conducted by the plans. We often hear from the plans that their marketing materials are approved by HCFA, but what exactly does that mean. We asked the GAO to take a look at what the review process entails and how it is working. One of the key components of the marketing process is the document beneficiaries receive describing their benefits and rights as an enrollee in a Medicare+Choice plan. It may come as a surprise to you as it has to me, that HCFA does not require any standard type of document that contains a full disclosure of benefit coverage. Plans send an array of materials with no one identifying piece of information designated as the beneficiaries' contract of benefits with the plan. The plans must simply provide a

summary of benefits and this can vary greatly across plans in format and content. Some plans choose to disclose the benefits in greater detail, but some plans merely provide a brief summary with a disclaimer telling the beneficiaries they must request full disclosure. Many beneficiaries rely on the verbal assurances they receive from marketing representatives that a benefit is covered. Summaries are useful and assistance from plan representatives is essential, but this should not be the only way beneficiaries are told of their benefits. When information is inadequate or misleading, this leads to confusion and in some instances an appeal by the beneficiary over what is covered or not covered by the plan. To further add to their confusion, enrollees are not given a clear or consistent description of the appeals process, leaving them feeling helpless and alone. Many beneficiaries believe their only alternative is to disenroll from the plan. This is costly and time consuming for everyone involved and as our witnesses will tell us, is not always their preferred choice.It is often the case that when seniors leave traditional Medicare for a managed care plan, they believe they are no longer in Medicare. Their inability to identify their Medicare+Choice plan as being part of Medicare can often lead to confusion and a misunderstanding of what they are entitled to under the program. We will hear from two Medicare enrollees this afternoon who will describe how their difficulties in obtaining the kind of useful and reliable information and assistance they needed reeked havoc on their lives. We will also hear from a representative from a State Health Insurance Program, which I will refer to as SHIP, who will testify about her experiences assisting Medicare beneficiaries through the maze and confusion of understanding their benefits and their rights to appeal when problems arise. The SHIPs are to many beneficiaries the ombudsmen of Medicare. These programs provide a tremendous amount of support and counseling to Medicare enrollees across the country and train volunteers in local communities to assist with their mission. For the third year in a row, Senator Breaux and I are requesting additional federal funds for this program. We are also seeking recognition of this program by the appropriators through a distinct line item, which the program used to have. Their funding is now part of HCFA's budget and is inadequate to meet the increasing demands for information and assistance by seniors. Our hope is that the program can expand its capacity to help educate and provide counseling to Medicare beneficiaries across the country in both traditional Medicare and Medicare+Choice. We encourage our colleagues on this committee and in the Senate to support increased funding and recognition for these statewide programs.We will also hear from a former HCFA regional director who ran the managed care division in the Atlanta region, during a time of high growth in managed care, about the problems he saw with the review process and program operations. Also, we will hear from HCFA about what they are doing to improve program operations. Finally, the GAO will testify about their findings and recommendations.Our goal at this hearing is to offer constructive insight and recommendations on ways to improve the HCFA review process and the means by which seniors get information about their benefits and rights under Medicare+Choice. I do not want folks to leave this hearing with the impression that we want to restrict plans from marketing to Medicare beneficiaries or from running their business the way they see fit. That is not my objective. Our focus and attention should be on the beneficiary because that is what this program is about. Medicare is a federal program, and Congress has the responsibility of making sure beneficiaries are receiving the kind of high quality care and assistance they deserve. My primary interest and the interest of this committee is to learn how we can improve the operations of the program and to simplify the information seniors are provided when they enter a managed care plan. Beneficiaries are bombarded with information daily from many different sources, but it is our jobs in Congress and at HCFA to make sure we provide them with the tools they need to understand the program; to know what their benefits are regardless of their choice of how to receive those benefits; and to be able to successfully navigate the appeals process when problems arise. I hope this hearing will shed some light on these issues. I look forward to hearing from all of our distinguished witnesses here today.

STATEMENT OF SENATOR BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman, for once again having a hearing that really directly impacts on the day-to-day lives of average Americans, particularly those who have to deal with the incredibly complicated problem of deciding what is the best health care for themselves and their families. It is very, very clear that in the area of health care, bad information leads to bad decisions, which produce bad results.

Therefore, it is very clear to me that the most accurate and clearly presented information should be a priority of all health programs. That is particularly correct when we are talking about health programs that the Federal Government and the Federal tax dollar are involved in producing and offering to our citizens.

I think most Members of Congress today think that more choices and more information are key ingredients in any type of overall health care reform that we are going to have for the Nation's citizens, particularly the approximately 40 million who happen to be involved in Medicare programs.

People obviously cannot make good decisions if they have bad information. They cannot make the right decision if they have the wrong information. So, as the chairman has said, what this hearing is all about is trying to ensure that the information that is being made available is both accurate and sufficient in detail, but not so detailed that it is impossible to understand.

We have had a lot of examples of the problems, and obviously, we are trying to work on solutions. I was looking with staff at some of the problem areas, and this is just a typical example of one proposal under the Medicare+Choice. It consists of a whole bunch of different papers that have been presented outlining one health plan. People get it at different times. It is sent 1 month, and the next month, there is an addendum to it, the next month, there is another proposal added to it, and then, finally, during the course of a year, all of it gets collected by the beneficiary, and they are supposed to make an informed decision on which is the best plan for them and what their plan covers. I do not know about most people, but I would probably have lost half of it before I got it all into the same box.

As a comparison, the Federal Employees Health Benefits Plan, which our Medicare commission tried to pattern our recommendations after, has all the information received at the same time, in the same booklet, so people can look at it, and it is all presented in the same format, so it is much easier for the average person to understand what he or she is deciding on and what the various benefits are.

We are making progress—I do not want to take up too much time, Mr. Chairman—but HCFA, to its credit, has taken the advice of Senator Grassley and myself and other members of the commission, and in a previous hearing, we talked about it. I want them to compare apples to apples, not apples to oranges and bananas and lemons. You cannot get a comparison if you are not comparing the same things. They will probably talk about this, but this is just an example of what they are attempting to do, where it would be clearly presented to the beneficiary what the benefit is and how that benefit is covered under Medicare and how that benefit would

be handled under the plan that is offering its services, so the beneficiary can say, well, if I stay in Medicare, this is what I get, but if I go to the new plan, this is the difference—here is the difference in cost, here is the difference in what is covered and what is not covered—so you can compare apples to apples and not apples to oranges to lemons and never know where the hell you are.

Anyway, this is what we are trying to get to, and I think that if we can accomplish this—and HCFA is making progress—I think we can all say that we have done the right thing. This hearing is all about that, and I think it is very, very valuable, Mr. Chairman.

Thank you.

Chairman GRASSLEY. Thank you.

Before I call on Senator Bayh, the most significant thing about the chart that I left out as I was speaking—I was saying that some of these plans are very, very detailed, but some give you a little bit of information, and then down at the bottom in the very fine print, it says if you want to know what these things mean, you have got to go and ask the plan for the document. It is that sort of lack of full disclosure and, more importantly, lack of candor that bothers me. It is the sort of candor and openness that Senator Breaux and I have been fighting for in regard to since we had our first hearing 2 years ago.

Senator Bayh.

STATEMENT OF SENATOR EVAN BAYH

Senator BAYH. Thank you, Mr. Chairman.

I would like to express my appreciation to you and to Senator Breaux for this latest hearing. This is one of a series that has helped us focus on the important issues of Medicare and Social Security.

I would also like to thank our panelists for being here today. We are here to try to assist you; that is the function of this hearing, to assist you and others like you across our country in making some of the most important decisions you will ever make. So your information, your stories, the knowledge that you can provide to us can be very, very helpful in assisting us to perform our tasks.

Mr. Chairman, I will just say one thing about the marketplace. We live in a time in which many of us are looking for ways to harness the effectiveness of the marketplace, the efficiency and the cost-effectiveness of the marketplace, to accomplish socially worthwhile objectives in the most humane way possible. But an effectively functioning marketplace assumes access to adequate information. A market can be neither cost-effective nor humane if the consumers making the decisions do not have all the information at their disposal to be able to make well-informed decisions.

I know the desire is there. Just this last year, in my own home State of Indiana, we had 50,000 people attend a seminar about Medicare and information for Medicare consumers. So there is a real thirst out there for more information, accurate information, fully disclosed information, not hidden information. So as we go through this, I am going to encourage all those on the governmental side of things to make it as uniform as possible, as simple as possible.

Frankly, Mr. Chairman, as I was walking over here, I was thinking about proposing an "English only" requirement, and I do not mean vis-a-vis some other foreign language, but I mean compared to bureaucrat-ese or the kind of language that occasionally gets used in the insurance industry around this town..

So again, I want to thank you, Mr. Chairman, and Senator Breaux and the panelists for being here. We are very grateful, and we are here to try to be helpful, and you are going to assist us in that process.

Thank you.

Chairman GRASSLEY. Thank you.

Senator Lincoln.

STATEMENT OF SENATOR BLANCHE LINCOLN

Senator LINCOLN. Thank you, Mr. Chairman.

A special thanks to you, Mr. Chairman, and to Senator Breaux for your leadership on this issue and many of the issues that we have been dealing with this year and in the past on behalf of the elderly citizens in our State.

I want to applaud my colleague and neighbor Senator Bayh. I think you are exactly right—it has got to be English, it has got to be in layman's terms, and it has got to be something that we can all understand.

I understand that this is the third Aging Committee hearing focused on the Medicare Choice Program, and since the Balanced Budget Act of 1997 was passed, this committee has been concerned with the rights of seniors as greater numbers of them join managed care plans as part of Medicare.

Today's hearing is certainly not meant to be an attack on managed care, but millions of our Nation's seniors rely on managed care for health care services and receive important benefits, like prescription drug coverage, through these managed care programs which they could not get otherwise.

However, the Medicare Choice Program has been operating long enough for us to know that there are a few issues being raised by seniors who utilize these new programs, and we must address those issues. It is our job today to examine their concerns and these issues that have been brought before us.

In Arkansas, managed care is a much smaller segment of the health care delivery system than in most States, but we have nearly 7,000 seniors enrolled in three different Medicare Choice plans. I want to be sure that all of the current and future enrollees in Medicare Choice plans understand exactly what they are buying when they enroll in these plans. Giving someone half of the information in any situation is very dangerous and very alarming, but in a health care situation, it is absolutely dangerous, and it is something we must be very cautious about.

Often, seniors may be ill and experience confusion in dealing with the technical language and the terms, so it is highly important that these health plan materials be simply laid out in an easy-to-read format in layman's terms, as I mentioned earlier.

The information should be clear and easy to understand so potential enrollees understand exactly what each plan covers, what rights they have if they terminate their coverage and switch to

other plans, and what the appeals process is if they are denied treatment. Seniors count on their health insurance to be there when they need it, when illness strikes, so providing clear and concise information up front before they sign up for the programs will save much confusion for all of us involved, and the frustration down the road for both seniors and the managed care plans and the congressional offices that are getting the complaints.

So I look forward to hearing the testimony today from our witnesses, working with you to come up with some of the solutions that we must present our seniors in order to better understand these health care plans that are being made available to them.

Thank you, Mr. Chairman.

Chairman GRASSLEY. Thank you.

Senator Reed.

STATEMENT OF SENATOR JACK REED

Senator REED. Thank you, Mr. Chairman.

Let me join my colleagues in commending you and the ranking member for your leadership on this issue and also say how pleased I was to join you and Senator Breaux in asking the General Accounting Office to review the disclosure and the information available to seniors who are participating in Medicare managed care plans. Their reports, which we have in hand today, reveal deficiencies, some of them significant deficiencies. Some might be attributed to the simple complexity of trying to provide a comprehensive review of benefits, but there are certain indications that some of these deficiencies might be deliberate, and that causes me great concern.

But in any case, I think we have to use this information and the testimony of our witnesses today to try to provide more opportunities for that type of concise, complete information which is so essential to making good choices about your health care.

I would also suggest that this might be another indication that we need some complementary structures to HCFA to provide that type of assistance individually to seniors who are looking for answers. I have introduced legislation with respect to an ombudsman program, that there might be in each State an office that would provide first-hand assistance to seniors who are seeking to understand their policies, which are often difficult to understand even for lawyers.

We are, I think, making progress, but we have a long way to go, so I am pleased that we are here today and very pleased to have these witnesses.

I thank you, Mr. Chairman.

Chairman GRASSLEY. Thank you, Senator Reed.

I want to thank each of the four Members who are here today. You have been very faithful this year in coming to the hearings——

Senator BREAUX. That is four Democrats.

Chairman GRASSLEY [continuing]. And I am going to ask you if you can help me recruit some Republicans to come; I would appreciate that very much. [Laughter.]

Now we are ready to go to our first panel, and we will start with Mr. William Stringer from Ohio, who is retired from the U.S. Air Force as a colonel. He served active duty from 1951 to 1977 and

was awarded the Legion of Merit as well as the Air Force Commendation, with two Oak Leaf Clusters. His experience with HMO medical coverage during his time in the Air Force was very good because he decided to enroll in Medicare+Choice in Ohio. So he is going to discuss the plan's marketing materials as well as the timeliness of the plan's notification of changes in policy.

Then, we will hear from Ms. Lois D. Watts. For 10 years, she was with the Department of Surgery at UCLA Medical Center. She has been married for 50 years and has three grown children. Over the past two decades, she has had to deal with two different types of cancer. Ms. Watts has experienced the confusion of the Medicare+Choice marketing materials and appeals notices for two different plans in the State of California, so she is going to highlight for us the need for clear and easy-to-read plan information. Ms. Watts will also discuss her experience with the appeals process under these plans.

Our next witness will be Ms. Julie Schoen. Ms. Schoen is a well-known speaker in Southern California for the rights of Medicare beneficiaries. She is legal counsel for the Orange County, CA Health Insurance Counseling Advocacy Program, special projects director for California Health Advocates, and director of the Senior Counselors Against Medicare Swindlers Project. She will identify the Medicare+Choice program and the appeals process. Ms. Schoen will offer recommendations to address the inconsistencies in content and distribution of plan materials.

And our last witness, Mr. Chris Mulholland, will offer a unique perspective to this hearing. His last position with the Federal Government was manager of a managed care branch in the HCFA Atlanta Regional Office. For 3 years, he was in charge of overseeing HCFA's review process of managed care contracts for Medicare+Choice programs. Mr. Mulholland will give an overview of HCFA's review process of plan materials and will also explain the problems that he encountered during the review process and offer some recommendations for improving it.

We will start with Mr. Stringer and hear from the rest of the panel in the order I introduced you.

STATEMENT OF WILLIAM L. STRINGER, BEAVERCREEK, OH

Mr. STRINGER. My name is Bill Stringer, and I am currently a Medicare beneficiary living in Beavercreek, Ohio. I want to thank you both, Senator Grassley and Senator Breaux, for inviting me to testify before this committee on a topic that is very important to me.

To give you my context, my family's medical care has been provided by an HMO operation during 27 years in the Air Force and actual HMOs during 22 years of contractor employment. I am accustomed to HMO operations, and I prefer them to the available alternatives.

I joined Anthem Senior Advantage, a Medicare HMO, on April 1, 1998, when I retired from active work, and was quite happy with their support. I will refer to Anthem Senior Advantage as ASA in the rest of my testimony.

I was surprised to receive a letter from ASA dated May 23, 1998, announcing that they would no longer offer their Medicare HMO

in Greene County, where I live, after December 31, 1998. ASA's letter did not provide any explanation for their decision, but later newspaper articles identified ASA's profit—or lack thereof—as the reason.

In the absence of any warning, I had assumed that the ASA contract with HCFA did not provide for unilateral withdrawal by ASA. The 1997 Guide to Health Insurance for People with Medicare, developed jointly with the National Association of Insurance Commissioners and HCFA, provided to me by ASA, did not even suggest that this was a possibility.

HCFA also sent me directly a brochure that described how I could disenroll but did not mention that ASA could disenroll me.

Despite the adverse publicity in the local newspapers about ASA's intent to withdraw from the Medicare HMO market at the end of the year, my wife received a letter from ASA in early June 1998 inviting her to join ASA since she would reach 65 in October 1998. Nothing in the letter mentioned that this coverage would end on December 31, and she would have to disenroll and find other options, if they existed, under Medicare. In early July 1998, she received a second marketing notice from ASA, again with no warning that the coverage offered would end in December.

In a June 26 Dayton Daily News article, ASA later blamed HCFA, saying that "under law, ASA is required to offer its plan to any Medicare recipient until its coverage ends." In the same article, Bette Weisburg, a HCFA official from the Chicago Regional Office, said, "ASA's pullout was legal," but added, "the law may need to be changed." Again, HCFA remained silent about ASA's marketing tactics, implying their approval.

Despite all this, my wife enrolled in ASA in October 1998 to protect her termination rights, whatever they might turn out to be. Termination rights, as they were explained to us, relate to mandatory Medicare supplement coverage with no delay in coverage for pre-existing conditions.

I received a copy of the 1998 Guide to Health Insurance for People with Medicare, still developed jointly by the National Association of Insurance Commissioners and HCFA, from Medicare supplement providers, not from ASA. Page 25 of this guide describes "Medicare Protection when Other Health Insurance Ends or is Lost, Effective July 1, 1998," but is totally confusing to me, and I challenge the committee to tell me how it applies to my situation.

The page in question shows six conditions, and they are all checked. I think it is impossible that anybody could be in a situation where all six conditions apply.

Medicare supplement sources told me that we would have termination rights under the Balanced Budget Act of 1997 if ASA disenrolled us, but none if we did the disenrolling. In a July 1998 article in the Beavercreek newspaper, Bette Weisberg, whom I mentioned earlier, said that "the contracts are renewed every calendar year, and an HMO operator can choose not to renew for any reason." The only requirements are that they must notify their members and prevent coverage gaps.

HCFA did not choose to make this information available in their many publications and did not specify when the notices must be

provided to current or prospective enrollees, or how coverage gaps would be prevented.

In a September 10, 1998 letter to me, Representative Hobson said that he had contacted HCFA to get their interpretation of Section 4031 of the 1997 Balanced Budget Agreement. "HCFA stated that the various Medigap programs are not required to adhere to Section 4031 until State laws are passed. Moreover, the States have until 1999 to effectuate a change." This information appears to me as substantially different than that published in the 1998 HCFA Guide. This information dashed our earlier hopes that we had some termination rights.

ASA's October 15, 1998 letter said that they had reached an agreement with HCFA to continue HMO coverage in 1999, but with benefit and premium changes. The letter said: "These benefits are subject to approval by HCFA. Upon approval, all active members will receive an annual notification that provides more detailed information regarding the approved 1999 plan benefits." ASA did not mention HCFA's requirements for timely notices to us. HCFA again remained silent.

My wife has pre-existing conditions for diabetes and heart ailments, and I have had two heart attacks and open heart surgery. We no longer trusted ASA to do more than the minimum to offset the adverse publicity and respond to the political pressure on them. I enrolled both of us in a Medicare supplement plan effective January 1, 1999. I had assumed that the notification from ASA in May that they were disenrolling all Greene County participants was still in effect. I was wrong.

Just one month before I thought the ASA plan was dead, we received letters from ASA dated November 23, 1998 defining the 1999 rates and benefits. The letter included their announcement that Senior Advantage would become a Medicare+Choice program effective January 1, and my enrollment would continue unless I disenrolled before the end of the year and attached six pages of new rules.

One new rule was that "If the plan terminates its contract with HCFA, it must inform members in writing at least 60 days prior to the date of termination." It seems to me that most Medicare beneficiaries cannot evaluate the many alternatives and intelligently respond within 60 days, let alone the 30 days that ASA gave me to decide.

The time required for any alternative provides to receive, process, and respond to any applications seems to have been ignored in the determination of the 60-day criteria. HCFA presumably waived or ignored the 60-day requirement. It now appeared that ASA was no longer disenrolling us, and we had no termination rights.

On November 26, 1998, I advised ASA and HCFA that we should be disenrolled from ASA effective December 31, 1998. Fortunately, we had already received coverage from our Medicare supplement provider with no delay for pre-existing conditions. We preferred Medicare HMO care to fee-for-service, and the ASA package appeared cheaper, but we disenrolled because we had lost confidence in ASA and, more importantly, in HCFA's oversight of the Medicare HMO program.

The bottom line is that both my costs and Medicare costs have increased, but at least I have no more unreasonable deadlines to meet or confusing rules to comprehend.

In summary, I believe that HCFA's performance left much to be desired in four areas: First, inadequate coverage of risk of HMO pullouts in Medicare publications. There was nothing in the 1997 Guide and confusing information in the 1998 Guide, and almost nothing in 1999.

Second, there was no effective means of communication with HCFA by those facing pullout-related decisions. There are no HCFA 800 numbers, fax numbers, e-mail addresses, and there are errors in the HCFA Medicare web site.

Third, there was unwillingness to make full disclosure of HCFA requirements regarding ASA continuance or replacement by another HMO. There was poor oversight of Medicare HMO marketing efforts and lack of full disclosure in ASA materials and public statements.

Fourth, there was lack of initiative in implementing congressional direction regarding termination rights and no visible effort to inform ASA victims in terms understandable to Medicare recipients.

That concludes my statement.

[The prepared statement of Mr. Stringer follows:]

Statement by William L Stringer,
April 13, 1999

My name is Bill Stringer, and I am currently a Medicare beneficiary living in Beavercreek, Ohio. I want to thank you both, Senator Grassley and Senator Breaux, for inviting me to testify before the Senate Special Committee on Aging on a topic that is very important to me.

To give you my context, my medical care has been provided by a HMO-like operation during 27 years in the Air Force and actual HMOs during 22 years of contractor employment. I am accustomed to HMO operations and prefer them to the available alternatives. I joined Anthem Senior Advantage on April 1, 1998 when I retired from active work and was quite happy with their support. I will refer to Anthem Senior Advantage as ASA in the rest of my testimony.

I was surprised to receive a letter from ASA dated May 23, 1998 announcing that they will no longer offer their Medicare HMO in Greene County (where I live) after December 31, 1998. ASA's letter did not provide any explanation for their decision but later newspaper articles identified ASA's profit (or lack thereof) as the reason.

I had assumed that the ASA contract with HCFA did not provide for unilateral withdrawal by ASA. The 1997 Guide to Health Insurance for People with Medicare (developed jointly by the National Association of Insurance Commissioners and HCFA) provided to me by ASA did not even suggest that this was a possibility. HCFA also sent me directly a brochure that described how I could disenroll but did not mention that ASA could disenroll me.

Despite the adverse publicity in the local newspapers about ASA's intent to withdraw from the Medicare HMO market at the end of the year, my wife received a letter from ASA in early June 1998 inviting her to join ASA since she would reach 65 in October 1998. Nothing in the letter mentioned that this coverage would end on December 31 and she would have to disenroll and find other options, if they existed, under Medicare. In early July 1998, she received a second marketing notice from ASA, again with no warning that the coverage offered would end in December.

In a June 26 Dayton Daily News (DDN) article, ASA later blamed HCFA, saying "under law, ASA is required to offer its plan to any Medicare recipient until its coverage ends. In the same article, Bette Weisburg, a HCFA official from the Chicago regional office, said, "ASA's pullout was legal" but added, "the law may need to be changed". Again HCFA remained silent about ASA's marketing tactics, implying their approval. Despite all this, my wife enrolled in ASA in October 1998 to protect her termination rights, whatever they might turn out to be. Termination rights relate to mandatory Medicare supplement coverage with no delay in coverage for pre-existing conditions.

I received a copy of the 1998 Guide to Health Insurance for People with Medicare (still developed jointly by the National Association of Insurance Commissioners and HCFA) from Medicare supplement providers at a seminar sponsored by Greene Memorial Hospital (GMH) in August 1998. Page 25 of this Guide describes "Medicare Protection When Other Health

Insurance Ends or Is Lost-Effective July 1, 1998" but is totally confusing to me and I challenge the committee to tell me how it applies to my situation.

Medicare supplement sources told me that we would have termination rights under the Balanced Budget Act of 1997 if ASA disenrolled us but none if we did the disenrolling. In a July 1998 article in the Beavercreek News-Current (BNC) paper, Bette Weisberg, the HCFA Chicago regional official I mentioned earlier, said that "the contracts are renewed every calendar year and an HMO operator can chose not to renew for any reason. The only requirements are that they must notify their members and prevent coverage gaps". HCFA did not choose to make this information available in their many publications and did not specify when the notices must be provided to current (or prospective enrollees) or how coverage gaps would be prevented.

In a September 10, 1998 letter to me, Rep Hobson said that he contacted HCFA to get their interpretation of Sec. 4031 of the 1997 Balanced Budget Agreement. "HCFA stated that the various Medigap programs are not required to adhere to Sec. 4031 until State laws are passed. Moreover, the States have until 1999 to effectuate a change". This information appears to me as substantially different than that published in the 1998 HCFA Guide. This information dashed our earlier hopes that we had some termination rights.

ASA's October 15, 1998 letter said they had reached an agreement with HCFA to continue HMO coverage in 1999 but with benefit/premium changes. "These benefits are subject to approval by HCFA. Upon approval by HCFA, all active members will receive an annual notification that provides more detailed information regarding the approved 1999 plan benefits." ASA did not mention HCFA's requirements for timely notices to us. HCFA again remained silent.

My wife has pre-existing conditions for diabetes and heart ailments and I have had two heart attacks. We no longer trusted ASA to do more than the minimum to offset the adverse publicity and respond to the political pressure on them. I enrolled both of us in a Medicare Supplement plan effective January 1, 1999. I assumed that ASA notification in May that they were disenrolling all Greene County participants was still in effect despite the optimism in their October letter. I was wrong.

Just one month before I thought the ASA plan was dead, we received letters from ASA dated November 23, 1998 defining the 1999 rates/benefits. The letter included their announcement that Senior Advantage would become a Medicare+Choice program effective January 1, 1999, my enrollment would continue (unless **I disenrolled** before the end of the year), and attached six pages of new rules. One new rule was "If the plan terminates its contract with HCFA, it must inform members in writing at least 60 days prior to the date of termination". It seems to me that most Medicare beneficiaries cannot evaluate the many alternatives and intelligently respond within 60 days, let alone the 30 days ASA gave me to decide. The time required for any alternative providers to receive/process/respond to any applications seems to have been ignored in the determination of the 60-day criteria. HCFA presumably waived or ignored the 60-day requirement. It now appeared that ASA was no longer disenrolling us and we had no termination rights.

On November 26, 1998, I advised ASA and HCFA that we should be disenrolled from ASA effective December 31, 1998. Fortunately we had already received coverage from our Medicare Supplement provider with no delay for pre-existing conditions. We preferred Medicare HMO care to fee-for-service and the ASA package appeared cheaper but we disenrolled because we had lost confidence in ASA and, more importantly, in HCFA's oversight of the Medicare HMO program. The bottom line is both my costs and Medicare costs have increased but I have no more unreasonable deadlines to meet or confusing rules to comprehend.

In summary, I believe that HCFA's performance left much to be desired in these areas:

Inadequate coverage of risk of HMO pullouts in Medicare publications:
- Nothing in the 1997 Guide, confusing info in the 1998 Guide.

No effective means of communication with those facing pullout-related decisions:
- No 800 numbers, no fax numbers, no email addresses, and errors in Medicare web site.

Unwillingness to make full disclosure of HCFA requirements regarding ASA continuance or replacement by another HMO:
- Poor oversight of Medicare HMO marketing efforts.
- Lack of full disclosure in ASA materials and public statements.

Lack of initiative in implementing congressional direction regarding termination rights:
- No visible effort to inform ASA victims in terms understandable by Medicare recipients.

Chairman GRASSLEY. Thank you, Mr. Stringer. We are going to wait until all four witnesses have concluded their testimony before members ask questions, so I will now go to Ms. Watts.

STATEMENT OF LOIS D. WATTS, LEISURE WORLD, ORANGE COUNTY, CA

Ms. WATTS. Good afternoon. My name is Lois Watts. I am 70 years old, and I live with my husband in a two-bedroom condominium in Leisure World, Orange County, CA. I am a wife, mother, grandmother, friend, volunteer, and part-time employee. Today I come to you as an example of the good and the bad of America's health care system.

For most of my life I have been in good health, but in 1990, I began my battle with cancer—first with breast cancer and then 2 years later with an intestinal tumor caused by a melanoma mole on my face which had been surgically removed 12 years prior. Since 1990, I have had six major and three minor surgeries related to cancer.

In order to battle melanoma, I was referred to the life-sustaining vaccine program at the John Wayne Cancer Institute located at St. John's Medical Center, Santa Monica, CA. Through the efforts of Dr. Donald Morton and his staff, I am able to be here today. Their program is the only one of its kind offered on the West coast, and I believe it has prolonged my life.

Basically, I have participated in a program of regular blood studies, vaccines, x-rays and physician consultations to minimize and watch for a metastatic recurrence of the melanoma, which can recur anyplace in my body.

Prior to this, my husband was diagnosed with Parkinson's disease and had to take an early retirement. We have had to dramatically reduce our living expenses.

Our supplemental insurance premiums kept increasing, and the costs for my husband's prescriptions for Parkinson's were escalating. So in 1995, while I continued treatment at the John Wayne Cancer Institute, my husband and I elected to sign up with Care America. We understood from the representative who called on us at home that they would cover the necessary costs to sustain our health. Unfortunately, instead, they made the next 2 years a battle of appeals to get health care.

In March 1997, Dr. Morton informed me that a blood test had changed, and I should have a full body scan, which is an MRI, to locate a possible tumor. My Orange County oncologist requested authorization; it was denied. He requested and received approval for a CAT-scan, which showed a tumor in my left buttock. A follow-up x-ray series then had to be performed to pinpoint the tumor.

Care America's geographic limitations, which do not have regard for existing physician-patient relationship or quality, required that I seek care in Orange County. I was referred to a local vaccine program and had an unnecessary surgery to harvest cells. The new team of doctors told me that if I had the entire tumor removed, I would probably never walk again.

After 3 months, the vaccine research doctor concluded that the program did not work for me. Another request for authorization was submitted for Dr. Morton to complete the surgery. It was de-

nied. After covering my medical history multiple times with representatives at Care America, they told me to see a new primary care physician in Santa Monica, which I did. I was also sent to a new oncologist. They both recommended surgery by Dr. Morton, and I scheduled my surgery.

Bay Area Physicians denied the authorization request, and I was advised to appeal, which I did. I also appealed directly to Care America, and they told me I was approved, including an approval number, for surgery at St. John's Hospital with Dr. Morton. My surgery was scheduled for the following Monday. On Friday afternoon, I was rudely informed that despite my approval from Care America, I was denied authorization. I felt abandoned and helpless. I was not informed that a grievance committee existed.

A few days later, a friend who handles problems such as this for a hospital in Orange County told me to cancel Care America immediately and return to Medicare. I did and rescheduled my surgery for October—this all started in March. I had a successful surgery with Dr. Morton's staff. I lost the opportunity to have Dr. Morton do the surgery, because he was going to be gone.

As you can see, I am able to walk. The irony is that while recovering at St. John's Hospital, a representative from Care America called and left a message on our home answering machine informing us that they were now willing to cover all expenses after Medicare. But true to form, they continually postponed payments. So with hospitalization bills still outstanding and put into collections, my husband and I submitted a complaint to the State of California Division of Corporations, which really did not do anything. We were also advised to consult with attorney Julie Schoen of SHIP. Her efforts prompted action from Care America and, 1 year from the date of surgery and after much aggravation, the bills were paid.

In March 1998, we elected to join a new coverage group, Secure Horizons. I was advised to enroll in the "65 Choice" plan, which would cover my ongoing vaccine treatment for a monthly premium of $45 and copayments of $25. In August, I was informed that by the end of the year, this plan would be discontinued. My oncologist requested authorization to continue the vaccine program, and it was denied. I was told to appeal to Greater Newport Physicians, and it was denied. I then appealed directly to Secure Horizons, and it was denied.

My appeal was then submitted to the Center of Health Dispute Resolutions in New York. I received confirmation that they would look into it. I have recently received a letter from Secure Horizons, saying that they will again let me continue my vaccine treatment and to request another authorization. This all started in December 1998, and ironically, their letter was dated March 25, 1999, after I had been asked to speak here.

This has been a tangled web of appeals. Before I left home, after I had been notified by CHDR that the appeal had been dropped, I called Secure Horizons as my doctor had not received the authorization—it was still being discussed, is what I was told. The next day, they called to say it was on its way. I told them that the vaccine is done on a regular 8-week schedule, and I had to keep my

appointment this week. They were kind of surprised at that. Anyway, we are still in limbo.

There must be an easier and more efficient way of making appeals, obviously, from what I have gone through, and patients should be informed up front about helpful organizations like SHIP and HICAP.

Thank you for allowing me this opportunity to share my experience.

Chairman GRASSLEY. Well, you faced it all, didn't you, the medical problems as well as the red tape?

Ms. WATTS. Yes. I persevered, and I survived.

Chairman GRASSLEY. Thank you very much.

[The prepared statement of Ms. Watts follows:]

Testimony of Lois D. Watts
Before The
United States Senate
Special Committee On Aging
April 13, 1999

Good afternoon. My name is Lois Watts. I am 70 years old and I live with my husband in a two-bedroom condominium in Leisure World, Orange County, California. I am a wife, mother, grandmother, friend, volunteer, and part-time employee. Today I come to you as an example of the good and the bad of America's healthcare system.

For most of my life I have been in good health, but since 1990, I began my battle with cancer. First, with breast cancer, then two years later with an intestinal tumor caused by a melanoma mole on my face, which had been surgically removed twelve years prior. Since 1990, I have had six major and three minor surgeries related to cancer.

In order to battle melanoma, I was referred to the life-sustaining vaccine program at the John Wayne Cancer Institute, located at St. John's Medical Center, Santa Monica, California. Through the efforts of Dr. Donald Morton and his staff, I am able to be here today. Their program is the only one of its kind offered on the West Coast, and I believe it has prolonged my life. Basically, I have participated in a program of regular blood studies, vaccines, x-rays, and physician consultations to minimize and watch for a metastatic recurrence of the melanoma, which can reccur in any place in my body.

Prior to this, my husband was diagnosed with Parkinson's disease and had to take an early retirement. We have had to dramatically reduce our living expenses and sell our home. At one point, before I turned 65, we had to pay a $1,000 monthly premium for my health insurance. After joining Medicare, we thought it best to take supplemental insurance coverage given our health histories.

Our supplemental insurance premiums kept increasing and the costs for my husband's prescriptions for Parkinsons were escalating. So in 1995, while I continued treatment at the John Wayne Cancer Institute, my husband and I elected to sign up with Care America. We understood from the representative who called on us at home that they would cover the necessary costs to sustain our health. Unfortunately, instead, they made the next two years a battle of appeals to get health care.

In March 1997, Dr. Morton informed me that a blood test had changed, and I should have a full body scan (MRI) to locate a possible tumor. My Orange County oncologist requested authorization. It was denied. He requested and received approval for a cat scan, which showed a tumor in my left buttock. A follow-up x-ray series then had to be performed to pinpoint the tumor.

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I had the entire tumor removed, I would probably never walk again. After three months, the vaccine research doctor concluded that the program didn't work for me.

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A few days later a friend, who handles problems such as this for a hospital in Orange County, told me to cancel Care America immediately and return to Medicare. I did, and rescheduled my surgery for October-this all started in March. I had successful surgery with Dr. Morton's staff, and as you can see, am able to walk. The irony is, while recovering at St. John's Hospital, a representative from Care America called and left a message on our home answering machine informing us that they were now willing to cover all expenses after Medicare. But true to form, they continually postponed payments. So with hospitalization bills still outstanding and put into collections, my husband and I submitted a complaint to the State of California Division of Corporations. We were also advised to consult with attorney Julie Schoen of HICAP. Her efforts prompted action from Care America. One year from the date of surgery, and after much aggravation, the bills were paid.

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This has been a tangled web of appeals. There needs to be an easier and more efficient way of making appeals, and patients should be informed up-front about helpful organizations, such as

HICAP.

Thank you for allowing me the opportunities to share my experiences with you. I hope that you will be able to bring about positive changes_and return humane treatment to all who seek healthcare_regardless of our age. I know too many senior citizens and fine doctors who are completely disillusioned with the current state of our healthcare_especially with HMO's.

If I had a time to make three recommendations for change, I would ask that you consider the following:

1. Simplify the process. Create one health history form that will be used by Medicare and all supplemental programs. Computerize it, like Germany did with the ADP Company.

2. Have a Medicare Review Committee that would draft suggested guidelines for all supplemental insurance companies to follow. Call it "A Patient Bill of Rights" which would be sent to every Medicare recipient, and include restrictions for policies, future coverage changes, and detail the appeal process.

3. Eliminate the barriers for patients to receive the best care possible (whether geographic, physician politics, or uninformed insurance representatives). Give some power back to the patients and their doctors.

Chairman GRASSLEY. Ms. Schoen, please.

STATEMENT OF JULIE SCHOEN, LEGAL COUNSEL, HEALTH INSURANCE ADVOCACY PROGRAM OF ORANGE COUNTY, CA

Ms. SCHOEN. Thank you very much, Senator Grassley. Thank you for this opportunity to present Medicare beneficiaries' perspectives, and I really want to thank Senators Grassley and Breaux for recognizing that the SHIP programs nationwide are providing ombudsman services to Medicare beneficiaries. We really appreciate that recognition.

Let me give you a little background on what SHIPs are and what we do. In California, there are 3,740,000 Medicare beneficiaries, and almost 40 percent of our population is in managed care, so that is a big number to work with. We are able to provide community education to 62,000 Medicare beneficiaries every year. We go to senior centers and wherever we are asked to go, and we will give talks on topics like Medicare+Choice, Medicare fraud, and even long-term care issues, which are not addressed by Medicare specifically.

But really the heart and soul of our program is that we have a network of 750 volunteers, the most incredible people you would ever want to meet, who volunteer their time. They are placed in senior centers and in Social Security offices, and they will counsel Medicare beneficiaries one-to-one. We are able to reach about 35,000 people per year by their efforts and, hopefully, save Medicare money and also save some lives as we go.

I have to tell you a little bit about Medicare+Choice. When the "Medicare and You" pamphlet came out last year—California, of course, is not one of the five pilot States—but we received 17,000 calls in the month of November from people wanting to know what this meant and in a panic about what they should do. So we were able to field as many of those phone calls as we could and tried to urge people not to panic and not to make any drastic changes, because everything was OK, and just to keep in touch with us.

The things we really want to address today are some of the issues with HCFA oversight of managed care, and I think the thing to look at is the marketing materials themselves when we start. They all represent glossy pictures of healthy, active seniors. They have names like Senior Advantage, Maxi-65-Plus, Secure Horizons, Health Care for Seniors. A Medicare person under the age of 65 has no idea that he or she is able to join these plans. We get calls from the Medicare disabled every day who think they have no options left; they cannot afford a Medicare supplement, and they just do not know what to do—and then they find out they can join an HMO. But that is not easily disclosed and not readily available to them, so we would like to see that information in brochures like this, with pictures of some younger, disabled people on the covers. That would be wonderful.

Another great source of confusion in the Medicare program is the layers. You have a system where the beneficiary joins the HMO, and the HMO contracts down to a network of providers; the network of providers then contract down to other groups, skilled nursing facilities, home health agencies, and the beneficiaries themselves have no idea where they fall into this realm. So when the

provider actually denies a service, the beneficiary does not know where to turn, and they get put into a loop of appeals and denial. Basically, if they are ill and older and discouraged, they will give up and not appeal at all. That is what we would like to address.

The flaws in those appeals systems are recognized and illustrated by Ms. Watts, and we have blown up for you a couple of the appeal notices. The one dated December 31, the one closest to the Senators, is just a check-off of reasons for denial. Unfortunately, nothing was checked off. She got that in the mail and did not know why it was denied because they could not even check off the reason. That was the first one she got, and notice that the medical group is highlighted at the top, not the HMO; that happens to have been when she was with Care America.

The second one, she is still with the same medical group, but now she is in Secure Horizons, but there is no mention of Secure Horizons here, so she has no idea of their involvement or that she should access them or call them.

That is the first of six pages of appeals, and her actual denial is one little line in there that says she can receive services in-plan, which she has described to you was not the case.

So that is what she got for her appeals. She had no idea that she could submit evidence, that she had access to her HMO files and records. None of these things were disclosed to her, and she should have known that she had these rights. Even if she had known that she could have requested an expedited appeal. Those requests are frequently denied, and it is up to the HMO which has already denied the medical service to determine if the appeal should be expedited or not. So that frequently, an HMO will advise a beneficiary that the situation is not life-threatening, and therefore, they are not entitled to the 72-hour expedited appeal. That is not true. The law says when the person's health or ability to function could be seriously harmed by waiting 30 days for the standard appeals process, that is when you can initiate an expedited appeal. That is a big difference from life-threatening, and that is what we want beneficiaries to know, and we think that that should be stated very clearly.

So we work very well with HCFA in our State. We have a nice relationship with them, and they work with us, but unfortunately, the Medicare beneficiary does not have the access that we have, and that is what we want to bring down to their level.

So in our recommendations, the one thing we were going to bring up was that marketing materials should be standardized and centralized, and I am very pleased to see this, but what I would also like to see is basically a flow sheet showing "You are here," if you will, in this maze of the layers of the system, showing the brand name of the HMO, showing the medical group that you are part of, showing the actual provider you have, and in nice, bold print, if you feel you need an expedited appeal, this is where you should go, and this is how you do it, and here is the phone number. And also, of course, we would like SHIP's number put on there, and please contact your SHIP program.

The managed care industry is allowed to spend a tremendous amount of money in their advertising, and we think that that should not be the case. We think that the beneficiaries' rights

should be put ahead of advertising and the nice, glossy printouts that they put together.

As I have stated previously, I think we just need this one-page notice on our expedited appeal. If a denial notice refers a beneficiary to the medical group, it also needs to refer him or her to the HMO, and the plan has to be held directly accountable for the care that HCFA is paying them to provide or cover.

In addition, a denial notice should contain a clear statement of when a beneficiary is entitled to that appeal and, again, telephone numbers very clearly stated.

In conclusion, HCFA has shown its willingness to assist beneficiaries when individual requests are made by HICAP programs, and people like Ms. Watts who are fighting cancer or other life-threatening conditions should not have to fight their managed care and HCFA as well.

I just want to thank Ms. Watts for her courage and determination in being here today, and I hope the problems that we have identified will help others so they will not have to fight as hard as Ms. Watts has had to.

Thank you very much.

Chairman GRASSLEY. Thank you, Ms. Schoen.

[The prepared statement of Ms. Schoen follows:]

Testimony submitted by Julie Schoen
on behalf of
California Health Advocates (the California HICAP Association)

April 13, 1999

INTRODUCTION

My name is Julie Schoen and I am here today in several capacities: (1) as the attorney who provides technical support for the Orange County, California, Health Insurance Counseling Advocacy Program (HICAP); and (2) on behalf of California Health Advocates, the California HICAP Association (CHA). CHA is the umbrella organization for all of the 24 non-profit organizations that provide HICAP, or SHIP, services to Californians. Primarily, however, I testify today on behalf of Medicare beneficiaries, for whom SHIP/HICAP is a beacon of assistance.

Thank you for the opportunity to share with you Medicare beneficiaries' perspective and the crucial role played by the SHIP programs. Also, a special thank you to Senators Grassley and Breaux for your recognition and support of the State Health Insurance Assistance Programs (SHIPs) nationwide, especially at a time when Medicare+Choice has increased the demand for SHIP services and when ombudsman programs for managed care are being discussed. The SHIP programs provide objective information, assistance and support for Medicare beneficiaries nationwide, including with respect to managed care issues.

SHIPs' CRUCIAL ROLE IN HELPING MEDICARE BENEFICIARIES.

More than 3,740,000 Medicare beneficiaries live in California. California's HICAPs, or SHIPs, provide community education forums to 62,000 individuals and one-to-one information and assistance to an additional 35,000 beneficiaries every year. In order to accomplish this, we depend upon a network of 750 highly trained volunteers, who enable us to serve so many beneficiaries with such limited funds and to do so with a personal connection.

Each HICAP has been in its local community for at least ten years and reflects its rural or urban setting, its culturally diverse population and its unique aging community. Each of the 24 HICAPs share its expertise and supports the other HICAPs so that this established network of services reaches into every senior center in the state and provides a one-to-one basis for older and disabled persons to voice his/her concerns and to receive assistance.

The community education topics provided by HICAPs range from "Medicare Plus Choice" and "Understanding Your Rights as a Medicare Beneficiary," to long-term care and Medicare fraud issues. In our one-to-one counseling, we help Medicare beneficiaries with such issues as reading a Medicare Summary Notice, choosing Medicare supplemental insurance or an HMO, understanding Medicare + Choice, and the implications for their individual health care situations. Our focus is to make sure that Medicare beneficiaries understand their benefits, options and rights, and to help them

access needed care such as inpatient hospital or nursing home care. Each day brings new information and new challenges.

California contains almost 50% of the Medicare managed care system, currently known as Medicare + Choice. In my area, Orange County, each year about 70% of our one-to-one assistance deals with managed care issues. Due to the complex nature of the managed care system, HICAP has assumed a very varied caseload. We have dealt with problems such as denials of nursing home or home health care or physical therapy, which unfortunately are too common, and have dealt with the ramifications on beneficiaries of HMOs entering or leaving the market as well as the bankruptcy of a major medical network.

A consistent theme for Medicare managed care enrollees is the system's failure to provide them complete and accurate information regarding their managed care system and how to navigate it. For example, HMO enrollees may disenroll from their HMO at any time, but are often advised that can not do so for at least three months. This time frame allows HMO marketing representatives to collect their commission. In addition, HMO beneficiaries are often denied access to specialists and are not provided their appeal rights.

As this nation implements the most dramatic changes to Medicare since its inception more than 30 years ago, the complexity of options and problems faced by aged and disabled beneficiaries has already begun to mushroom. In the first year of Medicare+Choice, when no new choices were actually available, the demand for SHIP services has increased tremendously. In California, which was not one of the five pilot states last November for Medicare+Choice information, in one month our statewide HICAP information line received 17,000 calls, when Medicare beneficiaries received their summary brochure of *Medicare and You*. As new managed care choices do become available, other choices leave the market, and the nation continues to focus on a patients' bill of rights, the complexity of beneficiaries' questions and concerns and the demand for SHIP services will undoubtedly continue to grow. SHIPs are Medicare beneficiaries' focal point for assistance with managed care and other issues and concerns.

ISSUES CONCERNING HCFA OVERSIGHT OF MANAGED CARE

California's HICAP programs have a good working relationship with our Regional Office of HCFA. When we present individual situations, which require HCFA's intervention, the HCFA personnel are willing to assist. However, most beneficiaries experiencing problems with their managed care organization are not fortunate enough to find their local SHIP program or to have personal contacts at HCFA. Based upon the experiences brought to us by HICAP clients, beneficiaries experience a number of systemic problems with Medicare managed care that could be addressed by better oversight.

Confusion About Program Benefits and Protocols

From the outset, consumers receive information that is misleading on a number of fronts. Written materials portray healthy, young looking, active seniors; and many plan names, such as Senior Advantage, Max 65Plus, Secure Horizons, Senior Care, Health Care for Seniors and Senior

Secure, focus exclusively on the senior population. Disabled beneficiaries and their families, looking at these materials, would have no idea that they are equally eligible to enroll. These names and materials are all approved by HCFA.

In marketing materials and presentations, the beneficiaries receive a glossy, surreal picture of what to expect. For example, Medicare covers a maximum of 100 days of nursing home care, but only as long as very strict criteria are met. Medicare HMOs must provide the same benefit, and use the same strict criteria. HMO marketing representatives often give the impression that this benefit covers 100 days in a nursing home without regard to any coverage criteria. The reality is that the national average for coverage of a nursing home stay for Medicare beneficiaries is 14 days. In marketing their plan, HMOs rarely explain such limitations. Yet HICAPs' experience is that beneficiaries who understand the limits of nursing home coverage and who understand that Medicare was not designed to cover long term care accept such limitations and know that they need to plan around it. Painting a false picture of HMO coverage leaves beneficiaries very vulnerable later, when they need the care.

Another source of great confusion comes from the often complicated and multi-layered managed care system. Marketing materials usually discuss a managed care plan in terms of the HMO itself. However, an HMO may contract with several different provider networks, each of which may then contract with several different medical groups, hospitals, nursing homes and home health agencies. A beneficiary joining an HMO receives a list of doctors and is advised to choose a primary care physician from this list. However, when medical services are denied or a problem occurs, any notices the beneficiary may receive will generally come from the medical group or from a third party administrator, whose name is new to him. The average HMO enrollee does not know where to turn. The beneficiary will likely begin with his or her doctor, who may blame the utilization review committee, which may blame the medical group, which may blame the network, which may blame the HMO, which may in turn blame the medical group or contracting network. An already ill and discouraged beneficiary usually gives up, rather than fights, the system.

At all stages, beneficiaries do not receive a clear picture of the managed care system. Plans need to be portrayed more accurately from the outset. This need for clear information continues even after enrollment, so that beneficiaries can successfully navigate their way through complex and confusing systems.

Flaws in the Appeals System

The appeals process is often a slow, frustrating and ineffective labyrinth, even when urgently needed medical care is at issue. Unfortunately, Mrs. Watts' struggle to get through the managed care system and obtain needed cancer treatment is not an uncommon experience. Also unfortunately, HCFA has fought reform and has failed to enforce beneficiaries' appeal rights.

Rather than implement a federal court order establishing an expedited appeals process when managed care beneficiaries are denied care, HCFA has established a different process that ignores some of the court order's key requirements. Mrs. Watts' experience illustrates some of the deficiencies in the current system. The denial notice that Mrs. Watts received on December 31,

1998, in its six pages, contains a one line denial that merely states: "The services you requested were reviewed . . . and determined to be available in Health Plan." This was not the case, due to the type of cancer and treatment needed by Mrs. Watts. Buried in the six pages, instead of presented prominently, was the fact that Mrs. Watts could request an expedited appeal. It also was not made clear to Mrs. Watts, an educated and generally sophisticated beneficiary, that she had the right to review the HMO's file, that she had the right to obtain and review her medical records, and that she had the right to present information on her own behalf.

Even if Mrs. Watts had known she could request an expedited appeal, such requests are frequently denied. It is up to the HMO, which has already denied the medical service, to determine if the appeal should be expedited. Frequently, an HMO will advise a beneficiary that the situation is not life threatening and that therefore the appeal will not be expedited. However, the real criteria for an expedited appeal is whether the person's "health or ability to function could be seriously harmed by waiting 30 days for the standard reconsideration decision." Another HICAP client suffered from prostate cancer. The HMO denied the treatment his doctor had recommended and had advised was the only effective treatment option. The client did request an expedited appeal, but the HMO refused to expedite it. By the time the standard appeal went through the system, the cancer had progressed too far to be treated. Furthermore, there is no timely way to challenge an HMO's failure to expedite the process.

Another deficiency in the current appeals process is that doctors and other providers may be discouraged from filing an appeal on behalf of a patient. For example, one local physician began to file an expedited appeal, but was told by the administrator of the medical group, "not to get involved." A nursing home administrator recently advised that she was afraid to refer patients to HICAP for assistance in appealing denials of coverage for fear that the nursing home's HMO contract would be canceled.

After an HMO has reconsidered its own denial and has again denied coverage, the beneficiary's appeal is forwarded to HCFA, which contracts with the Center for Health Dispute Resolution (CHDR) to handle the appeal. Although HCFA has set time limits for HMOs to process appeals, it has refused to require such time limits for itself. Mrs. Watts' case has sat at CHDR since February 24, 1999, after the HMO took almost two full months to reconsider its own denial, with no CHDR determination made. Furthermore, the information that is provided to beneficiaries does not include any information as to how to get in touch with CHDR, or the beneficiaries' right to review the HMO file and present additional information. Like most beneficiaries, Mrs. Watts did not know that she could request a copy of the HMO file or that she could provide additional evidence to CHDR. The few beneficiaries who are resourceful enough to locate and telephone CHDR are generally rebuffed in their efforts to find out anything about their case and to present their side of the appeal. Thus, this HCFA stage of review is essentially a one-sided review of whatever information the HMO has chosen to submit.

For many, if not most, beneficiaries, it is not until the next stage of review, a hearing before an administrative law judge, that they have the opportunity to present their case. In my experience, the beneficiary usually wins at this level of review, as he or she finally have the attention of a neutral party. However, an ALJ hearing frequently takes months or longer to obtain. Sadly, on more than

one occasion, I have had to represent the estate of the beneficiary, who has died during this lengthy appeals process.

When HICAP or SHIP becomes involved in the appeals process, we can usually secure the needed medical service for the beneficiary and move the case along more quickly. However, HCFA should not make the appeals system so complicated and unfriendly to beneficiaries that they have to find a HICAP or SHIP program in order to get needed medical care from their managed care plan.

Denials of High Cost Care

There are several areas in which beneficiaries frequently encounter problems that pertain to denial of or failure to provide particular types of care. These include premature discharge from hospitals or nursing homes, denials of access to specialists and durable medical equipment, and denial of home health care. Mrs. Watts was denied access to an appropriate specialist. HICAPs have assisted beneficiaries with heart problems who were denied access to a cardiologist. Too many beneficiaries have been told that their Medicare HMO does not cover home health care, which they are required by law to cover. The enormity of these problems is increased by the flaws in the appeals system. If beneficiaries were able to get through the appeals system effectively and in a timely manner, these other systemic concerns would not be such a problem.

In monitoring managed care plans, HCFA obtains information from the plans themselves as to the care needed by their Medicare enrollees and does not seek input from beneficiaries or beneficiary advocates. In addition, HCFA does not have any system for gathering and keeping track of beneficiary complaints as to denials of care, other than the formal appeals process. Thus, HCFA's monitoring systems are unlikely to even identify, much less address, such systemic problems as denials of nursing home or home health care coverage.

RECOMMENDATIONS

Marketing materials should be standardized and centralized.

Managed care organizations spend a tremendous amount of money trying to entice beneficiaries to join their plans. Yet the information provided to beneficiaries is often misleading, confusing and not helpful to beneficiaries trying to navigate their managed care system. Beneficiaries would be better served by spending less money on marketing and more money on patient care and educating them on how to use the managed care plan effectively. Consumers can make wise choices if they receive accurate information and can better weave their way through their managed care plan if given the tools to do so.

Managed care enrollees should be given information, at the time of enrollment and annually, about the different entities involved in providing, arranging and approving or denying care, including the role each entity plays, as well as telephone numbers and addresses for each such entity. Enrollees should also be given clear information about the process used, both for initial determinations and at every stage of the appeals process, to approve or deny care.

HCFA should be prohibited from approving plan names and marketing materials that target only the senior population.

Congress has forbidden plans from discriminating against enrollees and potential enrollees on the basis of health, health history or health conditions. However, by virtue of the plan names and marketing materials, plans target only the active senior population and ignore disabled Medicare beneficiaries. This should not be allowed to continue. Centralizing and standardizing marketing materials, as recommended above, should help address this problem.

HCFA should implement the expedited appeals process and appeal rights ordered in *Grijalva* and should stop challenging it at every step.

The federal district court and Ninth Circuit have ruled very clearly as to beneficiaries' constitutional rights with respect to an expedited appeals process. Beneficiary groups nationwide have urged HCFA to implement Grijalva. Full implementation of Grijalva would resolve many of the current deficiencies in the appeals process that adversely affect beneficiaries' ability to navigate the system and obtain needed medical services.

Beneficiaries who are denied medical services should be given simplified and more meaningful information.

A one page notice should be provided to beneficiaries, that states what service has been denied, the reason for the denial in easy to understand language, the fact that expedited appeals are available, and the telephone numbers for the HMO's expedited appeal department and the state SHIP program. Additional information could and should be provided on subsequent pages, but the fact that beneficiaries have immediate appeal rights and how to seek assistance should not be buried in the middle of a multi-page document.

If a denial notice refers beneficiaries to the medical group, it should also refer them to the HMO as well. The plans must be held directly accountable for the care that HCFA is paying them to provide or cover. In addition, a denial notice should contain a clear statement of when a beneficiary is entitled to an expedited appeal. For example, "You have the right to an expedited appeal if you believe the denial of service could mean serious harm to your health." The telephone number and facsimile number for the managed care plan's expedited appeals department should be included, as most HMOs have separate personnel that deal with expedited appeals than deal with standard appeals. The state SHIP number should be provided in bold print.

Plans and CHDR must provide beneficiaries the opportunity to review their files and present additional information throughout the appeals process.

The law currently requires that beneficiaries be provided a meaningful opportunity to participate in the HMO reconsideration process. As long as the appeals process continues to be one-sided with respect to availability of and opportunity to present information, it will continue to be a rubber stamp for HMO denials. In addition, HCFA must enforce such requirements; it is not sufficient to merely put them in writing if they are not routinely provided in practice.

Plan doctors and other providers should be surveyed by HCFA to ensure that they are not being discouraged from assisting beneficiaries through the managed care system.

It is not enough for HCFA to simply prohibit plans from discouraging doctors and providers from assisting patients with appeals, or to prohibit "gag clauses." Furthermore, surveying the plans as to these issues is not likely to produce evidence of such practices. Thus, the doctors and contracting providers must be surveyed and information that would identify such providers must be kept confidential so that such practices, when they exist, may be stopped.

HCFA's monitoring of managed care plans should include interviewing beneficiaries and beneficiary advocates.

HCFA's monitoring process is not designed to identify problems encountered by a plan's enrollees. When reviewing particular cases regarding quality of care, access to care and grievance and appeals issues, beneficiaries should be interviewed as well as reviewing the HMO's records. Local beneficiary advocates should also be interviewed to help identify recurring problems with a managed care plan.

HCFA should establish a system to intercede on behalf of beneficiaries in managed care plans.

Most regulatory agencies have systems in place to help consumers who are having problems with entities regulated by such agencies. HCFA has no such system, and should. A beneficiaries' ability to obtain help from HCFA should not depend on whether the beneficiary has the fortune to first find the local SHIP program, or on whether a beneficiary lives in a HCFA Region which is more inclined to help beneficiaries than another Region, or on whether a beneficiary reaches a managed care plan monitor who is willing to help on that particular day. As Congress and HCFA do more to encourage managed care plans and enrollment in them, the need for HCFA to have such a system becomes even greater.

CONCLUSION

SHIPS have a unique opportunity and ability to help managed care enrollees through the system, and to provide feedback to HCFA, Congress and to managed care stakeholders as to how the system is working and not working. Unfortunately, our health care system is so complex that the demand for SHIP services is tremendous. With the increased emphasis on additional managed care options and focus on patients' rights, the need for SHIP services continues to grow.

HCFA has shown its willingness to assist beneficiaries when individual requests are made by HICAP programs. However, with respect to oversight of the managed care system as a whole, much more could and should be done. If managed care is to be a success in the long run, beneficiaries must be satisfied that they can obtain clear and accurate information, that obtaining needed health care is not subrogated to profits, and that they are able to manage the managed care maze effectively.

Persons such as Mrs. Watts, who are fighting cancer or other life threatening conditions,

should not have to fight their managed care plan and HCFA as well. I also want to thank Mrs. Watts for her courage, determination and stamina in asserting her rights and in coming here to help other beneficiaries by her testimony. I hope that the problems identified here today can be addressed so that other individuals do not have to fight as hard as has Mrs. Watts in order to survive. On behalf of California Health Advocates, the SHIP programs nationwide, and Medicare beneficiaries, thank you for your concern for Medicare beneficiaries and managed care enrollees and for your support for them.

Chairman GRASSLEY. Mr. Mulholland.

STATEMENT OF CHRIS MULHOLLAND, MARIETTA, GA

Mr. MULHOLLAND. Thank you, Senator Grassley and Senator Breaux, for inviting me to come and testify today.

I retired from the Health Care Financing Administration 3 years ago after 36 years of Federal service, and as I understand it, the committee is exploring what the HCFA review process of health care plan materials contributes or fails to contribute to beneficiary understanding of their benefit coverage and of their rights and responsibilities under the Medicare program.

But before I get specific, I want you to know that I think the greatest problem is attitudinal in terms of advocacy for the beneficiaries. The Medicare program exists for the beneficiaries, but in my opinion, decisions are often not made with the beneficiary's best interest at heart. That is why, after these many years, we are still trying to give clear and comprehensive information to the beneficiaries.

There have been many different problems, but I will list two major problems with marketing. The biggest in my way of thinking is the marketing representative. This is the man or woman who sells the plan's program to the beneficiary. I truly appreciate what we are trying to do in getting written material that is clear and understandable, but we have already heard from other panel members today how they have relied on what they were told by sales representatives as being covered. To me, this is human nature. You are going to pay attention to what someone is telling you in person. But unless things have changed, and I do not think they have, these sales representatives are paid on commission according to how many people they enroll, and their incentive is to enroll people and not necessarily to see that the potential enrollee really understands what he or she is doing.

Now, I am not saying there are evil, mean people out there trying to mislead potential enrollees, although I have encountered some of those in my tenure. But the plain fact is that their incentive is to not show the negatives, and to show all the glossy positives, and their influence in my way of thinking is really tremendous.

When an enrollee is persuaded to enroll, and it turns out that it was not in his or her best interest, this can really be disastrous to them and to the program. The solution is obvious, and it has been held forth before—that there should be some sort of third party verification of enrollment by some entity other than the plan itself, an entity that the beneficiary is contacted by or the beneficiary must contact, who verifies that they really want this enrollment and that they really meant to do it.

I may feel this way more strongly than others because of my experience in Florida, where we had a tremendous amount of ping-ponging of beneficiaries or enrollees by sales representatives who would just enroll beneficiaries out of one plan into another. We had beneficiaries who had been enrolled in 10 or 12 different plans. So some sort of verification would be helpful.

The second problem to my way of thinking is that the material furnished by the plans is not standardized. Each plan is an individ-

ual business with its own way of presenting its product. This is the competitive American way and is usually healthy when applied to the population at-large. However, the Government contracts with these plans to serve a targeted population of aged beneficiaries, some of whom are very alert and astute, but many of whom are vulnerable. I think it wise and fair to require these plans to temper their tactics in marketing to this population and in providing them with information on their rights—for example, appeals notices.

One thrust of the marketing material review process is to assure that the material is correct and not confusing to the beneficiary. This includes looking at advertising as well as letters, contracts, notifications, handbooks and whatever else the plan sends to the beneficiary. When these materials are reviewed, it is really hard to visualize what the HCFA regional office reviewer is looking at. It can be two to four to six boxes of stuff, no telling how many big, three-ring binders of material that must be gone through on every aspect of that plan's contract, with some segment of it dealing with marketing material and other material sent to beneficiaries.

The reviewer is on alert to notice anything which does not meet requirements and anything which is confusing, but from the beneficiary's point of view, the plan's material may be expressed or arrayed differently from other plans they want to consider, and that is confusing. The challenge is how to permit plans their individuality and accommodate standardization and consistency.

You might also be interested to know that the review process is inconsistent among the regions. Some regions are more strict than others. Some of this is dictated by the nature of the plans in the region. Some plans in the Atlanta region were so abusive that we had to be more strict. Some of this difference is due to regional leadership attitudes or just different levels of expertise in personnel. And some of the difference might be due to the particular central office personnel relating to their assigned region. I will generalize that implementation of national guidelines could be standardized and made more consistent to bring about greater consistency.

Unless it has changed, and I do not think it has, there is variance in what plans furnish their enrollees in terms of annual notification. Some give clear information about changes, and some do not. Some give updated handbooks, and some give addenda which are confusing to use and easily lost. I think Senator Breaux paraded one of those before us. HCFA could and should have consistent requirements on this. I did not know Mr. Stringer before I came here today, but this certainly applies to his story.

The fact that some plans are withdrawing wholly or in specific counties because of the risk adjustment factor or other reasons illustrates that profitability is the engine that runs the machine. It is unconscionable that we do not have requirements which notify and protect affected beneficiaries. I understand that some plans continue to enroll in areas from which they plan to withdraw. This should be prohibited in the original contract and reiterated in any service area expansion. I can see how this works. If the plan has a contract, in a way, HCFA would be interfering with the plan's right to enroll if it forbade continued enrollment. This is another instance of decisions being made without having the beneficiaries as first priority.

Another problem for HCFA is allocation of resources to the managed care effort. Just before I retired, I was on a task force which recommended decentralization of the health care contracting function to the regional offices. This was recommended because it would eliminate duplication between the regional offices and the central office, thereby freeing central office personnel to concentrate on much needed policy and guidelines. This recommendation was dropped.

If such decisions could be made on the basis of good management instead of turf battles, the program would run more efficiently. The management in each region decides how many employees will work in the managed care area. Thus, the number of employees dedicated to managed care varies by region. In some regions, there is a persistent shortage of staff. There is no mechanism in place to reallocate personnel from components within regions, or from the HCFA central office to the regional offices when such shortages occur.

Another resource problem is competence. Where do you get the skilled managed care workers to work for the Government? They must be trained or hired from the industry, and HCFA is often not salary-competitive to get such workers. One answer is to standardize and even contract out if it can be done in a sensible way.

Two things in closing, and one of them is passe now, because Senator Reed beat me to it, but I would like to mention the idea again of a managed care ombudsman, at least in each region. This person's office could both assist the beneficiaries and support the oversight effort through experiential feedback.

And second, although I am not quite on Medicare yet, I would like you to know that I belong to a good HMO. It communicates clearly with me, has many interesting health-related programs, emphasizes prevention, gives me an appointment the day I call in sick, and has treated me extensively when I was seriously ill, and even paid my bills when I was ill out of their service area. So there is hope.

Thank you for this opportunity.

[The prepared statement of Mr. Mulholland follows:]

CHRIS MULHOLLAND III
April 13, 1999
Testimony before the Senate Special Committee on Aging

Thank you Senator Grassley and Senator Breaux for inviting me to testify before the Committee today. I hope my comments will assist you in making improvements to the Medicare managed care program. I retired from the Health Care Financing Administration (HCFA) three years ago, after thirty-six years of federal service. My last position was manager of the Managed Care Branch in the HCFA Atlanta Regional Office with responsibility for the managed care program in the eight southeastern states. Our primary function was contracting with HMOs and monitoring existing contracts. One aspect of this was review and approval of each contractor's marketing materials and other pertinent information distributed to the beneficiaries.

As I understand it, the Committee's objective is to assure that Medicare beneficiaries are clearly informed about what is covered by each HMO plan so that they can make informed decisions before joining. And after joining, beneficiaries are to be clearly and timely informed about changes through the annual notification. The committee is exploring what the HCFA review process of health plan materials contributes or fails to contribute to such beneficiary understanding of their benefit coverage and of their rights and responsibilities under the Medicare program.

Before I get specific, I want you to know that I think the greatest problem is attitudinal in terms of advocacy for the beneficiaries. The Medicare program exists for the beneficiaries, but decisions are not made with the beneficiaries best interests at heart. The main players are the government, the HMOs which are mostly publicly held companies, the medical profession, and last but not least, the beneficiaries. The government is a political entity subject to many influences which effect its performance and decision making. HMOs are interested in getting as many enrollees as possible and holding down costs. With respect to marketing material, how many HMOs take great pride in how well their prospective enrollees or current enrollees are informed, or is their pride in how many they enroll? I know there should be a balance here and perhaps the reason I think there isn't is that my experience included Florida, famous for the ping-ponging of enrollees. Medical practitioners are in a catch twenty-two. I believe that most want to give good quality care, but they are often limited when they practice in the HMO setting.

There are two major problems with marketing. The biggest is the marketing representative. This is the man or woman who sells the plan to the beneficiary. Unless things have changed, and I do not think they have, they are paid on commission. The incentive is to enroll, not help the beneficiary make an informed decision. When abused the effect can be disastrous to the beneficiary and the program. The solution is obvious, but apparently not politically palatable- third party verification of enrollment by some entity other than the plan.

The second problem is that material furnished by the plans is not standardized. Each plan is an individual business with it's own way of presenting it's product. This is the competitive American way and is usually healthy when applied to the population at large. However, the government contracts with these plans to serve a targeted population of aged beneficiaries, some who are very alert and astute and many who are vulnerable. I think it wise and fair to require them to temper their tactics in marketing to this population and in providing them with information on their rights, for example, appeal notices.

One of the thrusts of the marketing material review process is to assure that the material is correct and is not confusing to the beneficiaries. This includes advertizing as well as letters, contracts, notifications, handbooks, and whatever else the plan sends to the beneficiary. The reviewer is on the alert to notice anything which doesn't meet requirements and anything which is confusing. Often the reviewer is under a deadline. When a new contract is being processed the plan wants the material approved so that it can be

utilized immediately when the contract is approved. It is significant to note that the above effort is with respect to each plan individually. But from the beneficiaries point-of-view, that plan's material may be expressed or arrayed differently from other plans they want to consider and that is confusing. The challenge is how to permit plans their individuality and accommodate standardization and consistency across the board.

You would also be interested to know that the review process is inconsistent among the regions. Some regions are more strict than others. Some of this is dictated by the nature of the plans in the region. Some plans in the Atlanta region were so abusive we had to be more strict. Some is due to regional leadership attitudes or just different levels of expertise in personnel. Some is due to the particular central office personnel relating to their assigned region. I will generalize that implementation of national guidelines could be standardized and made more consistent.

Unless it has changed, and I do not think it has, there is variance in what plans furnish their enrollees in terms of annual notification. Some give clear information about changes and some do not. Some give updated handbooks and some give addendums which are confusing to use and easily lost. HCFA could and should have consistent requirements on this . I know producing a new handbook each year is expensive. Perhaps a new handbook could be required only if there are significant changes.

The fact that some plans are withdrawing wholly or in specific counties because of the Risk Adjustment Factor illustrates that profitability is the engine that runs the machine. It is unconscionable that we do not have requirements which notify and protect affected beneficiaries. There may be other areas, and this is certainly one, where HCFA could devise a standard form for this purpose and require that it be used. I understand that some plans continue to enroll in areas from which they plan to withdraw. This should be prohibited in the original contract and reiterated in any service area expansion. I can see how this works. If the plan has a contract HCFA would be interfering with the plans right to enroll if it forbade continued enrollment. HCFA might even get sued by the plan. So nothing gets done. Another instance of decisions being made without having the beneficiaries as first priority.

One of the problems for HCFA is allocation of resources to the managed care effort. Just before I retired I was on a task force which recommended decentralization of the health plan contracting function to the regional offices. This was recommended because it would eliminate duplication between the regional offices and the central office, thereby freeing central office personnel to concentrate on much needed policy and guidelines. This is another pendulum; centralization or decentralization. If it could be decided on the basis of good management thought instead of turf battles the program would run more efficiently.

The management in each region decides how many employees will work in the managed care area. Thus, the number of employees dedicated to managed care varies by region. In some regions there is a persistent shortage of staff in this area. There is no mechanism in place to reallocate personnel from the HCFA central office to the regional offices when such shortages occur.

Another resource problem is competence. Where do you get the skilled managed care workers? They must be trained or hired from the industry. HCFA is often not salary competitive to get such workers. One answer is to streamline and standardize, and even contract out if it can be done in a sensible way.

Two things in closing. First, I'd like to float the idea of a managed care ombudsmen at least in each region. This person's office could both assist beneficiaries and support the oversight effort through experiential feedback. Second, though I'm not on Medicare yet, I would like for you to know that I belong to a good HMO. It communicates with me clearly, has many interesting health related programs, emphasizes prevention, gives me an appointment the day I call in sick, and has treated me extensively when I was seriously ill, and even paid all my bills when I was ill out of their service area.

Thank you for this opportunity.

Chairman GRASSLEY. Thank you very much.

Each member will take 5 minutes for questions, and also let me say this for everyone, including the next two panelists. We may not be able to ask all of our questions orally today, so for members who are here or not here, we would like the opportunity to submit questions to you for written response within 2 weeks, if that is doable for you.

I am going to start with you, Ms. Schoen. Taking off from what Senator Reed and Mr. Mulholland just stated about the ombudsman, don't you see your role as being somewhat of an ombudsman?

Ms. SCHOEN. Absolutely.

Chairman GRASSLEY. OK. And every State has one of those?

Ms. SCHOEN. Yes.

Chairman GRASSLEY. And that does not denigrate the suggestion of Mr. Mulholland because his is within the HCFA organization.

Ms. SCHOEN. It strengthens it, actually.

Chairman GRASSLEY. Yes. In your experience with appeals, where do the problems stem from that lead to an appeal? What I am getting at is do a lot of the appeals you encounter come from a lack of beneficiary understanding of their benefits and rights under the program? It seems to me that a lot of folks are merely given verbal assurance by the marketing representatives that something is covered, and they do not get a complete description of their plan benefits in writing.

Ms. SCHOEN. Yes. They go to these luncheons and sales presentations, and they hear about certain coverage, and they leave and sign up. And what we find is that they live in different communities—for example, Ms. Watts lives in a community of 40,000 active senior citizens, and one will be on Medicare fee-for-service and have a certain service covered, and another one will be in an HMO and have a real struggle to get through. And they are not told about their appeals process; they are just told, no, it is not necessary for you to have that, and your doctor is telling you that, so what are you supposed to do? If your doctor says you do not need it, obviously, you do not.

So it is only when they hear from their neighbors that, yes, they are entitled that they start calling and asking questions, and in that regard, sometimes the doctor is put on the spot and goes to utilization review, and they pass it off. I think most people do not know they can appeal, and they do not.

Chairman GRASSLEY. Thank you.

Mr. Stringer, you were a consumer of Medicare+Choice, and you stated that the information sent to you by the plan was misleading and that HCFA could improve its oversight of plan materials and marketing. What could have helped you that you did not receive when you learned that your plan was leaving the market—and please start with the most helpful thing and then, if you have time, go to lesser things, but start with the most important.

Mr. STRINGER. First, certainly the idea that the Anthem contract was only good for a year, and they could cancel with 60 days' notice and have no right of appeal is an important fact that is not made known even today.

Second, certainly the idea that premiums and benefits are subject to change with no notice or appeal is also important. And the

fact that Anthem can cancel doctors or hospitals also with no notice of appeal I think is also important.

The final point is that neither the HMO nor HCFA has any obligation to help anyone who is being disenrolled to find alternative coverage.

Chairman GRASSLEY. Thank you.

Ms. Watts, when you joined managed care as a Medicare beneficiary, did you know that you were still in the Medicare program, and if you did not know that, why not?

Ms. WATTS. No, no. Medicare was back there, and now, we are HMO. The word "Medicare" is dropped then, and you become Care America, you become Secure Horizons. I have to say that our plan was dropped, also; my plan was dropped. And I asked why it was being dropped, because it fit my needs because of the vaccine, and that is the one that was up on the board before. I paid a premium monthly, and then I paid a copay. They had it for 1 year, and they canceled it. I asked why, and she said not enough people had enrolled. Then I asked my doctor why they canceled it, and he said they were not making enough money.

Chairman GRASSLEY. Thank you.

Mr. Mulholland, do you think that if there were greater standardization regarding benefits coverage documents, the reviewers' job would have been easier and less mistakes would have occurred?

Mr. MULHOLLAND. Well, I will say yes, but let me just say a little more than that. They have a tremendous volume of information to look at, and in this area, some of it is a little bit subjective, simply because maybe some things are expressed differently in different parts of the country. I think that if it were standardized better across the country, it would make their job easier.

Chairman GRASSLEY. I would follow up, then, with a question. From your perspective being inside the bureaucracy of HCFA, why is the agency reluctant to require plans to provide some sort of standard coverage document that clearly and fully describes a plan's benefits?

Mr. MULHOLLAND. Well, I could be catty and say I cannot fathom why, but I do know that there are a lot of pressures on the employees of HCFA. I know they are well-meaning people. It just seems that it takes forever for things to get done sometimes—maybe most of the time. And I do not mean to be evasive on this, but——

Chairman GRASSLEY. Well, let me help you. Are these pressures that you refer to to avoid standardizing things or are they unrelated to standardizing forms because people are so busy doing something else?

Mr. MULHOLLAND. The latter. For example, when a new plan wants a contract, all kinds of things enter into it, both in the central and the regional office, and you are looking for a way to get that done by a deadline because they are dependent on that. The comments I made about resources having to do with the number of resources as well as the training incompetence—I am not suggesting people are incompetent, but there just are not enough competent people on the staff to handle all this—I guess this is sounding like an excuse—but those other activities, or the many activities they have, may well divert attention from this. Now, I do not think it should, and I think there are many things that could be

taken care of and established, and we would not be forever going through all this.

Chairman GRASSLEY. But there is not a bureaucratic predilection against standardization per se.

Mr. MULHOLLAND. The only thing I can recall is that there are nuances of differences among regions, but I don't think that is a good excuse for it. I really think it is something that should be addressed and handled. I don't think there is anybody who is just fervently against it; I just think it has not gotten done.

Chairman GRASSLEY. Thank you.

Senator Breaux.

Senator BREAUX. I thank the chairman and the panel, particularly Colonel Stringer and Ms. Watts, for coming from such a long distance and for your contributions.

Mr. Mulholland, I take it that while you were a Federal employee, most of that time or a portion of it, you were covered by the Federal Employees Health Benefit Plan?

Mr. MULHOLLAND. Yes. I am familiar with that brochure you held up, and in fact I have used it many times to help decide.

Senator BREAUX. I am in the same plan, and all my staff are in the same plan, and it seems to me that the information we get to choose from every year is fairly clear and concise in the way that it is presented and much more easily understood than proposals that I have seen outlining Medicare+Choice and other private managed care plans. Is that your impression, or do you disagree with that?

Mr. MULHOLLAND. That is absolutely true, but there is a salient difference in the two. One is that the Federal presentation of the facts about what is covered, what is there, what you get, what you pay for it, and that is what makes it so simple and easy to use. The ones that the Medicare beneficiaries are encountering are constructed to sell something to them beyond what—the Federal employees are just information——

Senator BREAUX. Yes, we have got to change that. If they want to do business with the Federal Government, they are going to have to come up after these changes are made and present it in the same understandable fashion, or they are not going to get to participate. It is going to be that simple. Congress is going to require HCFA to do that, and that is what they are doing with this new plan here. They are saying, look, if you want to participate and sell to the 10 million Medicare beneficiaries, you have to present it in a fashion that is understandable, cut the advertising out of it, and just present the facts, as the old saying goes. If you do not want to do that, then do not sell; go and sell somewhere else.

Ms. Watts, you must have not known that Julie Schoen was just up the road doing all this good work.

Ms. WATTS. No. It was wonderful to find her. She is my chaperon.

Senator BREAUX. Yes, sort of after the fact. I think this is another problem. Here, you are in the same county in Laguna, Orange County, and she is just up the road, doing all the wonderful work to be an ombudsman, but you did not really realize that.

So the question, Julie, is how can we let more Medicare beneficiaries understand what the SHIP program actually does? How can we make it more knowledgeable to all the 40 million Americans under Medicare that there is someone who is going to help them in this?

Ms. SCHOEN. I think part of it is that we are buried on page 6 of the appeals notice here. We are required to be put in the marketing materials of the HMO; we are just somewhere on the last page. So it just needs to be up front.

Senator BREAUX. More clearly spelled out and understandable.

Ms. SCHOEN. Yes, and we talked about do we need to be present more at these sales presentations where they have the breakfasts, and we do need to be more of a presence. We do not want to look like we are endorsing a plan, but we do need to be more of a presence there; we even thought, well, we will have our volunteers shop some of these sales presentations, and won't that keep them a little more honest if they think there is a SHIP program volunteer in the audience who is going to go back and report.

Senator BREAUX. Maybe even some public service announcements, too, I think would be helpful in letting Medicare beneficiaries know if these things are out there if they are having problems.

It seems that most of your problems, Colonel Stringer's problem and Ms. Watts' problems have not been with deciding which plan you wanted to go into but problems that you had after the plan was there and not covering what you thought should be covered, and with Colonel Stringer canceling without you knowing that they could cancel.

So Ms. Cronin, who is sitting in the audience and is one of our next witnesses, I notice that in the draft mock-up of what HCFA is attempting to do, which I find to be very good, in the draft, you have—I love the names of these plans, Mr. Chairman; even in the mock-up from HCFA, it is called the Victory Plan. And what was yours, Ms. Watts?

Ms. WATTS. Care America.

Senator BREAUX. Care America. Isn't that great?

Ms. WATTS. And Secure Horizons. They just get you with the name if not the benefits.

Chairman GRASSLEY. The next one will have "Apple Pie" in it.

Senator BREAUX. Yes, the "Apple Pie Insurance Company." [Laughter.]

I see that you do not have—I am speaking to HCFA, and they can address it when they come up and testify—but they do not have in the proposed Victory Plan, which is just an example, the cancellation policy. I think that that would be very important to have in there. It should be one of the first things that the policy shows—can they cancel it after 12 months? Can they move out on you any time they want? Make them spell that out when they make their presentation, because the example we have does not have any little column on cancellation policy for the company, and I think that would be helpful. If a person knows that the policy they are getting ready to buy can leave the county in 6 months, or at any time without any notification, that is important information that the person should be able to have as well.

OK, you have been very helpful, and you have made some really good points. The only other thing is on the appeals process. I have been talking about how good the Medicare+Choice appeals process is and advocating that instead of just letting people go to court and file suit, but you talk about complicated—I never saw it spelled out. Here it is in a chart, all these little dots about thing that you would have to go through to appeal in Medicare+Choice, denial of a benefit claim, go to first base, second base, then go back to first base, circle home plate, go to third—they have all these terrible things. It is not really that complicated. The Medicare+Choice appeals process is really pretty good. You can get an expedited hearing within 24 hours or 72 hours, and if you are not satisfied with that, you can go to an external appeals process. If you do not like the external appeals process decision, you can go to an administrative law judge. If you do not like the administrative law judge's decision, you can take them to court if it is over $1,000. It is a pretty substantial procedure if you are denied benefits under the Medicare+Choice. However, I will bet you 99 percent of the people do not know that.

Ms. WATTS. Or they do not have the energy or the understanding. I was fairly sophisticated in medicine, although it was a long time ago, and my husband was on the board of Western Medical Center when it was a nonprofit hospital for 18 years, so we were more sophisticated in that department, and we became bulldogs. We were determined that we were going to get an answer. I think the geographic area needs to be touched on, because if you need somebody, like I did, with Dr. Morton in Santa Monica, we should be able to do that, because he is the only one. I did not have any choice if I was going to continue to live.

Senator BREAUX. Yes. Congratulations for your perseverance. It obviously has paid off, and you are helping a lot of other people today. Thank you very much.

Ms. WATTS. Thank you, Senator. Thank you for listening to me.

Chairman GRASSLEY. Senator Reed, and then Senator Collins.

Senator REED. Mr. Chairman, I want to thank all the witnesses for their testimony. It has been very insightful. And I particularly want to thank Mr. Mulholland for his kind endorsement of the ombudsman, and particularly Ms. Schoen, because you are doing this on behalf of the Medicare senior population. I think every State in the country has a SHIP program. My thought is that such a good program should expand to every managed care program in the country, not just the Medicare managed care.

But I wonder, in terms of your experience, my sense is that despite being there on the ground, if you will, and having the tools to do this job, do you think you are reaching all the seniors who have problems, and if not, why?

Ms. SCHOEN. No, no. When you think that there are 3 million in California, and we are getting 62,000 in public education and 35,000 in one-to-one, no—we are just at the tip of the iceberg.

A lot of it is that we are small. We are pretty grassroots. And California is one of the largest because we just have a long history over a decade of service, and the other States have been following suit and picking up on it. So managed care is relatively new, and we are growing with it. We in Southern California dealt with it

long before Northern California, and we were crying out about it, and they were not listening to us. So we also had to get the message out.

So I think we can make it stronger by letting people know we exist through public service announcements and the things you were talking about—and we do find that HCFA advertises us. They put us in the Medicare handbook. We get lots of calls. It is just a matter of them understanding what our role is. Our name in California is confusing—the Health Insurance Counseling Advocacy Program—people think we sell insurance. So we have our own things to work out nationally as an organization, but I do believe that slowly, people are asking where is an ombudsman program, and they are saying, oh, there is one, and it is SHIP. It is just starting to come to the forefront as people get into the system and realize the help that they need, but we are all growing with it.

Senator REED. And you have the wherewithal to grow, both the financial resources, and are you projecting growth?

Ms. SCHOEN. We hope so. Senators Grassley and Breaux have asked for increased funding for us, and we certainly hope that that goes through. The State of California, of course, does fund us, and that is why we were bigger in our State, because they have been behind this for a long time. But we depend on our volunteers. If we did not have 750 volunteers, we would not be able to do what we are doing.

Senator REED. Let me ask you another question. When you look at these ombudsman programs, there is the argument that in the long run, or even in the short run, you actually save money for the plans by resolving issues quicker, by preventing long-term delay and actually getting treatment which would be necessary and appropriate and resolving the issue before more expensive treatment. Is that your experience, and can you document that?

Ms. SCHOEN. Absolutely. Our documentation probably is not as sophisticated as it should be, and I would be the first to say that. We are, as I said, kind of grassroots. But we help numerous times throughout the week with early hospital discharges, and that is fee-for-service Medicare as well as Plus-Choice. And we feel that when we help people with those appeals, and they get the adequate hospital stays, they are not showing up back in the hospital 2 weeks later with complications, adding to the burden of the Medicare system.

We are also great fighters of Medicare fraud, and people are coming forward and reporting that to us. So on both hands, we feel like we are trying to save Medicare money as well as Medicare beneficiaries.

Senator REED. Now, I would assume that this concept as you have seen it applied to the Medicare program would make perfectly good sense for the broader population of HMOs?

Ms. SCHOEN. I would love to know there is a program like ours for people of all ages, absolutely.

Senator REED. Thank you.

Let me ask Colonel Stringer and Ms. Watts, did you ever get the impression that people were deliberately trying to mislead you?

Mr. STRINGER. Well, I think the HCFA approach has been to let the HMOs market as vigorously as they are willing to do, because

the perception at the national level is that they are going to save more Medicare money for those who are not entering HMOs. And that is a good thing for everybody—in fact the congressional intent was clear, to try to drive down the Medicare costs. I think the question is what will the traffic bear, and that is where we are now.

Senator REED. So you can detect behind all the paperwork and so on the sense that the fewer people know and the less people ask for, the more money is saved, and therefore, this is incentive?

Mr. STRINGER. If the HMO had told me in advance what rights the HMO had to abandon me, I would never have joined. It is just too much stress to cope with the possibility that any moment, you could be dropped, and then you are helpless.

Senator REED. Ms. Watts.

Ms. WATTS. They could do that to me. I never realized they could drop me. They did drop the plan that I had, and when we went to them and talked to them in person at one of their famous meetings and asked, "What are you going to do with me now?" they said, "Well, we are thinking about it, we are talking about it." And nothing was ever done.

Senator REED. I believe in the GAO report, they cite different examples, and one example is where a plan was actually publishing an erroneous figure for the prescription benefit. Have you found those types of things?

Ms. WATTS. Oh, yes. They compete with each other, so they both came up to a higher allowance, much higher than I noticed in the article. I believe it is a $2,500 allowance for generic drugs, which is very helpful to my husband, because otherwise, it would cost us $600 a month.

My daughter used to work at the Rehabilation Hospital in Santa Barbara, and she asked me to particularly say we need a patients' bill of rights.

Senator REED. Thank you. How old is your daughter?

Ms. WATTS. She is 36 years old, and she worked at a very interesting hospital in Santa Barbara that dealt with seniors and stroke victims and so on.

Senator REED. So as a professional and also as a consumer, she feels that we need a patients' bill of right.

Ms. WATTS. She was a fundraiser and grant writer. She also helped me with this testimony.

Senator REED. Thank you. That is good testimony. And she is a speech writer, too?

Ms. WATTS. Yes. [Laughter.]

Senator REED. Thank you very much. You have a charming and talented and I am sure multifaceted daughter, and I appreciate that comment.

I want to thank the panel for your contribution today. It really does put a human dimension to this issue, and I think it will give us more energy in terms of trying to get the information out in a simple, understandable form, comprehensively, so that people can really take advantage of what they pay for—and what we pay for.

Thank you, Mr. Chairman.

Chairman GRASSLEY. Thank you, Senator Reed.

Senator Collins.

Senator COLLINS. Thank you very much, Mr. Chairman, and thank you for calling this very important hearing this afternoon.

As we all know, the Balanced Budget Act of 1997 greatly expanded Medicare beneficiaries' choice of health plans, and thanks in no small part to our chairman and our ranking minority member, there were provisions included, which I cosponsored, which were designed to ensure that what we have just heard happened would not happen. Those provisions were designed to provide Medicare beneficiaries with the information they needed to make informed choices among the competing health care plans, so I think it is a great disappointment to us to learn that so far, the best efforts, particularly of our Chairman and Ranking Minority Member, have been frustrated, or at least, not yet realized.

I am particularly concerned about this because in the State of Maine, we have a disproportionately elderly population, and thus this is of great concern to me. In Maine, we have only one HMO serving Medicare beneficiaries at this point, so my hope is that before Medicare+Choice managed care penetrates Maine further, that we can straighten out all of these problems that you have helped us better understand today.

I do appreciate all of your testimony as well, and I do have a formal statement, Mr. Chairman, that I would like to put in the record if I may.

Chairman GRASSLEY. Without objection, it will be received.

[The prepared statement of Senator Collins follows along with the prepared statement of Senator Craig:]

PREPARED STATEMENT OF SENATOR SUSAN COLLINS

Mr. Chairman, thank you for calling this afternoon's hearing to discuss two crucial related issues. One is the quality of the information that managed care plans distribute to Medicare beneficiaries detailing their rights and options. The other is what the Health Care Financing Administration should be do to ensure that this information is clear, complete, and reliable.

The Balanced Budget Act of 1997 greatly expanded Medicare beneficiaries' choice of health plans with its creation of the Medicare+Choice program. Thanks in no small part to the Chairman and Ranking Minority Member of this Committee, the BBA also included provisions designed to provide Medicare beneficiaries with the information they need to make informed choices among competing health plans in the Medicare+Choice program.

The Balanced Budget Act requires the Health Care Financing Administration to provide beneficiaries with basic comparative information about plan benefits, premiums and out-of-pocket costs. However, for detailed information about their rights and benefits under a specific managed care plan, Medicare beneficiaries must rely upon the materials developed by the plan. Strict HCFA oversight is therefore critical to ensure that these communications are complete, correct, and understandable.

This is increasingly true as more and more Medicare beneficiaries are attracted to these new options. In the last three years, Medicare managed care enrollment has nearly doubled, and today, approximately 7 million of Medicare's 39 million beneficiaries—more than 17 percent—have enrolled in managed care plans.

It simply does not make sense to provide a dazzling array of new options for beneficiaries without making sure that they have the information they need to navigate the system and make the right health plan choice for their health care needs. HCFA has both the authority and the responsibility to approve all of the information distributed by health plans. Because the agency's leadership in this area is so critical, the testimony from our first panel of witnesses this afternoon troubles me deeply. So does GAO's finding that HCFA's oversight has fallen short of the mark and has not guaranteed the accuracy and completeness of the materials that Medicare beneficiaries rely on for important information about their benefits and appeal rights.

These are critical issues for our Nation's Medicare beneficiaries, and I look forward to working with the Administration and the Members of the Special Committee on Aging to find ways to resolve them.

PREPARED STATEMENT OF SENATOR LARRY CRAIG

I would like to thank the chairman for holding this hearing today regarding Medicare managed care marketing materials. I would also like to thank each of the witnesses for taking the time to appear before the committee to testify.

Medicare+Choice builds on the existing Medicare program, which allows health maintenance organizations (HMOs) to enter into risk contracts with the Health Care Financing Administration. Under Medicare+Choice, Medicare beneficiaries have the opportunity to choose from a variety of private health plan options and the health care plan that best suits there needs and preferences.

The Health Care Financing Administration provides guidelines for marketing material language to each of the managed care organizations with whom they contract. However, these guidelines are only suggestions. HCFA' review process does not ensure the plan information provided to the beneficiary is complete and offers sufficient guidance.

Today, we are here to explore whether the HCFA review process contributes or fails to contribute to beneficiaries understanding of their coverage options and of their rights and responsibilities under the Medicare Program.

It is crucial that Medicare beneficiaries have a clear understanding of the managed care system, not only prior to entering into the contract with the health maintenance organization, but after enrollment as well.

Again, I would like to thank the Chairman and our panel of witnesses here today. The insight you provide will be of great assistance to us as we focus our attention on what the necessary steps are to ensure that Medicare beneficiaries receive quality information which they can use to make informed health care decisions.

Thank you.

Senator COLLINS. Ms. Schoen, you mentioned in your testimony that some providers have been hesitant about referring their patients to you or exercising the appeals process, and they have actually been discouraged in some cases from filing an appeal on behalf of a patient. And when Ms. Watts was talking about that, she fortunately had the determination and the energy to go forward with her appeal. It struck me that you have identified a potentially very serious problem because some Medicare beneficiaries, particularly if they are struggling with a serious illness, are just not going to have that determination to appeal and will need to rely on the provider to carry that burden for them, or your office and the other SHIP programs.

Are you aware of any situations in which providers have actually said to you that they were reluctant to appeal? Aren't there protections in the Medicare law or in the Balanced Budget Act that should prevent this kind of situation? Do we need to do more in this area?

Ms. SCHOEN. Yes. I am not sure how we can. It is so subtle. The provider that I mentioned that was filing the appeal wanted to file the appeal and was told by the medical group not to get involved. This really took us aback, but then he went ahead and did file the appeal because he felt so strongly that she needed the surgery. And I am not sure if anything happened as far as repercussion.

In Orange County, the capitation rate is very good. It is almost $600 a month per beneficiary, with the HMO taking what we guesstimate as about 20 percent of the top and then trickling the moneys down to the different organizations. We understand the physicians receive anywhere from $30 a month or so per patient, so it is good business. But then, access to the specialist dips into that money.

We would love to know more about how that system works or how it is set up. It is very vague and elusive to us. And when we have talked to HCFA from time to time about why can't it be that

only a certain amount of money can be used for a budget for advertising, and so much has to go into patient care, and CEOs only get so much of a their salary out of this—when we ask why that cannot be done, they say, well, once HCFA do that contract, it is their money to trickle down as they see fit as long as they provide services to the Medicare beneficiaries, and I do not quite understand that.

So maybe something along those lines, where it did not make it such an incentive not to provide the service, if there were a better way of distribution. I do not know. I am not an economist by any means.

Senator COLLINS. Is the underlying fear that the health care provider's contract with the HMO would be jeopardized if they represent their patients in an appeals process or trigger appeals too often?

Ms. SCHOEN. Yes, I feel so. A woman called me—we have a bankruptcy now of a big medical group in our county, and we were contacted and told that two women who needed ambulance transportation were not going to be transported. They were told that that could not be done for them. Then she called me back and said, "I am sorry I reported that. It was not necessary. My supervisor tells me now that I reported to you, there will be repercussions."

And I said no, there would not be. We talked to HCFA about trends and things that we see, but HCFA does not have time to hear all the individual cases, and we do not call HCFA on the phone for each individual case. But there is a perception that they will not get referrals if we are involved.

Senator COLLINS. That is very troubling to me for just the reason that Ms. Watts outlined.

Mr. Mulholland, you talked about the difficulty that HCFA has had in reviewing these contracts. How high a priority did HCFA place on a careful review? Was there training done of the regional offices? Was this emphasized as an important responsibility?

Mr. MULHOLLAND. I think the answer to that is to say it would be the very top priority of especially new contracts. That is what the staff spent most of its time on. And second, they spend time on what they call annual reviews or periodic reviews, going back once the HMO is in operation to see whether they are really operating under their contract, and that takes a lot of person power.

The predominant training would be on-the-job training, usually with one or two senior people on the staff. I do not know how it is now, but when I retired, the central office had gone a long way in designing periodic, concentrated central office training for new people and refresher training. I started out with Social Security, and they had tremendous training for new entries into the organization, but they would all come in a class. But in HCFA, people do not come in a class. They come in individually, today, tomorrow, the next day, and so on, so it is hard to have that done in a formal fashion. But they were really doing a good beginning when I retired, and I do not know what the situation is now, but most of it was on-the-job training.

Senator COLLINS. We will follow up with HCFA on that issue.

My time has expired, but I have just one final comment. I think it is interesting that both Mr. Mulholland and Mr. Stringer have

talked about their good experiences with HMOs in different settings. That suggests to me that we need to be careful to distinguish among those HMOs that are doing it right, that are providing the information that is needed and the care that is promised, from those that are not. And we can certainly learn from the experience of those HMOs that are doing it right, that are providing beneficiaries, whether in the private sector or in Medicare or in other programs such as our programs, with the information we need to make informed choices, and certainly all HMOs should be held to that standard.

Thank you, Mr. Chairman.

Chairman GRASSLEY. Thank you, Senator Collins.

We are not going to have a second round of questions because we will keep our second panel too late. But as Senator Reed said, real life experiences are very important, because you are where the rubber meets the road as far as our national policy is concerned. So we thank you for your testimony, and as I indicated, there might be some questions in writing, and we would appreciate your cooperation in that.

Thank you all very much.

Chairman GRASSLEY. Now I would like to introduce our second panel. The first witness is Carol Cronin, who is director of the Center for Beneficiary Services at HCFA. Previously, Ms. Cronin served as senior vice president for Health Pages, a New York City-based consumer health magazine, which is also an online service providing community-specific comparative information about doctors, hospitals, health plans and other providers through partnerships with major newspapers and large employers. In this position, she also oversaw the collection and presentation of commercial and Medicare managed care information. In the past, Ms. Cronin has served as part-time executive director of Managed Health Care Association. She will discuss HCFA's process for reviewing Medicare+Choice marketing materials and explain how HCFA communicates beneficiary rights and responsibilities under the Medicare+Choice program.

Second, we have Dr. Scanlon with us again. We can hardly have a hearing without him, and we appreciate very much the help of his organization. Dr. Scanlon is director for Health Financing and Systems Issues at the U.S. General Accounting Office, and he will give us an overview of HCFA's process of reviewing Medicare+Choice plan materials. He will also recommend ways to improve HCFA's review process of these materials. The GAO reports on HCFA's review of plans' marketing materials and the appeals process, as I said in my opening statement, are being released at this hearing today. We thank Dr. Scanlon for moving that process along so we could have this hearing.

We will start with Ms. Cronin. Thank you very much for being here.

STATEMENT OF CAROL CRONIN, DIRECTOR, CENTER FOR BENEFICIARY SERVICES, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Ms. CRONIN. Thank you. Chairman Grassley, Senator Breaux, distinguished committee members, thank you for inviting me to discuss oversight of Medicare+Choice plan marketing and appeals.

I would also like to thank the GAO for its constructive report which will help us improve enforcement in these two important areas. I also want to note that I have quite a few staff here, and we were listening very carefully, and we want to thank the witnesses on the previous panel as well, because we take very seriously the issues that they raise.

We agree with all the Senators' opening statements that beneficiaries must receive accurate information about benefit rules and appeal rights. This is something that I have spent, as you indicated, quite a bit of my time over the last several years working on, and I cannot emphasize enough the importance of the information being accurate.

We are striving to meet this objective with our National Medicare Education Program. The testimony given this afternoon makes it quite clear, and these charts will probably indicate as well, that we need to do more, and we are doing more.

First of all, we are very interested in investigating the violations identified in the GAO reports and taking appropriate action.

Other things that we are doing relevant to the topic—we are developing a new system to monitor beneficiary appeals at the plan level. We have never done this before. We have never standardized the way in which HMOs collect information about the appeal before it gets to the external appeal vendor, so we are starting to standardize in that area. I want to emphasize that the notion of standardization will recur through most of my comments.

We are also going to be working on some unfinished business around Medicare appeals in terms of how beneficiaries must be notified that services are being reduced or discontinued. A part of our regs addressed the appeals, but there was some unfinished business, and that is part of it.

As indicated in the GAO report, we will as part of our oversight, sample denied claims that were not appealed. Currently, in terms of our oversight, we look at claims that were appealed, but we fully agree with the suggestion that we look at claims that were not appealed to assure that plans are properly notifying beneficiaries of appeal rights.

We are also making further revisions to our protocol for monitoring plans to specifically address whether appeals are handled properly.

As of January 1, 2000, we are requiring plans to provide beneficiaries upon request with a wide range of information including the number of appeals filed, the number decided in beneficiaries' favor, and the timeliness of the process. We think that this and other information will help us better monitor plan performance and motivate plans to improve responsiveness. We are also going to be starting a survey of beneficiaries, or continuing our activities around survey, but looking specifically at beneficiaries who disenroll to better understand the extent to which any issues around

misleading marketing materials might in fact have influenced their decision to enroll and then their subsequent decision to disenroll because it is not what they thought it was.

For marketing materials, we will no longer assume that plans have made required changes without seeing the corrected documents themselves. This was another very specific finding of the GAO.

We are also looking—and this addresses some of Mr. Mulholland's comments—to implement a pilot project to test whether centralized review of marketing materials by an independent contractor will improve the process. That is something that we have been working on for a while, possibly when Mr. Mulholland started at HCFA, but we are actually implementing that pilot now.

Senator Breaux referred to the Summary of Benefits. This is the result of a lot of work since last year and since the direction of this committee to try to develop a piece that would, hopefully in simple English, give some basic information in a standardized format, kind of key information about the plan, and then go through a standardized way of describing the benefits, leaving at the end, the last couple of pages at the end, an opportunity for plans to put in more customized features. So we do allow some opportunity for customization, but the rest of it is standardized.

I might also add that per the Senate Aging Committee's desires, we are also looking now at standardizing the rest of the marketing materials that beneficiaries will receive, the evidence of coverage and other types of materials, so that in fact, hopefully, this time next year, we will be able to show you other examples of standardized marketing materials.

I want to emphasize that this is a draft. We want to focus group test this with beneficiaries to make sure that it is in fact understandable, and we also want to make sure that we get public comment on it as well.

We are also working on standardizing a lot of other materials, and particularly relevant to the former panel, we are going to be standardizing the denial notice that beneficiaries receive so that in fact it will be quite clear what their rights are, why they were denied and what they are supposed to do next.

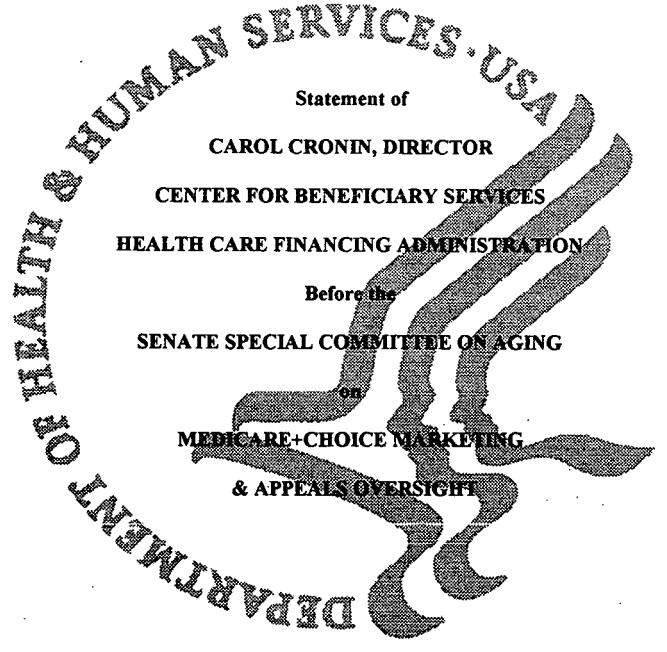
One thing that is going to be helping us in all of this is that we are also standardizing the way in which we collect information from the plans, so at the front end of this whole process, we are standardizing our data collection, and that will allow us to standardize information in some of the information materials that we conduct through the National Medicare Education Program.

There is more we can talk about, and I would be happy to answer questions on this. I think it is fair to say that we take this very seriously. We are working to address marketing and appeals problems, and we appreciate the committee's leadership, and you have provided leadership in this area, and the GAO's important work in pinpointing needed improvements.

Thanks very much.

Chairman GRASSLEY. Thank you.

[The prepared statement of Ms. Cronin follows:]



Statement of

CAROL CRONIN, DIRECTOR

CENTER FOR BENEFICIARY SERVICES

HEALTH CARE FINANCING ADMINISTRATION

Before the

SENATE SPECIAL COMMITTEE ON AGING

on

MEDICARE+CHOICE MARKETING

& APPEALS OVERSIGHT

April 13, 1999

HCFA
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Health Care Financing Administration

TESTIMONY OF
CAROL CRONIN, DIRECTOR
CENTER FOR BENEFICIARY SERVICES
HEALTH CARE FINANCING ADMINISTRATION
on
MEDICARE+CHOICE MARKETING AND APPEALS
before the
SENATE SPECIAL COMMITTEE ON AGING
April 13, 1999

Chairman Grassley, Senator Breaux, distinguished committee members, thank you for inviting me to discuss oversight of Medicare+Choice plan marketing and response to beneficiary appeals of care denials. I would also like to thank the General Accounting Office (GAO) for its reports, which will help us improve enforcement of requirements for plans in these two important areas.

Managed care and the other types of private insurance plans that comprise Medicare+Choice are important as voluntary options along with original fee-for-service Medicare. We are committed to ensuring that Medicare+Choice continues to grow and flourish. For Medicare+Choice to succeed, beneficiaries must receive accurate information about plan benefits, rules, and rights to appeal denials of coverage. We are striving to meet this objective with our National Medicare Education Program. It is incumbent upon health plans, as our partners in this effort, to work with us to ensure that beneficiaries receive accurate information. However, as the GAO reports make clear, misinformation and abuses in marketing and of beneficiary appeal rights have not been adequately addressed.

In 1997 and 1998, the Health Care Financing Administration (HCFA) issued managed care marketing guidelines and established the strongest appeal rights for managed care beneficiaries anywhere in the country. However, the new GAO reports make clear that we must do more to ensure that beneficiaries receive accurate information about their rights and options.

First, we must send a loud and clear message to the industry that we are taking enforcement very seriously. We will start by investigating the violations identified by the GAO and impose sanctions where appropriate.

Today, I am announcing that we are taking several additional steps to strengthen oversight and enforcement, many of which are already underway.

- We will no longer assume that plans have made required changes without seeing the corrected documents ourselves.
- We will soon implement a pilot project to determine whether centralized review of marketing materials by an independent contractor will improve the process. Our expectation is that centralized review by fewer people will result in more uniform decisions, and that use of an independent contractor will provide HCFA staff with more time for other oversight activities. We have already let a contract and selected 12 plans to participate in this demonstration, which we expect to begin soon.
- We are well on our way to implementing standard formats and language for use in the Summary of Benefits documents that plans provide to beneficiaries. This action was recommended to us by this Committee last year, and we believe it will enable beneficiaries to make apples-to-apples comparisons among plans more easily. We expect to release a draft for public comment this Spring, and will require plans to use the standardized Summary of Benefits in time for this Fall's open enrollment season.
- We will be consumer testing model language for enrollment, appeals, and care denial forms. Once we are sure that this model language is clear and helpful to beneficiaries, we will require that standardized forms be used by plans.
- We are moving to require plans to use a standardized format for submitting the detailed information about benefits, premiums, and cost-sharing. This is the information that we use to review the accuracy of marketing materials and the financial soundness of benefits packages. The new format will reduce the need for separate data collection and verification efforts. It will help flag plan policies that violate Medicare policy, for example, requiring a referral for mammography. And it will make it easier for the independent contractor that hears beneficiary appeals to make judgments based on a clear, standardized description of plan benefits and rules.
- We are defining requirements for a new system to monitor appeals at the plan level, which until now have never been tracked by HCFA.

- We require that all denial notices be in writing, include a detailed explanation of why care does not meet coverage criteria, and explain enrollee appeal rights.
- We will issue a proposed regulation detailing when and how beneficiaries must be notified that services, such as skilled nursing facility care, are being reduced or discontinued by the plan.
- And we are revising our protocol for monitoring plans to specifically address whether a plan and its provider groups handle appeals as required.

Marketing

An important information tool that Medicare beneficiaries use when choosing Medicare+Choice plans is called the Summary of Benefits. In the past, plans have been given wide discretion in developing their particular plan benefit descriptions. As a consequence, the material provided to beneficiaries has varied widely from plan to plan in format, content, and terminology. As this Committee has pointed out, this variation has made it difficult for beneficiaries to make easy comparisons of benefits offered by different plans.

To address this variation, we have been working in consultation with beneficiary advocacy groups, the health plan industry, State regulators, and the Federal Trade Commission to develop a standardized plan benefit document. This new standardized document will govern coverage and benefit information and materials distributed to beneficiaries by managed care plans. It will be based on a universal, menu-driven template that allows health plans to choose from a list of items applicable to its offerings. The form will contain three main sections:

- a beneficiary information section, providing information on the Medicare managed care program in general terms;
- a benefit comparison section informing beneficiaries of the benefits offered as compared to original, fee-for-service Medicare; and
- a special features section where plans may provide additional information, such as provider network information, clinic location maps, graphics, etc.

Beginning with the November 1999 open enrollment period, all Medicare+Choice plans will be required to use this standardized format when describing or comparing their benefits in marketing activity. We expect to distribute the new standardized format to all plans by the end of May 1999, after which we will conduct training sessions on how to use the format.

In addition, after consulting with beneficiary groups and plan representatives, we will require standardization of other beneficiary notification materials, including enrollment application forms and materials related to complaints. We anticipate that these new standardized materials will be ready for use in the Fall of 2000 for the annual beneficiary education campaign.

Currently, review of plan marketing materials is conducted primarily by staff in HCFA's ten regional offices across the country, in coordination with HCFA's central office in Baltimore. We share the concern of the GAO and the managed care industry regarding the inconsistency in our marketing review decisions and our interpretations of national marketing regulations and guidelines. We are aware that the subjectivity of different regional office reviewers has in the past led to different approval or rejection determinations by multiple reviewers on identical, or nearly identical, marketing materials. In addition, local market operational factors that affect health plans and regulators at the local level have influenced the reviewers' interpretation of regulations. Our review process must be improved so that conflicting review of plan materials is minimized and consistency and uniformity in decision-making is maximized.

One key step in improving the current process is to revise how plans transmit the plan benefit information to HCFA at the outset. In the past, such information has been supplied by the plans in multiple formats and with non-standardized terminology to describe the benefits provided by the plan. This has made it difficult for HCFA review staff to determine the actual type and scope of benefits provided by the plans.

As mentioned above, to address the inconsistency in the information provided by plans and the reviews conducted by HCFA staff, we have developed a new standardized form for plans to use in

providing detailed descriptions of their benefit package to us. This new form will provide us with more detailed benefit information in a standard format, using standard terminology to facilitate a more accurate and consistent review of marketing materials. This standardization promotes our goal of providing beneficiaries with accurate information with which to make health plan decisions by assisting our review staff in determining whether plan marketing material complies with current Medicare law, and ensuring that plans are indeed providing the benefits they are marketing to beneficiaries.

Furthermore, the new standardized format will assist our independent contractor that hears appeals which have been rejected by plans to more quickly and accurately adjudicate beneficiary appeals. When beneficiary coverage disputes arise, the standardized format will allow the independent contractor to readily determine the scope of the plan's benefit package, as well as any exclusions or fees associated with the disputed benefit or coverage decision.

We anticipate that the new standardized form for transmitting benefit information will be fully implemented in 2001, as recommended by the GAO.

In addition to steps mentioned above, we are taking the following steps to further improve our plan marketing review process:

- directing our Medicare Managed Care Marketing Product Consistency Team, which includes representatives from HCFA's ten regional offices and our central office, to review and actively address the GAO findings;
- requiring annual training sessions for HCFA staff engaged in Medicare managed care marketing review activities whenever new marketing policies are implemented; and
- updating the Medicare Managed Care National Marketing Guide, in consultation with the managed care industry and beneficiary advocacy groups, for use in the marketing material review process.

We recognize and acknowledge the importance of establishing standard formats and common language for all managed care appeal-related information.

- Recently, we gave all managed care plans model language for the Notice of Discharge and Appeal Rights form issued by plans. This notice informs all beneficiaries in inpatient hospital settings of their appeal rights when they are discharged from the facility.
- We are developing model language for service and payment denial notices issued by plans, and are requiring that the denials be made in writing by the plan and explain in detail why the care does not meet the plan's coverage criteria.
- And, in collaboration with the regional offices, we have developed model language for enrollment letters and forms sent to enrollees by managed care plans. This model language will ensure that plans meet all of our enrollment notification requirements when they distribute this information to eligible enrollees.

This model language is currently undergoing consumer testing. Once refinements are made to the language and we are confident that the language is understandable to beneficiaries, we will require all plans to use this standard language.

Appeals

Effective and efficient systems to appeal managed care plan coverage denials are essential. The Clinton Administration has made appeal rights for Medicare+Choice beneficiaries among the strongest for any managed care enrollees in the country, and it is incumbent upon us to ensure that these rights are enforced. Since August 1997, plans have been required to:

- respond within 72 hours on appeals of care denials that could jeopardize life, health, or ability to regain maximum function;
- respond within 30 days to all other appeals of service denials;
- state the reasons for a denial in writing;
- use denial notice forms that describe beneficiary appeal rights;
- accept oral requests for expedited appeals;
- follow up verbal notifications in writing within two working days;
- grant automatically all physician requests for expedited appeals; and

- maintain logs and periodically report on requests for expedited appeals.

Since the federal government is the largest purchaser of managed care, our expedited appeals regulation for urgent care cases set a new, higher standard for the entire managed care industry.

All appeals rejected by plans are automatically forwarded to our independent appeals contractor for independent review, with no monetary threshold or other barrier. This independent contractor, currently the Center for Health Dispute Resolution, is also required to act on expedited appeals within 72 hours, and within 30 days for all other service denials.

Beneficiaries have up to 60 days to appeal decisions of the independent review process to the Department of Health and Human Services Administrative Law Judges. These appeals must involve at least $100, and there is no time limit on Administrative Law Judge action. Beneficiaries have up to 60 days to request a review of Administrative Law Judge rulings by the Department of Health and Human Services Appeals Board. Finally, beneficiaries have up to 60 days after an Appeals Board decision to request federal district court review for cases involving at least $1000.

Medicare+Choice beneficiaries are informed of their appeal rights at the time of initial enrollment, upon every denial of service or payment, in notices provided when they are admitted and discharged from hospitals, in the annual *Medicare & You* handbook, and in the detailed description of benefits plans provide known as the Evidence of Coverage. Enrollees also can get information by calling our toll-free telephone service at 1-800-MEDICARE (1-800-633-4227).

Medicare also provides extensive appeal rights in fee-for-service, where most appeals are filed by providers. But managed care appeals are essential to beneficiaries because the incentives are so very different and denials come before, rather than after, care is delivered. Beneficiaries must be confident that managed care incentives to reduce unnecessary care will not be allowed to limit appropriate care, and we are committed to strengthening and refining the Medicare+Choice appeals system as appropriate.

The GAO report highlights areas where the Medicare+Choice appeals system can be refined and our oversight strengthened. We generally concur with the report's recommendations and will work to implement them.

Our beneficiary research tells us that the vast majority of beneficiaries are satisfied with the care Medicare+Choice plans provide, and have never filed appeals. Until now we have not gathered statistics on appeals at the plan level. We do know now that in 1998, with more than 6 million beneficiaries in managed care plans, our independent appeals contractor reviewed only 14,745 cases. Of these, 22 percent were decided in the beneficiary's favor. We recognize that the appeals process will become more important when beneficiaries, under the Balanced Budget Act, are no longer allowed to disenroll from plans on a monthly basis.

We are now requiring plans to collect data and, as of January 1, 2000, report to beneficiaries the number of appeals filed, the number decided in beneficiaries' favor, and the timeliness of the process. We will be collecting this and other appeals data ourselves, including:

- how many cases are resolved at the plan level;
- the average and maximum length of time each plan takes to resolve appeals;
- the percentage of plan rulings that occur within the mandated time frames;

This and the other information we will collect will help us:

- better monitor plan performance;
- motivate plans to improve responsiveness;
- determine whether any new plan standards need to be set or any specific interventions warranted to improve the system;
- understand the types of services being appealed;
- ensure that beneficiaries have full access to and understanding of their appeal rights; and
- target specific beneficiary groups who may need additional assistance in understanding their appeal rights.

We are surveying beneficiaries who have disenrolled from a Medicare+Choice plan to better

understand the extent to which care denials and improper appeals procedures may be involved in decisions to disenroll from plans. We should have our first report of the findings by mid-2000. We also are testing a process whereby beneficiaries can request a disenrollment from via Medicare's toll-free help line, 1-800-MEDICARE (1-800-633-4227), and this will also allow us to ask beneficiaries directly why they are leaving a plan at the time they are leaving. This should provide another helpful way to monitor potential problems with plan appeals information.

We are planning to sample denied claims for further review to ensure that plans are implementing their internal processes in the required manner. Our June 1998 Medicare+Choice regulation makes explicit that plans themselves are ultimately accountable for their appeals processes, regardless of whether they are handled by a subcontractor. And we are considering regulations to establish a standard grievance procedure to ensure consistency among all Medicare+Choice organizations.

CONCLUSION

Medicare beneficiaries and those who help them make decisions about their health plan options need and deserve accurate, reliable information. We are doing a great deal to address problems with marketing and appeals identified in the GAO reports. And we will ensure that beneficiaries receive clear and accurate information about the rights and options in the Medicare+Choice program. We appreciate this Committee's leadership in this area, and the important work that our colleagues at the GAO have done in pinpointing aspects of our program that need improvement.

D R A F T M O C K U P

VICTORY
HEALTH PLAN

Summary of Benefits
2000

VICTORY HEALTH PLAN

This Summary of Benefits is meant to highlight some of the important aspects of the Victory Health Plan. It should not be used as a complete listing of your health care coverage under this plan. To help you compare Victory Health Plan with Original (Fee-for-Service) Medicare, we're giving you some information on the benefits that Original Medicare covers and what we cover.

The Medicare Program allows you to choose among different Medicare options. You may choose Original Medicare or you may choose to enroll in a Medicare + Choice plan. You make the decision. No matter what you decide, you are still in the Medicare program.

We are Victory Health Plan, a Medicare + Choice HMO, offered by Victory Services, Inc. We offer the same benefits that Original Medicare offers. We also offer additional benefits, which may change from year to year. If you are thinking of joining Victory Health Plan, there are a few things you need to know:

- ★ In most cases, to get benefits under our health plan, you must get care from the doctors, specialists and hospitals in our network.
- ★ The doctors, specialists and hospitals in our network may change during the year.
- ★ You may have to pay for the services that are not arranged for or provided by Victory Health Plan. Original Medicare and Victory Health Plan may not pay for those services.
- ★ If you have or are eligible for employer group coverage, you should talk to your employer before making a decision.
- ★ If you have Medicare supplemental insurance that fills gaps in Original Medicare, you may not need it if you join Victory Health Plan. You should carefully consider what you need before making a decision, because you may not be able to get this supplemental insurance back if you drop it.
- ★ You have the right to appeal a denial of services. If a service is denied, you will receive a detailed explanation from us.

The service area for this plan is: Baltimore City, Baltimore County, Howard County, Carroll County and Anne Arundel County.

If you have special needs, this Summary of Benefits may be available in other formats.

Please call Victory Health Plan at 1-888-123-4567 (TTY 1-877-987-6543) for more information.

For more information on Medicare health plans, please call 1-800-633-4227 (TTY 1-877-486-2048).

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
PREMIUM	★ You pay the Medicare Part B premium of $45.50. NOTE: This is the 1999 amount and may change January 1, 2000.	★ You pay $30 for each month. ★ You also pay the Medicare Part B premium.
DOCTOR AND HOSPITAL CHOICE (See below for Emergency and Urgently Needed Care)	★ You may go to any doctor, specialist or hospital that accepts Medicare.	In most cases: ★ You must go to plan doctors, specialists and hospitals. ★ You need a referral to go to non-plan doctors, specialists or hospitals. ★ You need a referral to see plan specialists.
DOCTOR OFFICE VISITS	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $5 for each primary care doctor office visit. ★ You pay $10 for each specialist office visit.
OUTPATIENT MENTAL HEALTH CARE	★ You pay 50% of Medicare approved charges; annual deductible applies.*	★ You pay $20 for each individual visit. ★ You pay $10 for each group visit.
OUTPATIENT SUBSTANCE ABUSE CARE	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $20 for each individual visit. ★ You pay $10 for each group visit.

* Each year, you pay ONE $100 deductible. If your doctor does not accept assignment from Medicare, you pay any charges up to 115% of the Medicare approved amount.

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
OUTPATIENT SURGERY	★ You pay 20% of Medicare approved charges for the doctor; annual deductible applies.* AND ★ You pay 20% of outpatient facility charges; annual deductible applies.*	★ You pay $25.
EMERGENCY ROOM CARE (You may go to any emergency room)	★ You pay 20% of the facility charge for each emergency room visit; you do not pay this amount if you are admitted to the hospital within 1–3 days of the emergency room visit; annual deductible applies.* AND ★ You pay 20% of doctor charges; annual deductible applies.* ★ Not covered outside the U.S. except under limited circumstances.	★ You pay $30 for each emergency room visit; you do not pay this amount if you are admitted to the hospital for the same condition. ★ Not covered outside the U.S. except under limited circumstances.
URGENTLY NEEDED CARE (Not emergency room care, and in most cases out of Service Area)	★ You pay 20% of Medicare approved charges; annual deductible applies.* ★ Not covered outside the U.S. except under limited circumstances.	★ You pay $10 for each visit at the doctor's office. ★ You pay $25 for each visit at the urgent care facility. ★ Not covered outside the U.S. except under limited circumstances.
AMBULANCE SERVICES (Medically necessary ambulance services as described in Medicare guidelines)	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $15 for each ride in an ambulance; you do not pay this amount if you are admitted to the hospital.

* Each year, you pay ONE $100 deductible. If your doctor does not accept assignment from Medicare, you pay any charges up to 115% of the Medicare approved amount.

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
DURABLE MEDICAL EQUIPMENT (includes wheelchairs, oxygen, etc.)	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $50 for oxygen each year. ★ You pay $130 for each wheelchair. ★ You pay 20% for each other item of durable medical equipment.
PROSTHETIC DEVICES (includes pacemakers, braces, artificial limbs and eyes, etc.)	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $100 for each pacemaker. ★ You pay 20% for each other prosthetic device.
DIAGNOSTIC TESTS AND X-RAYS	★ You pay 20% of Medicare approved charges except for approved lab services; annual deductible applies.* ★ You pay $0 for Medicare approved lab services.	★ You pay $10 for each diagnostic test. ★ You pay $10 for each X-Ray. ★ Office visit copayment may apply.
RADIATION THERAPY	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $0 for each visit.
MANUAL MANIPULATION OF THE SPINE (to correct subluxation as shown by x-ray, provided by chiropractors or other providers)	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $10 for each visit.
MEDICALLY NECESSARY FOOT CARE	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $10 for each visit.

* Each year, you pay ONE $100 deductible. If your doctor does not accept assignment from Medicare, you pay any charges up to 115% of the Medicare approved amount.

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
OUTPATIENT REHABILITATION SERVICES ★ Occupational Therapy ★ Physical Therapy ★ Speech and Language	★ You pay 20% of Medicare approved charges; annual deductible applies.* ★ You pay 20% of the first $1,500 for all physical therapy and speech and language services and 20% of the first $1,500 for all occupational therapy services, and 100% of all charges thereafter.[1] (Hospital outpatient therapy services do not count towards the $1,500 limit.)	★ You pay $10 for each visit.
INPATIENT CARE		
INPATIENT HOSPITAL CARE (includes Substance Abuse and Rehabilitation Services)	You pay for each benefit period:[1] ★ Days 1–60: an initial deductible of $768 ★ Days 61–90: $192 each day ★ Days 91–150: $384 each lifetime reserve days[2] **NOTE:** These are 1999 amounts and may change January 1, 2000.	★ You pay $100 for each hospital stay up to $200 each year.

[1] A benefit period begins on the first day of admission to a hospital and ends when you have been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row. Benefit days are renewable.

[2] Lifetime reserve days can be used only once.

* Each year, you pay ONE $100 deductible. If your doctor does not accept assignment from Medicare, you pay any charges up to 115% of the Medicare approved amount.

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
INPATIENT MENTAL HEALTH CARE	★ You pay the same initial deductible and copayments as inpatient hospital care (page 6) except there is a 190-day lifetime limit. ★ There is a 190-day lifetime limit.	★ You pay $100 for each hospital stay up to $200 each year. ★ You pay $15 for each hospital day up to $300 each year. ★ 190-day lifetime limit does not apply.
SKILLED NURSING FACILITY (in a Medicare-approved skilled nursing facility)	You pay for each benefit period[1], following at least a 3-day hospital stay: ★ Days 1–20: $0 for each day ★ Days 21–100: $96 for each day ★ There is a limit of 100 days for each benefit period. **NOTE:** These are 1999 amounts and may change January 1, 2000.	★ You pay $0 for days 1–100. ★ You pay $30 each day for days 100 and on. ★ 3-day prior hospital stay is not required.
HOME HEALTH CARE (includes skilled nursing care, home health aide services and rehabilitation services, etc.)	★ You pay $0 for all covered home health visits.	★ You pay $0 for all covered home health visits.
HOSPICE	★ You pay limited cost sharing for outpatient drugs and inpatient respite care.	★ You may pay limited cost sharing for outpatient drugs and inpatient respite care.

[1] A benefit period begins on the first day of admission to a hospital and ends when you have been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row. Benefit days are renewable.

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
PREVENTIVE SERVICES		
ANNUAL SCREENING MAMMOGRAMS	★ You pay 20% of Medicare approved charges; annual deductible does not apply.*	★ You pay $0. ★ No referral necessary.
PAP SMEARS AND PELVIC EXAMS	★ You pay $0 for the Pap Smear once every 3 years unless high risk. ★ You pay 20% of Medicare approved charges for Pelvic Exam; annual deductible does not apply.*	★ You pay $0 for the Pap Smear each year. ★ You pay $0 for the Pelvic Exam for 1 exam each year. ★ No referral necessary for plan providers.
BONE MASS MEASUREMENT	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $10 for 1 exam each 2 years. ★ No referral necessary for plan providers.
COLORECTAL SCREENING EXAMS	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $10 for 1 exam each 2 years. ★ No referral necessary for plan providers.

* Each year, you pay ONE $100 deductible. If your doctor does not accept assignment from Medicare, you pay any charges up to 115% of the Medicare approved amount.

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
PROSTATE CANCER SCREENING EXAMS	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $10 for 1 exam each 2 years. ★ No referral necessary for plan providers.
DIABETES MONITORING (includes coverage for glucose monitors, test strips, lancets and self-management training)	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $10 for 1 exam each 2 years. ★ No referral necessary for plan providers.
IMMUNIZATIONS		
★ *Pneumococcal pneumonia vaccine*	★ You pay $0.	★ You pay $0. ★ No referral necessary.
★ *Flu vaccine*	★ You pay $0.	★ You pay $0. ★ No referral necessary.
★ *Hepatitis B vaccine* (for those at risk of contracting the disease)	★ You pay 20% of Medicare approved charges; annual deductible applies.*	★ You pay $0. ★ No referral necessary.

* Each year, you pay ONE $100 deductible. If your doctor does not accept assignment from Medicare, you pay any charges up to 115% of the Medicare approved amount.

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
ADDITIONAL BENEFITS		
OUTPATIENT PRESCRIPTION DRUGS	★ You pay 100% for most prescription drugs.	For prescription drugs on plan approved list (formulary), you pay for each prescription or refill: ★ $5 for generic drugs up to a 31 day supply. ★ $8 for brand name drugs up to a 31 day supply. ★ $10 for mail order generic drugs up to a 90 day supply. ★ $16 for mail order brand drugs up to a 90 day supply. There is a $600 limit each year for generic drugs. There is a $400 limit each year for brand name drugs. You are not covered for prescription drugs NOT on plan approved list (formulary).

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
OUTPATIENT PRESCRIPTION DRUGS (cont'd)		Note about dollar limits: ★ Any unused amounts cannot be carried forward to the next year. Call Victory Health Plan to find out how we determine drug costs that count towards these limits. ★ You must use designated pharmacies. ★ There may be additional restrictions on your drug benefit. Please call Victory Health Plan for details.
ROUTINE PHYSICAL EXAMS	★ Routine physical exams are not covered.	★ You pay $0 for each exam each year.
VISION SERVICES	★ You pay 20% of Medicare approved charges; annual deductible applies.* AND ★ Routine eye exams and glasses are not covered. You are covered for diagnostic and therapeutic services for the eye.	★ You pay $10 for each vision exam limited to 1 exam each year. ★ You pay $50 for each pair of eyeglasses limited to 1 pair each year. ★ You pay $40 for each pair of contacts limited to 1 pair each year. ★ Reduced rates available for designer frames. Call Victory Health Plan for details.

* Each year, you pay ONE $100 deductible. If your doctor does not accept assignment from Medicare, you pay any charges up to 115% of the Medicare approved amount.

VICTORY HEALTH PLAN

Benefit	Original Medicare	Victory Health Plan
DENTAL SERVICES	★ In general, dental services are not covered.	★ You pay $0 for each routine cleaning, x-rays and exam up to 2 visits each year. ★ Reduced rates available for other dental services. Call Victory Health Plan for details. ★ You must use designated providers.
HEARING SERVICES	★ You pay 100% for routine hearing exams and hearing aids. You pay 20%* for diagnostic hearing exams.	★ You pay $10 for each hearing exam up to 1 visit each 2 years. ★ You are covered up to $300 allowance for hearing aids each 2 years. ★ You must use designated providers.
CHIROPRACTIC SERVICES	★ Not covered	★ You pay $10 for each visit.
HEALTH EDUCATION/ WELLNESS	★ Not covered.	★ You pay $0 for a Nursing Hotline. ★ You pay $10 for health education classes for each class. ★ You pay $50 for Smoking Cessation and Drug and Alcohol Abuse Assistance.
PODIATRY SERVICES	★ Not covered.	★ You pay $10 for each visit.

* Each year, you pay ONE $100 deductible. If your doctor does not accept assignment from Medicare, you pay any charges up to 115% of the Medicare approved amount.

VICTORY HEALTH PLAN

Special Features

★ Victory Services, Inc. has been providing quality health care in your community for over 14 years. We provide services in 17 states and contract with over 25,000 medical professionals.

★ As a member of Victory Health Plan, you will have access to Victory NurseLine. A team of professional and experienced registered nurses are available to talk with you 24 hours every day at no cost to you. With Victory NurseLine, you can talk with a professional when you have concerns about your health care.

★ When you join, you'll be invited to a special orientation meeting to help you become familiar with Victory Health Plan. We want you to get the most out of your membership with us. At the meeting, you'll have the chance to meet with other members and talk to Victory Health Plan employees.

★ Our members report 95% satisfaction with the overall care they receive from our providers.

★ As a member, you will receive monthly newsletters updating you on current health care issues, as well as travel and lifestyle articles. These newsletters are informative and fun.

★ Virtually no paperwork!

★ If your current doctor is not with Victory Health Plan, we'll help you find a new doctor that is convenient and suitable for you!

Victory—A Name You Know and Trust

VICTORY HEALTH PLAN

Member Quotes

"Before I joined Victory Health Plan, I was paying over $600 a month for my prescription drugs. Now, I only spend $20 a month, and I have everything I need. Thank you, Victory Health Plan!"

Mr. Clark

"We always get the care we need right away, and with a smile. We're so happy we joined Victory Health Plan!"

Mr. & Mrs. Smith

When I found out I had diabetes, Victory Health Plan doctors and nurses took very good care of me. They gave me so much information and made sure I knew what was happening. They've really made a difference."

Mrs. Patterson

VICTORY HEALTH PLAN

Locations

Want to know where our hospitals and facilities are located?

Call us anytime for the latest copy of our provider directory. In it, you will find:

- ★ All our primary care and specialty doctors
- ★ All our hospitals and other facilities
- ★ All the pharmacies where you can get your prescriptions filled.

Chairman GRASSLEY. Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the committee.

I am very pleased to be here today as you discuss how to improve the usefulness and dependability of the information that Medicare beneficiaries receive from their health plans. I have had the privilege of being at your two prior hearings to discuss some of the obstacles and burdens that Medicare beneficiaries face in trying to get information about health plans and believe that the work of this committee in terms of oversight has been very influential in keeping our attention focused on this important issue.

Adequate health plan information is going to assume even greater importance as the Medicare+Choice program increases beneficiaries' health care options and Medicare moves toward the private sector practice of having an annual open enrollment period and then locking beneficiaries into their health plan for the remainder of the year.

HCFA plays a key role in helping to ensure that beneficiaries have information to make informed health plan choices. The agency has the authority to set information standards, and reviews and approves all materials that plans distribute to beneficiaries. The Balanced Budget Act expanded HCFA's plan information responsibilities, in part by requiring the agency to distribute summary information about the plans' benefits packages. This basic information will increase beneficiaries' awareness of Medicare+Choice options and is an important step toward providing the comparative information that beneficiaries need to select among plans.

However, beneficiaries still need to consult plans' own literature to obtain detailed information on covered services and fees. Consequently, plans' literature—and HCFA's oversight of that literature—remain critical for informed decisions.

As you have heard today, the materials that plans distribute do not facilitate informed choice and are not consumer friendly. Our two reports, prepared for this committee and released today, discuss the serious shortcomings we found in the information plans distributed about their benefit packages and about appeal rights to beneficiaries denied services.

One shortcoming was that plans' descriptions of benefits are sometimes difficult to compare. They vary considerably in the terms used, in the amount of detail provided and in the format. Moreover, for many plans, the complete description of their benefit packages is distributed across multiple documents. As a result, Medicare beneficiaries must sift through various nonstandardized pieces of literature.

To illustrate this problem, we identified the location in plans' literature where beneficiaries could find answers to four basic questions about their prescription drug coverage. That is illustrated in this graphic right here.

To answer their questions for just three plans, a beneficiary would have had to have gotten 12 different documents—two for

Plan A, five for Plan B, and five for Plan C. You can also see that for Plans B and C, the documents differed; they were not the same. That adds to the burden and potential confusion a beneficiary faces in trying to gather the necessary information.

A second shortcoming of the literature the plans distribute is that prospective enrollees are often not told the full details of the benefit package. Some plans provide detailed benefit information only after beneficiaries have enrolled. Other plans do not disclose important restrictions in any of the literature distributed to members.

The recourse in such a situation is to consult the plan's contract with Medicare. The Catch-22 is that those contracts contain proprietary information and cannot be obtained by beneficiaries.

In sharp contrast to Medicare, each plan that participates in the Federal Employees Health Benefits Program is required to provide a single document that fully describes its benefit package, including all limitations and exclusions. That document must contain a benefits summary using the terms and format prescribed by the Office of Personnel Management.

And as you can see in the graphic over here, it includes the reassurance that this document is something that enrollees can rely on for a full description of the benefits they have under their plan.

The most serious shortcoming, however, that we found in Medicare plans' literature was that some of the information was incorrect. For example, materials from several plans contradicted Medicare's policy by requiring physician referrals for screening mammograms. As you can see in the chart here, while Medicare prohibits the referral requirement, three plans' literature clearly indicated a referral by one's primary care physician was necessary. One plan specified in its Medicare contract that it would provide brand name prescription drug coverage of $1,200 per year. However, the plan's literature given to beneficiaries had lower coverage limits, in some areas as low as $600 per year.

We also found problems with plan information related to the appeals process. When plans deny services, they are required to explain the reason for the denial and inform beneficiaries of their appeal rights. However, we found that plans sometimes did not issue the required denial notice or too frequently issued notices that did not contain sufficient information regarding why a service was denied. Not knowing the basis for denial leaves the beneficiary poorly equipped to decide whether to appeal.

The problems we encountered relating to both plan benefit and appeal information went uncorrected in part because of inadequate standards for plan information and weaknesses in HCFA's review process. In some cases, HCFA reviewers identified problems in the plan materials, but the plan never made the required changes. And as you have heard, that is being addressed now. In other cases, errors slipped through the review process. Some HCFA reviewers told us that they lacked access to information necessary to determine whether a plan's materials are correct. They also told us that the review process is more difficult and time-consuming than it needs to be because of the virtual lack of standards for format and content of information that plans submit.

In conclusion, I would like to say that we are very encouraged by HCFA's initiatives to address the problems we have been discussing today and the recommendations that we have made. HCFA's intentions to improve the information it receives from plans, to tighten its review process and to make sure the process is implemented consistently should improve the reliability of information that beneficiaries receive. By developing a standard format for plans' benefit summaries, HCFA will facilitate comparisons among plans.

We also recognize the significant challenges that HCFA faces not only in this task but in the implementation of the more than 200 provisions applicable to Medicare from the Balanced Budget Act. Nevertheless, in creating the Medicare+Choice program, Congress articulated a new vision for Medicare for now and for the immediate future. Beneficiaries in the program are to benefit from an expanded array of health plans engaged in quality-based competition. Such competition will only develop if beneficiaries have adequate, accurate and accessible information about their health plan choices.

HCFA's actions are steps in the right direction. We hope that they can be fully implemented as expeditiously as possible, for they are absolutely essential if Medicare+Choice is going to achieve its potential.

Thank you very much. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Scanlon follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
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MEDICARE+CHOICE

HCFA Actions Could Improve Plan Benefit and Appeal Information

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-108

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the quality of information that Medicare managed care organizations (MCO) distribute to beneficiaries and steps that the Health Care Financing Administration (HCFA) could take to ensure that this information is reliable, complete, and useful. HCFA's leadership in this area is important. The agency is responsible for approving all of the information that MCOs distribute and has the authority to set standards for that information. By successfully fulfilling this responsibility, HCFA can help make certain that MCOs provide the information that beneficiaries need to make informed health plan choices and understand their rights under Medicare managed care.

MCOs' Medicare plans differ from one another in the services they cover and the fees they charge.[1] At a minimum, plans must provide all Medicare-covered services, but many plans cover additional services, such as outpatient prescription drugs and routine physical examinations. Some plans charge a monthly premium (in addition to Medicare's part B premium), but others do not.[2] Although the Balanced Budget Act of 1997 (BBA) required HCFA to make available some basic comparative plan information, the membership literature that MCOs distribute remains the only source of detailed information that beneficiaries have about plans' fees and covered services. This information helps beneficiaries select a plan that fits their needs. Once they are enrolled, this information helps shape their understanding of their plan's obligations to its members. In addition, MCOs distribute other plan information that can affect the extent to which beneficiaries understand their rights, such as complaints about plan care. Consequently, it is vital that beneficiaries trust the plan information that they receive from MCOs and that HCFA ensures that their trust is not misplaced.

The importance of plan information will grow as the Medicare+Choice program, created by BBA, generates an expanded array of health plan alternatives to the traditional fee-for-service arrangement and attracts more and more beneficiaries to those options. In just the last 3 years, Medicare managed care enrollment has nearly doubled. Approximately 7 million of Medicare's 39 million beneficiaries (more than 17 percent) are currently enrolled in managed care plans. Informed choices will be particularly important as BBA phases out the opportunity for beneficiaries to disenroll

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[1]A plan is a package of specific health benefits, fees, and terms of coverage. An MCO is an entity that offers one or more plans.

[2]Plans may charge other fees in addition to a monthly premium. However, plans cannot charge fees–in the form of monthly premiums, copayments, or other cost sharing–that are higher than what a beneficiary would likely pay under traditional Medicare.

from a plan on a monthly basis and moves toward the private sector practice of annual reconsideration of plan choice.

My comments today will focus on (1) the accuracy, completeness, and usefulness of the information Medicare MCOs distribute about their plans' benefit packages; (2) the extent to which MCOs inform beneficiaries of their plan appeal rights and the appeals process; and (3) HCFA's review, approval, and oversight of the plan information that MCOs distribute. My remarks are based on two recently released reports done for this Committee.[3]

In brief, we found problems with the benefit information distributed by all of the 16 MCOs we reviewed.[4] For example, although HCFA had reviewed and approved all of the information we examined, some MCOs misstated the coverage they were required by Medicare or their contracts to offer. One MCO advertised a substantially less generous prescription drug benefit than it had specified in its Medicare contract. In addition, some MCOs provided complete benefit information only after a beneficiary enrolled; others never provided full descriptions of benefits and restrictions. Finally, as we have reported previously, it is difficult to compare available options using literature provided to beneficiaries because MCOs use different formats and terminology to describe the benefit packages being offered. The variation in Medicare plan literature contrasts sharply with the uniformity of plan information distributed by MCOs that participate in the Federal Employees Health Benefits Program (FEHBP).[5] MCOs participating in FEHBP are required to provide prospective enrollees with a single, comprehensive, and comparable brochure to facilitate informed choice.

In our study of the appeals process, we found that when MCOs deny plan services or payment, they do not always inform beneficiaries of their appeal rights. Sometimes MCOs issue denial notices that do not contain all the information that HCFA requires. We also found that some MCOs delay issuing denial notices until the day before discontinuing services, such as skilled nursing care. This delay can increase a beneficiary's potential financial liability should the beneficiary appeal the plan's decision and lose.

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[3]Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS-99-92, Apr. 12, 1999) and Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights (GAO/HEHS-99-68 Apr. 12, 1999).

[4]We examined the membership literature for 26 plans offered by 16 MCOs in four HCFA regions. We focused our review on three benefits: ambulance services, routine mammograms, and outpatient prescription drug benefits. A complete description of our objectives, scope, and methodology is contained in GAO/HEHS-99-92.

[5]FEHBP is administered by the Office of Personnel Management (OPM).

Many of the information problems we identified regarding plan benefit packages and beneficiaries' appeal rights went uncorrected because of shortcomings in HCFA's review practices. In addition, HCFA has not exercised its authority to require MCOs to distribute plan information that is more complete, timely, and comparable. Agency officials recognize many of the shortcomings we identified and are beginning efforts to address them. However, we believe that the agency could do more. In our two accompanying reports, we recommend that HCFA undertake a variety of additional actions including (1) following the lead of FEHBP and requiring Medicare MCOs to distribute brochures that fully describe--using a prescribed format and terminology--plan benefits, fees, and coverage restrictions; and (2) setting standards for when MCOs distribute certain information and that the agency improve the consistency and thoroughness of its oversight practices. In commenting on our two reports, HCFA generally agreed with our recommendations.

BACKGROUND

About two-thirds of all Medicare beneficiaries live in areas where they can choose among traditional fee-for-service and one or more managed care plans. Although approximately 82 percent of beneficiaries are in the fee-for-service program, the percentage of beneficiaries enrolled in managed care plans is growing. Over the last 3 years, Medicare managed care enrollment has nearly doubled to almost 7 million members, as of March 1999. Most Medicare managed care enrollees are members of plans that receive a fixed monthly fee for each beneficiary they enroll.

BBA Sought to Widen Health Plan Choices and Increase Availability of Comparable Information

In enacting BBA, the Congress sought to widen beneficiaries' health plan options. BBA permitted new types of organizations--such as provider-sponsored organizations and preferred provider organizations--to participate in Medicare. It also changed Medicare's payment formula to encourage the wider availability of health plans.

BBA also mandated that HCFA make available certain information to increase beneficiaries' awareness of their health plan options. The law directed HCFA to provide beneficiaries with general information about managed care plans through a variety of means, including a toll-free telephone number to answer general questions and an Internet site to provide some basic comparative information about the various health care options available. HCFA is also required to mail basic comparative and other information to all beneficiaries. However, for detailed information about specific managed care plans, all of these resources direct beneficiaries to the MCOs that offer those plans--the only source for specific plan information.

HCFA Reviews Plan Benefit Information and Other Materials Distributed to Beneficiaries

To inform Medicare beneficiaries–both those interested in enrolling and those already enrolled–about plan-specific information, MCOs distribute membership literature–packets of information that describe plan benefits, fees, and coverage restrictions. Membership literature may be mailed to interested beneficiaries or distributed directly by sales agents who work for the MCO.

HCFA requires MCOs to include certain explanations in their member materials, such as provider restrictions; but otherwise, MCOs have wide latitude in what information is included and how it is presented. However, HCFA reviews all materials that MCOs distribute to beneficiaries. In addition to membership literature, HCFA reviews enrollment forms; administrative letters, such as those notifying beneficiaries of benefit changes; all advertising; and other informational materials. The review process is intended to help ensure that the information is correct and conforms to Medicare requirements. MCOs must submit these materials to HCFA, which has 45 days to conduct its review. If the agency does not disapprove of the materials within that period, the MCOs can distribute them.

MCOs Must Inform Beneficiaries of Their Appeal Rights

Medicare beneficiaries enrolled in a managed care plan have the right to appeal if their plan's MCO refuses to provide health services or pay for services already obtained. If an MCO denies a beneficiary's request for services–such as skilled nursing care or a referral to a specialist–it must issue a written notice that explains the reason for the denial and the beneficiary's appeal rights. Such notices must also tell beneficiaries where and when the appeal must be filed and that they can submit written information to support the appeal.

A beneficiary first appeals to his or her health plan's MCO by asking it to reconsider its initial decision. If the MCO's reconsidered decision is not fully favorable to the beneficiary, the case is automatically turned over to the Center for Health Dispute Resolution (CHDR)–a HCFA contractor that reviews the decision and may overturn or uphold it. Beneficiaries who are dissatisfied with CHDR's decision have additional appeal options, provided certain requirements are met. A member who loses an appeal is responsible for the cost of any disputed health care services that were obtained. HCFA reviews each MCO's plan appeals process as part of its biennial evaluation of each organization's compliance with HCFA regulations.

PLAN BENEFIT INFORMATION IS NOT ALWAYS CORRECT, CURRENT, OR COMPLETE AND IS NOT READILY COMPARABLE

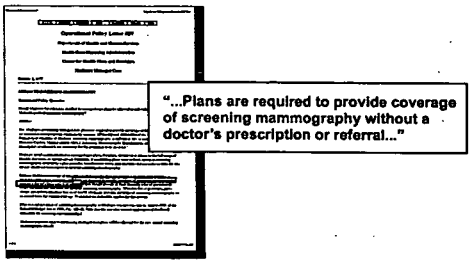
Our review of 16 Medicare MCOs found various types of flaws in the membership literature they distributed. The documents we examined were used by MCOs to inform prospective enrollees and members about covered services, fees, and restrictions. Although HCFA had reviewed and approved the documents, some incorrectly described plan benefit packages. In several instances, the information was outdated or incomplete. Some MCOs provided beneficiaries with detailed benefit information only after they had enrolled in a plan. We also found it difficult to compare benefit packages because MCOs are not required to follow common formats or use standard terms when describing their benefits. In contrast, each MCO that participates in FEHBP is required to distribute a single, comprehensive booklet that describes its benefit package using a standard format and standard terminology.

Plan Benefit Information Not Always Correct

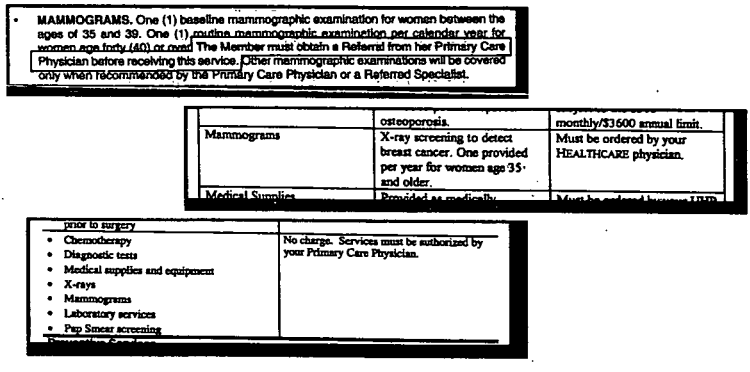
Most MCOs' plan documents contained errors or omitted information about the three benefits we reviewed—prescription drugs, mammography, and ambulance services. Problems ranged from minor inaccuracies to major errors. For example, documents from five MCOs we reviewed erroneously stated that beneficiaries needed a referral to obtain a routine annual mammogram--a Medicare-covered service. HCFA policy clearly states that plans cannot require a referral for annual mammograms and must inform beneficiaries of this policy. (See fig. 1 for HCFA policy and excerpts from Medicare plan materials.)

Figure 1: Examples of Plan Referral Requirements for Screening Mammogram Contradicting Medicare Coverage

HCFA Operational Policy Letter #57



Excerpts From Medicare 1998 Plan Materials



Note: Sources as indicated in figure. Emphasis added.

We also found serious problems with plan information regarding coverage for outpatient prescription drugs—a benefit that attracts many beneficiaries to Medicare managed care plans. For example, a large, experienced MCO specified in its Medicare contract that its plan would provide brand name drug coverage of at least $1,200 per year. However, the plan's membership literature indicated lower coverage limits—in some areas as low as $600 per year. Based on 1998 enrollment data, we estimate that over 130,000 plan members may have been denied part of the benefit to which they were entitled and for which Medicare paid. Another MCO, which used the same documents to promote its four plans, stated in its handbook that all plan members were entitled to prescription drug coverage. However, only two of the MCO's four plans provided such coverage. A third MCO provided conflicting information about its drug coverage. Some documents stated that the plan would pay for nonformulary drugs,[6] while other documents said it would not.

Some Plan Benefit Information Outdated

Some MCOs distributed outdated information, which could be misleading. HCFA allows this practice if MCOs attach an addendum updating the information. HCFA officials believe this policy is reasonable because beneficiaries can figure out a plan's coverage by comparing the changes cited in the addendum with the outdated literature. However, we found that some MCOs distributed outdated literature without the required addendum and that when MCOs included the addendum, it often did not clearly indicate that the addendum superseded the information contained in other documents. In addition, some MCOs did not put dates on the literature they distributed, which obscured the fact that the literature was no longer current.

Some MCOs Did Not Provide Complete Benefit Information

Some MCOs did not disclose important plan information, including information about Medicare required benefits, in documents designed to provide detailed plan information. For example, most MCOs we reviewed did not provide detailed information about ambulance services–a Medicare required benefit. One MCO did not mention ambulance service coverage at all in any of the documents we reviewed. Three MCOs stated that ambulance services were covered "per Medicare regulations" but did not explain Medicare's coverage. Most of the other MCOs' documents provided general descriptions of their plans' ambulance coverage but did not explain the extent of the coverage.

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[6]A drug formulary is, in general, a list of drugs that MCOs prefer their physicians to use in prescribing drugs for enrollees. The formulary includes drugs that MCOs have determined to be effective and suppliers may have favorably priced to the MCO. Any drug not included on a formulary is considered a nonformulary drug.

HCFA's instructions regarding benefit disclosure are vague, only advising MCOs to provide information sufficient for beneficiaries to make informed enrollment decisions. Moreover, MCOs that adopted HCFA's suggested disclosure language may send beneficiaries to an information dead end. In the guideline it provides to MCOs, HCFA suggests that a plan's member policy booklet (or other document used to describe a plan's benefit package) direct beneficiaries to the MCO's Medicare contract for full details of the plan. According to HCFA, a member policy booklet should state that the document

> constitutes only a summary of the [plan]. . . . The contract between HCFA and the [MCO] must be consulted to determine the exact terms and conditions of coverage.

HCFA officials responsible for Medicare contracts, however, said that if a beneficiary were to request a copy of the contract, the agency would not provide it due to the proprietary information included in an MCO's contract proposal. Furthermore, an MCO is not required to provide beneficiaries with copies of its Medicare contract. MCO officials with whom we spoke differed in their responses about whether their organizations would provide beneficiaries with copies of their Medicare contracts.

Some MCOs we reviewed provide detailed benefit information only after beneficiaries had enrolled. The information packages distributed by several MCOs we reviewed stated that beneficiaries would receive additional, detailed descriptions of plan benefits, costs, and restrictions following enrollment. In addition, four MCOs did not provide 1998 benefit details until several months after the new benefits took effect.[7] In fact, one MCO did not distribute its detailed benefit information until August—8 months after the benefit changes had taken effect.

Plan Benefit Information Was Not Readily Comparable

The membership literature we reviewed varied considerably in terminology, depth of detail, and format. These variations are similar to those that we encountered in previous reviews undertaken for this Committee and greatly complicated benefit package comparisons.[8] The lack of clear and uniform benefit information likely impedes informed decisionmaking. HCFA officials in almost every region noted that a

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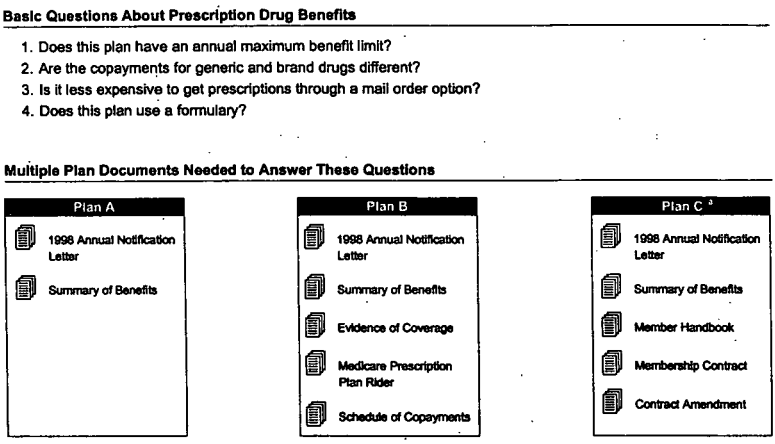
[7]Plan contracts, which define plans' benefit packages, generally take effect January 1 of each year and run for 1 calendar year.

[8]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 23, 1996); Medicare Managed Care: Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices (GAO/T-HEHS-98-162, May 6, 1998); GAO/HEHS-99-92, Apr. 12, 1999.

standard format for key membership literature, along with clear and standard terminology, would help beneficiaries compare their health plan options.

To illustrate this problem, we identified the location in each MCO's plan literature where enrollees would find answers to basic questions regarding coverage of the three benefits we studied. This information was often difficult to find; enrollees would have to read multiple documents to answer the basic coverage questions. For example, to understand the three plans' prescription drug benefits, we had to review 12 different documents: 2 from Plan A, 5 from Plan B, and 5 from Plan C. (See fig. 2.)

Figure 2: Multiple Plan Documents Needed to Answer Basic Drug Benefit Questions



[a]Plan documents contradict one another as to whether the plan will cover a nonformulary drug.

Source: GAO analysis of MCO plan membership literature.

It was also not easy to know where to look for the information. For example, the answer to our question about whether a plan used a drug formulary was found in Plan A's summary of benefits, in Plan B's Medicare prescription drug rider, and in Plan C's contract amendment. Plan C's materials required more careful review to answer the question because the membership contract indicated the plan did not provide drug coverage. However, an amendment–included in the member contract as a loose insert–listed coverage for prescription drugs and the use of a formulary.

Each FEHBP Plan Distributes a Single, Standard, Comprehensive Benefit Booklet

To avoid the types of problems found in Medicare MCOs' membership literature, OPM requires each participating health plan to describe, in a single document, its benefit package–that is, covered benefits, limitations, and exclusions–and to include a benefit summary in a standardized language and in OPM's prescribed format. OPM officials update the mandatory language each year to reflect changes in the FEHBP requirements and to respond to organizations' requests for improvements. Finally, OPM requires health plans to distribute plan brochures prior to the FEHBP annual open enrollment period so that prospective enrollees have complete information on which to base their decisions. OPM officials told us that all participating plans publish brochures that adhere to these standards.

ADEQUATE INFORMATION ABOUT APPEALS PROCESS AND BENEFICIARY RIGHTS IS OFTEN NOT PROVIDED

Plan membership literature is required to contain information on beneficiaries' appeal rights. In addition, beneficiaries are supposed to be informed of their appeal rights when they receive a plan's written notice denying a service or payment. HCFA requires denial notices to contain information telling beneficiaries where and how to file an appeal. Furthermore, denial notices are required to state the specific reason for the denial because vaguely worded notices may hinder beneficiary efforts to construct compelling counterarguments. Vague notices may also leave beneficiaries wondering whether they are entitled to the requested services and should appeal. Finally, HCFA regulations state that whenever MCOs discontinue plan services, such as skilled nursing care, they must issue timely denial notices to beneficiaries.

Substantial evidence indicates, however, that many beneficiaries did not receive the required information when their MCOs denied services or payment for services. Denial notices were frequently incomplete or never issued, and many notices did not indicate the specific basis for the denial. Furthermore, beneficiaries often received little advance notice when their MCO discontinued plan services.

Denial Notices Are Sometimes Incomplete, Never Issued, or Do Not Indicate Specific Reasons for the Denial

Reviews by HCFA, studies by the Department of Health and Human Services' Office of Inspector General (OIG), as well as studies we conducted found numerous instances of incomplete or missing denial notices. In 1997, HCFA performed monitoring visits to 90 MCOs; about 13 percent of these MCOs were cited for failing to issue denial notices. In addition, nearly one-quarter of the 90 MCOs were cited for issuing denial notices that did not adequately explain beneficiaries' appeal rights. Two studies by the OIG, using different methodologies, provide additional evidence that beneficiaries are not always informed of their appeal rights.[9] In one study, the OIG surveyed beneficiaries who were enrolled or had recently disenrolled from a managed care plan. According to the survey results, 41 respondents (about 10 percent) said that their health plans had denied requested services. Of these, 34 (83 percent) of the respondents said that they had not received the required notice explaining the denial and their appeal rights.

Most notices that we reviewed contained general, rather than specific, reasons for the denial. In 53 of the 74 CHDR cases that contained the required denial notices (notices were missing in 32 cases), the notices simply said that the beneficiary did not meet the coverage requirements or contained some other vague reason for the denial. Likewise, representatives from several advocacy groups told us that in cases brought to their attention, the denial notices were often general and did not clearly explain why the beneficiary would not receive, or continue to receive, a specific service.

Notices of Discontinued Coverage Are Often Issued the Day Before Services Are Stopped

HCFA regulations state that whenever MCOs discontinue plan services, they must issue timely denial notices to beneficiaries. The regulations, however, do not specify how much advance notice is required before coverage is discontinued. Beneficiaries who receive little advance notice may not be able to continue to receive services because of their potential financial liability. If the beneficiary appeals and loses, he or she is responsible for the cost associated with the services received after the date specified in the denial notice.

In three of the MCOs we visited, the general practice was to issue the denial notices the day before the services were discontinued. We found that many skilled nursing

[9]Department of Health and Human Services, OIG, Medicare HMO Appeal and Grievance Processes, Review of Cases (OEI-07-94-00283, Dec. 1996) and Medicare HMO and Grievance Processes, Beneficiaries' Understanding (OEI-07-96-00281, Dec. 1996).

facility (SNF) discharge notices were mailed to the beneficiary's home instead of being delivered to the facility. In other cases, it appeared that the beneficiary or his or her representative received the notice a few days after the beneficiary had been discharged from the SNF or the SNF coverage had ended. Ten of the 25 SNF discharge cases we reviewed at CHDR also involved the receipt of a notice after the patient had been discharged.

The fourth MCO we visited issued SNF discharge notices 3 days prior to the discharge date. This lead time helped ensure that a beneficiary received the notice before the discharge date. It also allowed more time for the beneficiary to file an expedited appeal and receive a decision from the plan. Consequently, beneficiaries in this MCO's plan who appeal and lose are less exposed to the SNF costs incurred during the appeals process. Officials from all the MCOs we visited said that, in almost every instance, the decision to discharge a beneficiary from a SNF is made days in advance and that discharge notices could be issued several days prior to discharge.

WEAKNESSES IN HCFA'S REVIEW PROCESSES AND REQUIREMENTS ALLOWED PROBLEMS IN PLAN MATERIALS TO GO UNCORRECTED

Although HCFA reviews and approves all materials that MCOs distribute to beneficiaries, weaknesses in the agency's review practices and information standards allowed the plan information problems we observed to go uncorrected. One weakness is that HCFA reviewers must rely on a faulty document to determine whether plan member materials are correct. In addition, HCFA review practices are sometimes inadequate to detect or correct the problems we found. Finally, HCFA has not used its authority to require that MCOs use a common format and terminology to describe their plans' benefit packages.

HCFA's Standard for Gauging Accuracy in Plan Materials Is Faulty

To ensure the accuracy of membership literature, HCFA reviewers are instructed to compare each MCO's membership literature to its Medicare contract. Specifically, HCFA reviewers are expected to rely on one particular contract document--the Benefit Information Form--which summarizes plan benefits and member fees. Reviewers told us, however, that this contract document often does not provide the detail they need. Consequently, they sometimes rely on benefit summaries provided by the MCOs to verify the accuracy of plan information. This practice is contrary to HCFA policy, which requires an independent review of MCOs' plan literature. The reviewer who approved the plan literature advertising a $600 annual drug benefit, instead of the contracted $1,200 annual limit, said that the mistake was caused by her reliance on a benefit summary provided by the MCO.

HCFA's Monitoring Practices
Allowed Problems to Go Uncorrected

Inadequate monitoring of MCOs' communications with beneficiaries--both about plan benefit packages and appeal rights--allowed the problems we observed to go uncorrected. For example, we found instances where MCOs agreed to make HCFA required changes, but the final printed documents did not incorporate the changes. Because HCFA staff generally do not receive copies of the printed documents, they are often unaware as to whether MCOs have made the required corrections.

Shortcomings in HCFA's monitoring procedures also limit the agency's ability to ensure that beneficiaries know that plans' service and payment decisions can be appealed. For example, to determine whether MCOs informed beneficiaries of their appeal rights, HCFA's monitoring protocol requires agency staff to review a sample of appeal case files. HCFA staff check these files to determine whether each contains a copy of the required denial notice. However, it seems reasonable to assume that beneficiaries who appeal are more likely to have been informed of their rights than those who do not appeal. Yet, HCFA does not generally check cases where services or payment for services were denied but not appealed. Furthermore, when MCOs contract with provider groups to perform certain administrative functions, such as issuing denial notices, HCFA staff generally do not check to see that the delegated duties were carried out in accordance with Medicare requirements.

Inadequate Instructions to MCOs
Hamper HCFA's Review Process

HCFA has the authority to set standards for the format, content, and timing of the plan information that MCOs distribute to beneficiaries. Unlike OPM, however, HCFA has made little use of its authority. Instead, each MCO decides on the format--and to large extent content and timing--of the plan information it distributes.

In addition to making plan comparisons more difficult, the lack of common information standards has adversely affected HCFA's review process. First, the lack of standards has resulted in inconsistent review practices and misleading comparisons. For example, one MCO representative told us that several MCOs' plans in its market area required a copayment for ambulance services if a beneficiary was not admitted to a hospital, but not every MCO was required to disclose that fact. Consequently, although the plans had similar benefit restrictions, the MCOs that were required to disclose the plan restrictions appeared to offer less generous benefits than the other MCOs' plans.

The lack of information standards also increased the amount of time needed to review and approve plan documents and increased the likelihood of undetected errors. Agency staff said that they could do a better job checking plan membership literature

for accuracy and completeness if every MCO presented its plan information in a common format and used standard terminology. Staff also said they spend a considerable amount of time reviewing plan documents that could be standard administrative forms—such as member enrollment applications—and thus had less time to spend reviewing important documents describing plan benefits.

HCFA Has Begun Efforts to Correct Problems and Shortcomings in Plan Information

HCFA is moving to address some of the problems and systemwide shortcomings we identified during our recent reviews. For example, HCFA is working to revise the contract document that agency reviewers use to verify the accuracy of plan information. The proposed new contract document will help ensure that HCFA collects the same information from each plan and presents the information in a consistent format and in greater detail than the current document. The agency expects to test this new document later this year and fully implement it in 2000. HCFA officials believe that the Office of Management and Budget's clearance process for the proposed new contract document must begin no later that August 1999 to meet this timetable. Otherwise, full implementation could be delayed.

Agency officials recognize the importance of more uniform membership literature and have articulated their intent to standardize key documents in future years. As a first step, the agency established a work group–consisting of representatives from HCFA, MCOs, senior citizen advocacy groups, and other relevant entities–to develop a standard format and common language for MCOs' plan benefit summaries. HCFA hopes to establish these new standards by next month so MCOs' fall 1999 benefit summary brochures can follow the new standards. HCFA's long-term goals involve the establishment of standards for other key documents. However, the agency has not yet developed a strategy for its long-term efforts or decided whether the information standards it sets will be voluntary or mandatory.

HCFA officials said they have also undertaken several initiatives to help ensure that beneficiaries are informed of their appeal rights and the steps necessary to file an appeal. Sometime this year, HCFA intends to publish additional instructions regarding the content of denial notices. The agency will also revise its monitoring protocol to better ensure that MCOs issue the required denial notices. Finally, HCFA is working to develop timeliness requirements for the issuance of notices when MCOs reduce or discontinue services, such as skilled nursing care, home health care, or physical therapy.

CONCLUSIONS

As the Medicare+Choice program grows and more health plan options become available, the need for reliable, complete, and useful information will increase. In our

recent reviews, however, we found major problems in the plan information that some MCOs provided to beneficiaries. In several instances the information was incorrect or incomplete; in other cases, the problem was poor timing—important information was distributed long after the benefit package had changed or only after beneficiaries had enrolled in a plan. None of the information was provided in a format that facilitated comparisons among plans. We also found that some MCOs did a poor job informing beneficiaries about their appeal rights and the appeals process.

HCFA has both the authority and the responsibility to ensure that Medicare MCOs distribute information that helps beneficiaries make informed decisions. To date, however, its policies and practices have fallen short of that mark. HCFA's review of plan information has been inadequate and has not prevented plans from distributing incorrect and incomplete information. Furthermore, unlike OPM, HCFA has not set standards for plan information that could facilitate informed decisions. The agency is taking some steps to address the problems we identified. We believe, however, that these problems will not be fully addressed until HCFA implements our past and current recommendations by setting information standards for MCOs and requiring them to adhere to those standards.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee might have.

(101803)

United States General Accounting Office

GAO

Report to the Special Committee on Aging, U.S. Senate, and the Honorable Jack Reed

April 1999

MEDICARE MANAGED CARE

Greater Oversight Needed to Protect Beneficiary Rights

Printed copies of this document will be available shortly.

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Health, Education, and
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April 12, 1999

The Honorable Charles E. Grassley
Chairman
The Honorable John Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Jack Reed
United States Senate

Since 1994, enrollment of Medicare beneficiaries in managed care has tripled to 7 million—comprising 18 percent of all Medicare beneficiaries. Beneficiaries who enroll in managed care are entitled to all Medicare-covered services. They also may benefit from lower out-of-pocket costs, additional covered benefits, and less paperwork than their counterparts in traditional fee-for-service Medicare. Unlike fee-for-service providers, however, managed care plans receive a fixed amount per month for each enrolled beneficiary, regardless of the type and number of services they provide. Consequently, plans have a financial incentive to limit beneficiaries' use of health care services. To safeguard access to appropriate covered services, Medicare allows beneficiaries to appeal—first to their managed care plans and then externally—whenever their health plans deny requested care or refuse to pay for services.[1]

Because the appeals process helps safeguard Medicare beneficiaries' right to covered services from managed care plans, you asked us to assess the adequacy of the process, including the recently instituted expedited process. Specifically, you asked us to focus on the appeals process at the plan level, providing information on (1) the appeals process available to beneficiaries when managed care plans deny care or payment for services, (2) beneficiaries' use of the appeals process and the extent to which they are informed of their appeal rights, and (3) the Health Care Financing Administration's (HCFA) oversight of this process.

To conduct our review, we interviewed officials from HCFA; the Center for Health Dispute Resolution (CHDR), HCFA's contractor that reviews plans' appeal decisions; and selected managed care plans. We also reviewed HCFA's 1997 managed care plan monitoring reports and reports by the

[1]Similarly, beneficiaries in fee-for-service Medicare who disagree with a decision on the amount Medicare will pay on a claim or whether services received are covered by Medicare may appeal the decision.

Office of Inspector General (OIG) in the Department of Health and Human Services (HHS), analyzed the results of a questionnaire sent to all health maintenance organizations (HMO) about their plan-level appeals, reviewed a number of appeals forwarded to CHDR, and collected statistical data from HCFA and CHDR on plan appeals. In addition, we accompanied agency staff on two monitoring visits to plans and visited four HMOs. We performed our work between June 1998 and April 1999 in accordance with generally accepted government auditing standards. (See app. I for details on our scope and methodology.)

Results in Brief

Medicare beneficiaries enrolled in managed care plans have the right to appeal if their plans refuse to provide health services or pay for services already obtained. For example, if a plan denies a beneficiary's request for skilled nursing care or a referral to a specialist, it must issue a written notice that explains the reason for the denial and the beneficiary's appeal rights. Upon receipt of the written denial notice, the beneficiary may appeal and the health plan must reconsider its initial decision. If the plan's reconsidered decision is not fully favorable to the beneficiary, the case is automatically sent to CHDR to review the decision. CHDR may overturn or uphold the plan's decision. A beneficiary is entitled to an expedited decision from the plan, both on the initial request and appeal, if the standard time for making the decision could endanger his or her health or life. A beneficiary who is dissatisfied with CHDR's decision may appeal further to an administrative law judge (ALJ) and then to a U.S. District Court, provided certain requirements are met.

HMOs reported an average of approximately 9 appeals per 1,000 Medicare members annually between January 1996 and May 1998. HMOs reversed their original denial in about 75 percent of appeal cases. The number of appeals, however, may understate beneficiaries' dissatisfaction with the initial decisions by HMOs for two reasons. First, some beneficiaries may disenroll and switch to another plan or fee-for-service Medicare instead of appealing. Second, some beneficiaries may not appeal because they are unfamiliar with their appeal rights or the appeals process. We found that beneficiaries frequently received incomplete notices that failed to explain their appeal rights; some beneficiaries did not receive any notices. In addition, notices often do not state a specific reason for the denial; as a result, beneficiaries may be uncertain as to whether they are entitled to the requested services and thus discouraged from appealing. We also found that beneficiaries may receive little advance notice when plans decide to discontinue paying for services, such as skilled nursing care,

which places these beneficiaries at financial risk should they decide to continue treatment during their appeal. In general, beneficiaries who lose their appeals are responsible for the treatment costs incurred after the date specified in the denial notice.

HCFA's oversight of health plans' appeals process has several shortcomings. The agency does not determine whether beneficiaries who were denied services but did not appeal were informed of their appeal rights. It also does not monitor provider groups that contract with health plans. Many of these groups play a key role in the appeals process by issuing denial notices and deciding whether to expedite initial decisions. HCFA has not ensured consistent implementation of the expedited appeals process because it has not issued specific criteria for expedited cases. We found that a group of health plans in one HCFA region had collaborated to develop such criteria. The HCFA regional office subsequently issued these criteria to plans in its region. Finally, HCFA has not used available information to develop more effective plan oversight strategies. The agency is planning to gather plan-level appeals data (similar to the data we collected for this report), but actual data collection may not begin for another year. In commenting on a draft of this report, HCFA agreed that the agency needs to improve its oversight of the appeals process. HCFA cited several initiatives it is currently undertaking to better protect beneficiaries' rights.

Background

In 1998, about 7 million—or 18 percent—of Medicare's 39 million beneficiaries were enrolled in a managed care plan. About 90 percent of Medicare managed care enrollees belong to one of 307 risk-contract HMOs.[2] These plans are paid a predetermined monthly amount for each Medicare enrollee, regardless of the amount of Medicare covered services the enrollee uses. The plans are called "risk" HMOs because they assume the financial risk of providing care for the amount Medicare pays.

Risk HMOs must provide all services covered by fee-for-service Medicare; in many instances, they provide additional services—such as outpatient prescription drugs and routine physical exams. Generally, plans require enrollees to use only providers that contract with the plan and to follow certain procedures to obtain health care services. For example, most plans require enrollees to obtain prior authorization for care either from their primary care physician or directly from the plan. If enrollees do not follow the procedures, plans may not pay for the services.

[2]There are also cost-contract plans, where Medicare pays the actual cost the entity incurs in furnishing covered services less the estimated value of beneficiary cost-sharing, and health care prepayment plans, which are similar to cost-contract plans except that they provide only Medicare part B services.

HCFA Performs On-Site Monitoring of Plans Every 2 Years

HCFA performs biennial on-site performance reviews of each health plan's operations, including the appeals process, to evaluate plan compliance with HCFA regulations. HCFA staff review a sample of appeal cases and evaluate whether the plan met Medicare process and timeliness requirements. Results of the performance review are reported in the monitoring report. The report documents whether a plan met all legal and policy requirements and describes any deficiencies and needed corrective actions.

Class Action Lawsuit Challenges Medicare HMOs Appeal Practice

In November 1993, a class action lawsuit filed against the Secretary of HHS challenged a number of the policies and practices of the Medicare managed care program. As a result of this lawsuit, HCFA is currently under an injunction and order issued by the federal district court that requires Medicare HMOs to give their enrollees written notices that meet certain criteria.[3] Specifically, the order required, among other things, that Medicare HMOs (1) issue denial notices no more than 5 working days of the request for service or payment and at least 1 working day before the reduction or termination of treatment, (2) clearly state the reason for the denial in the notice, (3) expedite appeals when services are urgently needed (within 3 working days of the request), and (4) continue acute care services until a final appeal decision is issued when the beneficiary requests an expedited appeal.[4]

Since the 1997 court order, HCFA has required each plan to implement an expedited process for decisions on initial requests for health services and appeals of denied health services. Subsequently, the expedited process was mandated along with other appeals procedures and beneficiary protections by the Balanced Budget Act of 1997 (BBA) and further addressed in the Medicare+Choice regulations published in June 1998. A beneficiary may now request an expedited decision if he or she believes that serious adverse health consequences could result from waiting for a decision under the standard process.

[3]Grijalva v. Shalala, 946 F. Supp. 747 (D. Ariz. 1996), Oct. 17, 1996; subsequent judgment implementing the order was issued Mar. 3, 1997.

[4]HCFA appealed the decision of the lower court to the U.S. Court of Appeals for the 9th Circuit, which on August 12, 1998, upheld the lower court's decision. HCFA's second appeal was also denied. On February 10, 1999, HCFA asked the U.S. Supreme Court to review the case.

Medicare Beneficiaries Can Appeal Plan Decisions

Medicare beneficiaries enrolled in managed care plans have a multilevel appeals process available if plans refuse to pay for requested services, refuse to provide requested services, or discontinue or reduce services.[6] Beneficiaries generally appeal to their plan first.[6] If the plan upholds the initial denial, the appeal is forwarded to CHDR for external review and resolution.[7] However, a further appeal to an ALJ and the court is possible. Under certain circumstances, a beneficiary or a health care provider may request that a plan expedite its decision on the initial request and any subsequent appeal.

Appeals Process Starts at Managed Care Plan but Is Subject to External Review

The appeals process may begin when a Medicare member asks his or her plan to provide a service, such as skilled nursing care or a referral to a specialist, or pay for a service already obtained and is turned down.[8] In such instances, Medicare requires plans to issue a written notice that states the reason for the denial and explains the beneficiary's appeal rights. A member has 60 days from the date of the denial notice to ask the plan to reconsider its initial decision.[9] The appeal request, which must be in writing, can be addressed to the member's health plan or the Social Security Administration, which will forward it to the health plan. A member is not required to submit additional information to support or clarify the request. However, health plans must provide their members the opportunity to supply such information.

The plan's reconsideration of its initial decision, the internal portion of the appeals process, must conform to certain requirements. Prior to July 27, 1998,[10] a plan had up to 60 days to complete this process; now a plan must reconsider its initial decision within 30 calendar days if the request is for

[6]Health plans must also have a process for handling beneficiary complaints about quality of services, timeliness of services, and administrative problems. Such complaints, known as grievances, may not be appealed outside the plan. In commenting on a draft of this report, HCFA said that it is developing an additional set of requirements for grievance processes.

[6]Beneficiaries discharged from a hospital by their HMO may appeal to peer review organizations—organizations that include practicing doctors and other health care professionals, under contract to the federal government to monitor the care given to Medicare patients.

[7]CHDR reviews plans' appeal decisions that are not wholly favorable to the enrollee. An independent review of a plan's adverse initial decision is required by 42 C.F.R. 417.614.

[8]All parties to the initial decision have a right to appeal. This includes the member, a representative of the member, a legal representative on behalf of a deceased member's estate, and any other entity determined to have an appealable interest in the proceeding, such as out-of-plan physicians or suppliers.

[9]A member may appeal a denied service or payment for service even if a notice is not issued.

[10]This was the effective date for Medicare+Choice regulations, issued on June 26, 1998.

health care services and within 60 calendar days if it is for payment.[11] The plan representative considering the appeal must not have been involved in making the initial decision. To make a reconsidered decision, the plan representative reviews the initial decision and all other evidence submitted by the beneficiary, beneficiary representative, provider, and health plan.

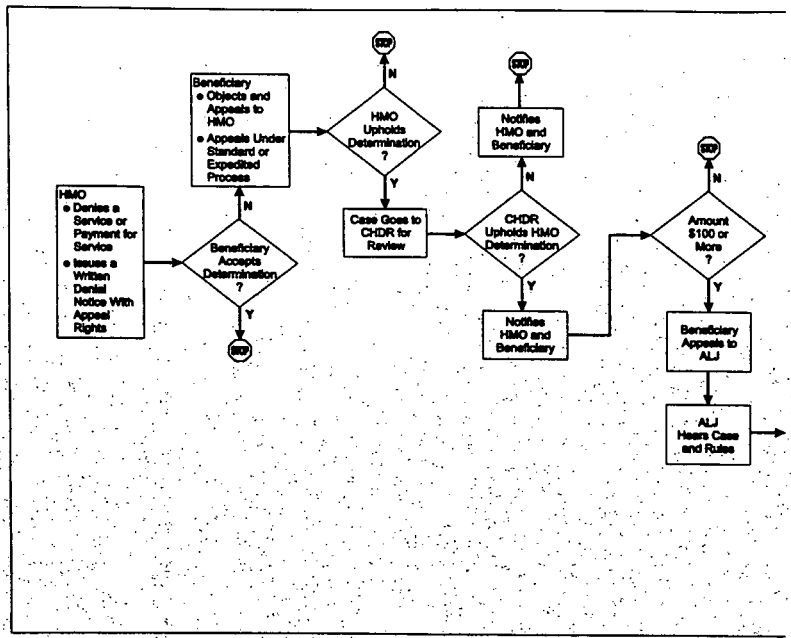
If a plan upholds, in whole or part, its initial denial, it must forward the case to CHDR for external review.[12] HCFA has modified its contract with CHDR requiring CHDR to be held to the same time standards as the plans for processing appeals. (Prior to the change, CHDR had 30 days to consider the case, make its ruling, and inform the beneficiary of its decision.) If CHDR upholds the plan's denial, the beneficiary can request an additional appeal before an ALJ, provided the services in question cost at least $100.[13] A beneficiary may ask that the Social Security Departmental Review Board review a denied ALJ appeal. If the board declines to review the ALJ decision or denies the appeal and the amount of the services in question is greater than $1,000, the beneficiary may request a hearing in U.S. District Court. A beneficiary who loses an appeal is responsible for the cost of any disputed health care services that he or she obtained. Figure 1 shows the Medicare appeals process, step by step.

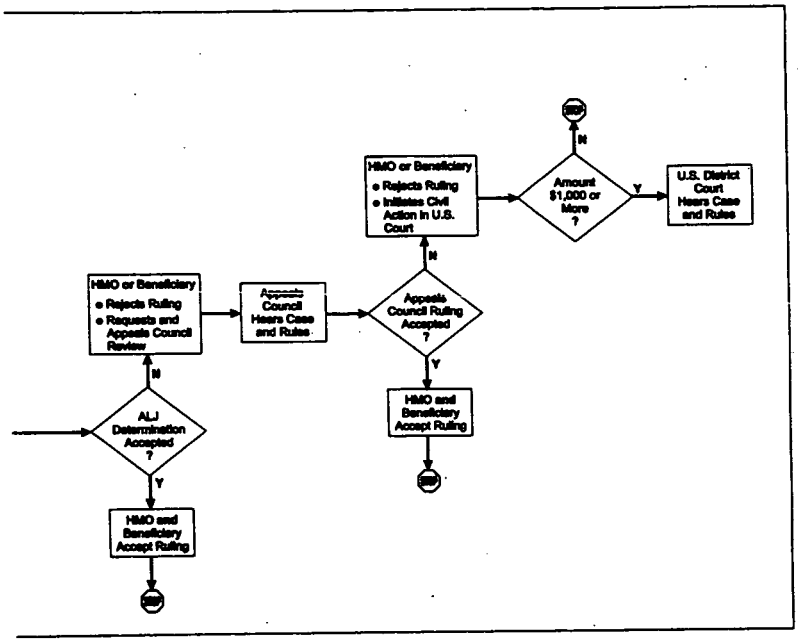
[11]HCFA also established new processing time frames for initial determinations. Plans must make these decisions within 14 calendar days for request of health services and 30 calendar days for payment of services. The time frames can be extended up to an additional 14 calendar days, if such extension would be helpful to the beneficiary.

[12]For calendar years 1996 and 1997 and the first 7 months of 1998, CHDR received 5,543, 8,152, and 6,334 appeal cases, respectively.

[13]The beneficiary has 60 days from the date of HCFA's reconsideration determination to request a hearing before an ALJ.

Figure 1: Medicare Appeals Process





Beneficiaries or Their Physicians Can Request an Expedited Decision

Since August 28, 1997, HCFA has required managed care plans to establish and maintain an expedited process covering both initial decisions and internal appeals. Medicare beneficiaries can request expedited decisions when they believe that waiting the standard time for an initial decision or an appeal of the initial decision could seriously jeopardize their health or

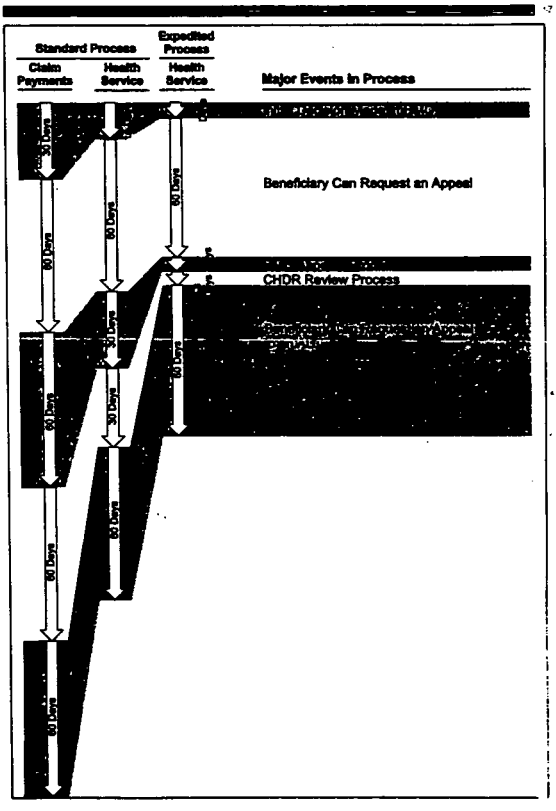
life. If a beneficiary makes the request, the plan determines whether the expedited process is warranted. If a physician makes the request on behalf of a beneficiary or concurs with the beneficiary's request, the plan must expedite its decision. Generally, health plans must make the expedited decision within 72 hours following the request.[14] An expedited decision that is adverse to the beneficiary must be forwarded to CHDR within 24 hours.[15] CHDR is required to process the expedited cases within 72 hours.[16] Figure 2 provides the time intervals for major events in the process.

[14]Certain exceptions allowed plans an extension of up to 10 additional working days. This was redefined to 14 calendar days, effective July 27, 1998.

[15]CHDR received 870 expedited appeal cases in 1997 and 1,755 expedited appeal cases during the first 7 months of 1998.

[16]Prior to August 1998, CHDR had up to 10 days to process expedited cases.

Figure 2: Elapsed Time for Major Events in the Appeals Process



Beneficiaries' Limited Use of the Appeals Process May Understate Dissatisfaction With HMOs' Initial Decisions

HMOs that responded to our survey reported receiving approximately 9 appeals annually per 1,000 Medicare members.[17] However, this number may understate beneficiaries' dissatisfaction with HMOs' initial decisions. First, dissatisfied beneficiaries may disenroll and switch to another plan or fee-for-service instead of appealing. Second, beneficiaries may be unfamiliar with their appeal rights or the appeals process. Plans may not always issue the required notices or may omit an explanation of beneficiaries' appeal rights. In other cases, beneficiaries may not appeal because the notices list nonspecific reasons for the denial.

Annual Appeals Per 1,000 Beneficiaries Varied Among HMOs

The number of annual appeals per 1,000 Medicare beneficiaries varied among HMOs and may be rising. The 242 Medicare HMOs that responded to our recent survey reported an average of about 9 appeals annually per 1,000 beneficiaries between January 1996 and May 1998 (see table 1). Generally, plans overturned nearly three-quarters of the requested appeals. Those not overturned were submitted to CHDR for further review and consideration. Between August 28, 1997, and December 31, 1997, plans expedited 861 appeals.[18] During the first 5 months of 1998, plans expedited 1,548 appeals.

Table 1: Medicare Risk HMO Internal Appeals, 1996 to May 1998

Year	Number of HMOs[a]	Percentage of all risk HMO enrollees	Average monthly enrollment (millions)	Total appeals	Annual number of appeals per 1,000 Medicare enrollees
1996	160	84	2.7	22,437	8.2
1997	223	85	3.9	31,844	8.1
1998[b]	242	89	4.8	21,138	10.5

Note: Table reflects responses from 242 HMOs that completed GAO's questionnaire on internal appeals.

[a]Number of HMOs that responded to our survey in 1998 and were active in given year.

[b]Includes first 5 months of 1998.

Source: GAO survey of Medicare risk HMOs active as of May 31, 1998.

[17]In July 1998, we surveyed all (307) HMOs with active Medicare enrollment as of May 31, 1998. Eighty percent of the HMOs, representing about 5 million (89 percent) of the Medicare beneficiaries enrolled in HMOs, responded to our questionnaire. During 1996, 1997, and the first 5 months of 1998, these HMOs reported receiving about 22,000, 32,000, and 21,000 appeals, respectively. Although the number of appeals increased from 1996 to 1997, the number of managed care enrollees also increased. Consequently, the average rate of appeals per 1,000 members was approximately the same in both years.

[18]About two-thirds of the plans responding to our survey reported the number of requests received that they had expedited. On average, these plans expedited about one quarter of the requests.

The number of annual appeals per 1,000 Medicare beneficiaries among HMOs ranged from 0 to 90. Over half of the plans reported between 1 and 10 appeals per 1,000 beneficiaries. A number of HMOs reported no appeals for each study year: 17 percent in 1996, 13 percent in 1997, and 9 percent in 1998. Nearly all of these HMOs (87 percent) had low Medicare enrollment. There was no similar pattern for plans with the highest appeal rates; they were spread nearly evenly across all plan sizes.[19]

The appeal rate may be rising. Plans reported just over 8 appeals per 1,000 beneficiaries in 1996 and 1997, but annualized data from the first 5 months of 1998 indicated more than 10 appeals per 1,000 beneficiaries. Aggregate appeals data may indicate potential problems with a plan's appeals process, but additional information is needed to assess whether a plan adequately performs this function. A relatively low appeal rate may be the result of a plan's low denial rate or members who are unaware of their appeal rights. Conversely, a plan that denies many requests or that actively educates members about their rights may experience a relatively high appeal rate. Consequently, appeals data should be considered in conjunction with other factors, such as the rates at which CHDR overturns plans' appeal decisions and HCFA's observations of plans' appeals process

Some Beneficiaries May Disenroll Instead of Filing Appeals

The number of appeals may understate beneficiaries' dissatisfaction with their HMO's initial decision if some disenroll instead of appealing. Currently, beneficiaries may disenroll and switch to another plan or Medicare fee-for-service at the end of any month. As we have previously reported, many Medicare HMOs experience high disenrollment rates.[20] The extent to which beneficiaries choose to disenroll rather than appeal is unknown. It is clear, however, that disenrollees report less satisfaction with the care they received from their HMOs than enrollees. According to a survey conducted by HHS' OIG, disenrollees were much more likely than enrollees to say that their primary HMO doctor failed to provide Medicare-covered services.[21] The survey showed that 12 percent of the

[19]We divided the plans into four equal groups based on the Medicare beneficiary enrollment in each year data were reported. For example, for 1998 data, the quartiles were (1) 7 to 2,357 members; (2) 2,358 to 8,135 members; (3) 8,136 to 21,200 members; and (4) 21,201 to 250,366 members.

[20]Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment (GAO/HEHS-98-142, Apr. 30, 1998) and Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996). Although some disenrollment is likely caused by beneficiaries' concerns over the care they received or their plans' unwillingness to provide requested services, other factors, such as the benefit packages offered by competing HMOs, likely play a role. GAO's data were unable to identify beneficiaries' reasons for disenrolling.

[21]HHS OIG, Beneficiary Perspectives of Medicare Risk HMOs, 1996 (OEI-05-95-00430, Mar. 1998).

disenrollees said that their doctors failed to provide covered services, whereas, only 3 percent of enrollees made such an assertion.

If some beneficiaries leave their plans instead of appealing adverse decisions, the number of appeals may rise as BBA's lock-in provisions take effect. Beginning January 1, 2002, beneficiaries will generally be able to change their enrollment decision only once each year outside the annual open enrollment period.[22] In 2002, this change must occur within the first 6 months of the year. In subsequent years, the change must occur within the first 3 months. After the disenrollment period ends (3 or 6 months), beneficiaries will be locked into their selected plans for the remainder of the year.

HHS' Inspector General and Advocacy Groups Find Beneficiaries Are Confused About Medicare Appeals Process

Studies by HHS' OIG and by the Medical Rights Center (MRC)[23] confirm the views of several advocacy group representatives that beneficiaries are confused about the Medicare appeals process.[24] HHS' OIG reported in March 1998 that 27 percent of Medicare HMO enrollees and 35 percent of disenrollees surveyed were uninformed about their appeal rights[25]—rates similar to those found by the Inspector General in 1993.

The results of an analysis conducted by MRC are consistent with the OIG's findings. MRC reported that 40 percent of the 179 beneficiaries who called the center between August 27, 1997, and February 28, 1998, were confused about their appeal rights. According to MRC officials, HMO physicians and customer service staff sometimes compounded beneficiaries' confusion. For example, MRC handled several cases where HMO customer service representatives allegedly gave out misleading, incorrect, or no information on beneficiaries' Medicare appeal rights. Representatives of other advocacy groups reported similar experiences and said that they believe many beneficiaries have difficulty understanding the appeals process.

[22]Exceptions are allowed for certain circumstances. For example, individuals who upon becoming eligible for part A at age 65, enroll in a Medicare+Choice plan may switch to a different plan or fee-for-service at any time during the 12-month period beginning on the effective date of enrollment.

[23]MRC is a national not-for-profit organization that aims to ensure that Medicare beneficiaries have access to quality, affordable health care.

[24]The advocacy groups are the American Association of Retired Persons; Center for Medicare Advocacy, Connecticut; Center for Health Care Rights, Los Angeles; and Legal Assistance to the Elderly, San Francisco.

[25]HHS OIG, Beneficiary Perspectives of Medicare Risk HMOs, 1996. The Inspector General selected a random sample that included enrollees who were enrolled as of June 1996 and disenrollees who had disenrolled between March 1996 and June 1996 for reasons other than death.

Denial Notices Are Sometimes Incomplete or Never Issued

Beneficiaries are supposed to be informed of their appeal rights when they receive a written notice from their plan denying a service or payment.[26] These notices are required to state that the beneficiary has the right to appeal if he or she believes the plan's initial determination is incorrect. The notices must also tell the beneficiary where and when the appeal must be filed. However, HCFA, OIG, and our own analysis of CHDR appeal cases found numerous instances of incomplete or missing denial notices.

HCFA monitoring reviews indicate that some denial notices were not issued and others failed to mention beneficiaries' appeal rights. In 1997, HCFA performed 90 monitoring visits to health plans. About 13 percent of the plans reviewed were cited for failing to issue denial notices. Nearly one-quarter of the 90 plans were cited for issuing denial notices that did not adequately explain beneficiaries' appeal rights. Two studies by HHS' OIG provide additional evidence that beneficiaries are not always informed of their appeal rights. In one study, the OIG found that in 39 out of 144 appeal cases there was no evidence that the beneficiaries had been sent the plans' initial decisions explaining their appeal rights.[27] In another study, the OIG surveyed beneficiaries who were enrolled or had recently disenrolled from a managed care plan.[28] According to the results of a survey, 41 respondents (about 10 percent) said that their health plan had denied requested services. Of these, 34 (83 percent) said that they had not received the required notice explaining the denial and their appeal rights.

Similar deficiencies were found in the appeal cases reviewed at CHDR. Of the 108 CHDR appeal cases reviewed,[29] 5 contained denial notices that failed to inform the beneficiary of his or her appeal rights. Another 32 cases sent to CHDR by the plans lacked the denial notices completely.

[26]In addition, plans are required to explain members' appeal rights in the marketing materials they distribute.

[27]HHS OIG, Medicare HMO Appeal and Grievance Processes, Review of Cases (OEI-07-94-00283, Dec. 1996).

[28]HHS OIG, Medicare HMO Appeal and Grievance Processes, Beneficiaries' Understanding (OEI-07-96-00281, Dec. 1996).

[29]We selected these cases from completed decisions at CHDR during the month of October 1998. We randomly selected 27 cases from four case types: (1) expedited decisions upheld by CHDR (459 cases), (2) expedited decisions overturned by CHDR (159 cases), (3) nonexpedited decisions upheld by CHDR (1,772 cases), and (4) nonexpedited decisions overturned by CHDR (500 cases).

Some Notices Do Not Indicate Specific Reasons for the Denial

HCFA requires that denial notice clearly state the specific basis for denial. HCFA officials said that vaguely worded denial notices hinder enrollees' efforts to construct compelling counterarguments for their appeals. Also, vague notices may hinder beneficiaries from appealing because they may be uncertain as to whether they are entitled to the requested services.

Most notices we reviewed contained general, rather than specific, reasons for the denial. In 53 of the 74 CHDR cases that contained the required denial notices, the notices simply said that the beneficiary did not meet the coverage requirements or contained some other generic reason. It is unclear whether beneficiaries who receive denial notices with nonspecific reasons are less likely to submit written support for their position compared to beneficiaries who receive more detailed notices. Beneficiaries had submitted written support in only 14 of the CHDR appeal cases.[20]

Reconsideration notices written by CHDR personnel provide much greater detail than notices written by plan personnel. For example, in one case, the a health plan issued a notice of noncoverage for skilled nursing facility (SNF) services stating

> you required skilled rehabilitation services—P.T. eval. for mobility + gait—eval. for ADL's, speech eval. swallowing—from 2/11/98 and these services are no longer needed on a daily basis.[21]

CHDR's letter to the beneficiary (upholding the HMO's denial) stated the following:

> The case file indicated that while [name] was making progress in his therapy programs, his condition had stabilized and further daily skilled services were no longer indicated. The physical therapy notes indicate that he reached his maximum potential in therapy. He had progressed to minimum assistance for bed mobility, moderate assistance with transfers, and was ambulating to 100 feet with a walker. The speech therapist noted that his speech was much improved by 2/18/98 and that his private caregiver had been instructed on safe swallowing procedures and will continue with feeding responsibilities.

Representatives from several advocacy groups told us that in cases brought to their attention, the denial notices were often general and did

[20] In one case, it was impossible to determine whether the beneficiary had submitted a written argument.

[21] "P.T." stands for physical therapy, "eval." stands for evaluation, and "ADL' stands for activities of daily living.

not clearly explain why the beneficiary would not receive or continue to receive a specific service. In August 1997, MRC established a hotline for HMO appeals and analyzed all calls it received during the first 6-month period (179).[32] MRC concluded that the explanations found in most plans' denial notices were unhelpful because of their generality—for example, the services were "not medically necessary."[33]

Notices of Discontinued Coverage Are Often Issued 1 Day Before Services Are Stopped

HCFA regulations state that whenever plans discontinue services, they must issue timely denial notices to beneficiaries. HCFA, however, does not specify how much advance notice is required and we found that many plans do not issue denial notices in what many would reasonably consider "timely." Although beneficiaries may appeal denied services upon receiving notice, those who receive little advance notice may not be able to continue to receive services because of their potential financial liability. If the beneficiary appeals and loses, he or she is responsible for the cost associated with services received after the date specified in the denial notice. The potential financial burden can be substantial, especially if the denial involves SNF services.

In three of the four plans we visited, the general practice was to issue denial notices the day before services were discontinued. We reviewed a number of SNF discharge notices at three HMOs and often found that the notices were mailed (usually by certified or express mail) to the beneficiary's home instead of being delivered to the facility where the beneficiary resided. In some cases, it appeared that the beneficiary or his or her representative received the notice a few days after the beneficiary had been discharged. Ten of the 25 CHDR cases we reviewed also involved a beneficiary or his or her representative receiving a discharge notice after the beneficiary was discharged from the SNF.[34]

The fourth plan we visited issued SNF discharge notices 3 days prior to the discharge date. This lead time helped ensure that the beneficiary received the notice before the discharge. It also allowed more time for the beneficiary to file an expedited appeal and receive a decision from the plan. Consequently, beneficiaries in this plan who appeal and lose are less exposed to SNF costs incurred during the appeals process.

[32]The hotline operated for 2 hours a day, 4 days a week. At other times, a caller was instructed to leave a message or seek assistance from another organization listed on their denial notice.

[33]MRC, Systemic Problems With Medicare HMOs: Case Studies From the Medicare Rights Center HMO Hotline (Sept. 1998).

[34]There were 27 cases involving SNF discharges, but 2 cases had conflicting data.

Officials in three plans indicated that when a beneficiary is being considered for discharge, a nurse or discharge planner probably would have discussed the issue with the beneficiary well in advance of the discharge. Even when a beneficiary knows a discharge is imminent, however, he or she cannot appeal until a denial notice is officially issued. Officials from the plans we visited told us that, in almost every instance, the decision to discharge a beneficiary from a SNF is made several days before the actual discharge date. Officials from all the plans agreed that, in most instances, such notices could be issued several days prior to the discharge date so that beneficiaries who wished to appeal could receive an expedited appeal decision before the planned discharge date.

HCFA's Oversight of Plans' Appeals Procedures Is Limited

HCFA's biennial monitoring of plans' appeals process focuses on timeliness and administrative issues, but we found several important weaknesses in the agency's monitoring procedures. For example, HCFA's sampling of cases to determine whether beneficiaries are appropriately informed of their appeal rights likely misses beneficiaries who were not informed. HCFA's monitoring also generally excludes the operations of HMO provider groups that may be responsible for making denial decisions and for issuing the required notices. HCFA officials believe that the agency can improve in many of these areas, and in commenting on a draft of this report, HCFA said that it has begun to address these weaknesses. However, to date, HCFA has made little use of the results of its HMO performance reviews to develop overall national trends and improve the agency's oversight function.

HCFA's Monitoring Protocol Systematically Misses Beneficiaries Who May Not Have Been Informed of Their Appeal Rights

To determine whether plans informed beneficiaries of their appeal rights, HCFA's monitoring protocol requires agency staff to review a sample of appeal cases. HCFA staff check these case files to determine whether each contains a copy of the required denial notice. However, it seems reasonable to assume that beneficiaries who appeal denials are more likely to have been informed of their rights than beneficiaries who do not appeal. Yet HCFA does not check cases where services or payment for services were denied and not appealed. HCFA might get a better indication of whether beneficiaries were told of their rights if agency staff examined a sample of denial notices from cases that were not appealed.

HCFA and Plans Exercise Little Oversight of Administrative Tasks Delegated to Provider Groups

Some health plans delegate the responsibility for deciding whether to expedite initial decisions, issuing denial notices, and other operating tasks to medical provider groups. For example, one plan we visited had delegated the responsibility of issuing service and payment denial notices including paying claims to approximately 250 provider groups with which it contracted. A plan official stated that his plan has never reviewed service denials and does not know how many services its provider groups have denied. The plan has, however, recently developed a monitoring protocol to review service denials and intends to implement it soon. According to several HMO officials, this practice is common in California and is increasing in other parts of the country.

Officials also said that HMOs typically exercise little or no oversight over provider groups' operations and have difficulty ensuring that groups adequately perform the delegated tasks. For example, according to an official from another HMO, provider groups on the West Coast expect plans to grant them the authority to issue denial notices because they are at financial risk for the services they provide. To contract with these groups, his plan must delegate that authority even though the practice is not desirable from his HMO's perspective. He said that provider groups often do not send the plans copies of issued denial notices, although the plans request them. The official estimated that his plan receives only about 30 percent of the denial notices issued by their provider groups. He added that his plan does not review the notices it does receive.

Moreover, according to a HCFA official, HCFA does not generally monitor HMO provider groups. Because provider groups may not submit requested information to HMOs and HCFA does not normally monitor provider groups directly, it is likely that no one reviews many of the initial decisions—including expedited decisions—made by these groups. A 1998 study done for HCFA noted that the delegation of authority to provider groups is problematic because health plans do not exercise sufficient control over the delegated functions.[25] The report recommended that HCFA pay closer attention to this issue.

HCFA Has Provided Limited Guidance to Plans on Expedited Appeals Process

Although HCFA has provided plans with general guidance, such as model language for denial notices, it has not produced specific guidelines to ensure consistent implementation of the expedited appeals process. Further, without clear guidelines on what should be expedited, HCFA has

[25]Built Health Purchasing, LLC, The Medicare Managed Care Compliance Monitoring Program: Recommendations for Modification and Improvement (Jan. 22, 1998).

no way of determining whether plans are expediting initial decisions and appeals appropriately. HCFA has not produced criteria or examples for HMOs to follow when deciding whether the standard appeal time frames could seriously jeopardize a beneficiary's health or life. In the absence of such criteria, Medicare HMOs have a wide latitude to determine whether a beneficiary's request for an initial decision or appeal should be expedited.

Receiving no specific guidance from HCFA, several California HMO and provider industry representatives formed a work group and developed clinical criteria for expedited initial decisions and appeals. In January 1998, the HCFA region responsible for Arizona, California, and Nevada provided the work group's criteria to all Medicare HMOs in those three states. HCFA officials said they are not aware of similar efforts in other regions. We found, however, that at least one Florida HMO had incorporated much of the California work group's criteria into its own procedures—possibly because the HMO also operated in California.

Without better guidance from HCFA, some cases that should be expedited may not be. In our review of cases sent to CHDR, we examined 42 appeals involving denied services that HMOs had not expedited. CHDR reviewers determined that seven (17 percent) of these cases should have been expedited. (CHDR expedited these cases for its own review process.)

HCFA Makes Little Use of Available Data for National Program Management

Staff from HCFA's central and regional offices told us that the agency has made little use of its monitoring reports as an overall program management tool. Each report documents the results of HCFA's biennial performance review of a plan and summarizes its compliance with Medicare regulations. Aggregating the findings from the individual monitoring reports could help HCFA monitor the relative performance of plans, identify variations among regions, and study national trends. However, when we requested all of the 1997 monitoring reports no one at HCFA's headquarters had a complete set. We were told that we would have to request them from each region.

Shortly after we requested the reports from the regions, the Health Plan Purchasing and Administration Group in HCFA's central office began collecting from the regional offices all 1996 and 1997 monitoring reports. According to HCFA officials, agency staff are now analyzing the information in the reports.

HCFA is planning to develop a health plan management system that will provide information to central and regional office staff and will aid plan and program oversight. The system will include information on appeals. HCFA had expected to complete the data design phase by now but has fallen behind schedule. According to the project manager, the system will not be operational until late 1999 or early 2000.

HCFA Has Not Required Plans to Collect and Report Data on Appeals

The need for both HCFA and Medicare beneficiaries to have information on HMO appeals is well recognized. In 1996, and again in 1998, HHS' OIG recommended that HCFA require managed care plans to report data on appeals, such as the number of cases, the number resolved internally and externally, issues involved, and the time needed to resolve cases.[26] Also, in implementing its expedited process, HCFA is requiring plans to report data on expedited appeals. Further, BBA requires plans to disclose information on the number and the disposition of appeals to interested Medicare beneficiaries.

On February 10, 1999, HCFA issued an operational policy letter that establishes the guidance for managed care plans to follow in collecting appeals data and making that information available to Medicare beneficiaries. Plans will report the number of appeals per 1,000 Medicare beneficiaries. Each plan's rate will be based on its contract market.[27] Plans will begin collecting and maintaining appeals data beginning April 1, 1999. Data collection periods will be based on a rolling 12-month period. (Prior 6 months of data are added to the next 6 months of data in order to come up with a 12-month data collection period.) The first 6-month period will begin April 1, 1999, and end September 30, 1999. Plans will report results from the first 6-month period on January 1, 2000.

HCFA, however, has not provided guidance on the type of appeals data plans should collect and report to HCFA. According to officials in HCFA's central office, the agency has formed a work group—consisting of plan representatives, advocacy representatives, and program officials—to develop appeals data requirements. HCFA expects to finalize these requirements later this year. Meanwhile, some HMOs may be waiting to receive HCFA's guidelines before they implement systems to track their appeals data. Although all the plans that responded to our survey reported

[26]HHS OIG, Medicare HMO Appeal and Grievance Process: Overview (OEI-07-94-00280, Dec. 1996), and Medicare's Oversight of Managed Care: Monitoring Plan Performance (OEI-01-96-00190, Apr. 1998).

[27]Contract market implies either reporting by contract or by a market area within a contract. This determination will be made by HCFA.

the total number of appeals upheld and overturned, only about two-thirds were able to break down their appeals into more specific service categories, such as nursing home care and emergency room use.

Conclusions

Medicare beneficiaries have access to a multilevel appeals process that allows them to challenge HMO decisions to deny services or payment for services. Relatively few beneficiaries—about 9 out of every 1,000 managed care enrollees—appeal each year. Some beneficiaries may not appeal, however, because they are unaware of their appeal rights or confused about the process. Evidence from a variety of sources—HCFA monitoring reports, studies by HHS' OIG, and our review of cases at plans and at CHDR—indicate that plans do not always inform beneficiaries of their appeal rights as required. In some cases, denial notices cite nonspecific reasons for the denial, making it more difficult for beneficiaries to challenge their plan's decision. In other cases, beneficiaries may be unnecessarily exposed to substantial health care costs because notices are not issued in a timely fashion. Furthermore, the agency has not issued specific guidance as to the types of cases plans should expedite.

HCFA reviews plans' implementation of the appeals process, but its monitoring protocol exhibits several weaknesses. For example, HCFA does not know whether provider groups have satisfactorily implemented the required appeals process because it exercises little oversight over provider group operations. The type of cases HCFA samples to determine whether beneficiaries were informed of their appeal rights likely systematically misses beneficiaries who were not informed. Further, the agency has not provided plans guidance on the types of appeals data they should collect and report to HCFA. HCFA agrees that it needs to strengthen its oversight of health plans' appeals process and noted that the agency has several initiatives under way.

Recommendations

To help ensure that the appeals process provides adequate protection to Medicare beneficiaries, the HCFA Administrator should take the following actions:

- Provide more explicit denial notice instructions to plans. Denial notices should explain the coverage criteria and state the specific reason or reasons why the beneficiary did not meet the criteria.

- Set specific timeliness standards for certain types of denial notices, such as discontinued SNF care services, to allow beneficiaries reasonable time to obtain an expedited appeal decision.
- Develop criteria for plans to use in determining when initial decisions and appeals should be expedited.

To improve the agency's monitoring of appeals process, the HCFA Administrator should take the following actions:

- Require each plan to collect sufficient information from its provider groups so that HCFA staff can, during the course of a normal biennial performance review, determine whether the plan and its provider groups satisfactorily implemented the required appeals process.
- Require agency staff conducting performance reviews to sample a number of denied cases that were not appealed to determine whether beneficiaries were informed of their appeal rights.
- Use the data the agency collects during plan performance reviews to assess the relative performance of plans, and develop strategies for better plan monitoring and program management.

To ensure that appeals data are available to HCFA and Medicare beneficiaries, the Administrator should develop requirements for the type and format of appeals data plans must collect and make available.

Agency Comments and Our Evaluation

HCFA agreed with our finding that its oversight of health plans' appeals process needs to be strengthened and generally agreed with our recommendations. (See app. II for HCFA's written comments regarding our recommendations.) The agency outlined several initiatives it has recently undertaken to better protect beneficiary rights. Some of these initiatives may be implemented shortly; others are in the early planning stage.

HCFA expressed concern, however, about our recommendation that the agency develop criteria to help plans determine when initial and appeal decisions should be expedited. HCFA said that a further refinement of the current general criteria might inadvertently exclude unspecified standards. HCFA said that it would explore possible options regarding the criteria, but that it would proceed cautiously to avoid unanticipated problems. We disagree with the premise that further refinement of the criteria would inadvertently limit beneficiary access to expedited initial and appeal decisions. As noted in this report, specific clinical criteria have been developed and used by plans in at least one HCFA region. HCFA could

develop specific criteria, to be implemented nationwide, that are understood to be an elaboration of the current general criteria and not a replacement for them.

In addition, HCFA provided several 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 1 day from the date of this letter. At that time, we will send copies to the Honorable Donna Shalala, Secretary of HHS; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; and interested congressional committees and members. We will also make copies available to others on request.

Please contact me at (202) 512-7119 or James Cosgrove, Assistant Director, at (202) 512-7029 if you or your staff have any further questions. This report was prepared by Cam Zola, Richard Neuman, and Beverly Ross.

Laura A. Dummit

Laura A. Dummit
Associate Director, Health Financing
and Public Health Issues

Contents

Abbreviations

ALJ	administrative law judge
BBA	Balanced Budget Act of 1997
CHDR	Center for Health Dispute Resolution
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
MRC	Medical Rights Center
OIG	Office of Inspector General
SNF	skilled nursing facility

Appendix I

Scope and Methodology

To obtain information on plan-level appeals handled by HMOs during 1996, 1997, and the first 5 months of 1998, we surveyed all (307) Medicare HMOs that were active as of May 31, 1998. We obtained responses from 250 plans (81.4 percent).

We visited three judgmentally selected HMOs—one in California and two in Florida. We selected these plans based on (1) geographic location, (2) high 1997 disenrollment rates, and (3) high Medicare enrollments. Our visit to one Florida HMO coincided with a monitoring visit by HCFA's region IV staff. During our visits, we discussed the appeals process with plan officials and reviewed a limited number of cases at three of the locations. The cases included standard appeals and expedited appeals that where upheld and overturned at the plan level within the 6 months prior to our visit. Each case reviewed was discussed with a plan official responsible for the plan's appeals process. In addition, we made a site visit to an HMO in Maryland during a HCFA monitoring visit. Our visit to the Maryland HMO was limited to overseeing the monitoring team's review of appeal cases and several discussions with plan officials.

We visited the two HCFA regional offices (region IX in San Francisco, California, and region IV in Atlanta, Georgia) responsible for the three plans we visited. We discussed the appeals process and the monitoring effort with appropriate officials in each region. We also spoke with regional personnel in HCFA's region X about the appeals process and HCFA's monitoring effort and results. In addition, we obtained from HCFA a summary spreadsheet that showed all the monitoring reports completed in 1997 and summarized plan compliance with Medicare requirements. From this list, we selected and reviewed the monitoring reports of plans that indicated deficiencies in the categories related to the appeals process, denial notices, or both.

With assistance from CHDR we randomly selected and reviewed 108 appeal cases that had been adjudicated by CHDR in 1998 and had not been sent to storage as of October 1998. We developed a data collection instrument and specific criteria for evaluating the case file information. A CHDR analyst, who reviewed each case and recorded the review results, used this instrument and criteria. We reviewed the results of over half of the 108 cases to ensure the data were recorded accurately and met our evaluation criteria.

We discussed HCFA's appeal policy and practice with HCFA officials and representatives from five advocacy groups representing Medicare

beneficiaries in health plans. In addition, we reviewed a number of HHS OIG reports covering several aspects of Medicare's appeals process in HMOs. Also, we reviewed a report done by the Medicare Rights Center that discussed systemwide problems with Medicare HMOs.

Our office of General Counsel reviewed the results of a class action lawsuit and the resulting appeal by HCFA before the 9th U.S. Circuit Court of Appeals.

Appendix II

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAR 12, 1999

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare Managed Care: Greater Oversight Needed to Protect Beneficiaries' Rights"

TO: William J. Scanlon, Director
Health Financing and Systems Issues, GAO

We appreciate the opportunity to review your draft report to Congress concerning the Medicare managed care appeals process. We agree with the report's findings that HCFA's oversight of health plans' appeals processes needs to be greatly strengthened, and we are currently undertaking several initiatives in that regard to better serve our Medicare beneficiaries.

In general, we agree with the recommendations the GAO has made in the report, and are enclosing our comments to the specific recommendations. We look forward to working with GAO and the Congress as we continue to ensure that beneficiaries are provided with ample information on both appeal and disenrollment rights.

Enclosure

Comment of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report, "Medicare Managed Care: Greater Oversight Needed to Protect Beneficiaries' Rights"

General Comments

HCFA has undertaken a number of initiatives to better protect Medicare beneficiaries' rights. The agency has established various vehicles to ensure that beneficiaries are provided with ample information on both appeal and disenrollment rights. Under HCFA's direction, plans annually create member materials to inform beneficiaries of their appeal rights (these member materials include but are not limited to member handbooks, evidence of coverage notices, and denial notices). These materials must be written in a culturally competent manner that is understandable to the beneficiary, and Medicare+Choice (M+C) organizations must obtain HCFA approval before dissemination.

HCFA is also piloting a disenrollment process at the Medicare Choices Helpline, 1-800-Medicar[e]. The pilot project will establish an alternative neutral mechanism enabling a beneficiary to disenroll from a managed care plan and revert to original Medicare fee for service without going to the Social Security Administration (SSA). As part of the pilot a tool will be devloped (the new HCFA R-257 disenrollment form) to capture useful disenrollment reason information from beneficiaries.

Additionally, HCFA is currently administering a disenrollment survey under the Medicare Consumer Assessment of Health Plan Study (CAHPS). The purpose of this survey is to obtain reasons why beneficiaries are disenrolling. This survey will be implemented nation-wide in the Fall of 1999, and it will provide HCFA with a cross section of nation-wide information while tracking ongoing disenrollment information.

HCFA has consulted with consumer groups and representatives of managed care plans to help determine the types of grievance and appeal measures that are valid, reasonable, and helpful to prospective enrollees. In the Fall of 1998, HCFA formed an Appeal/Grievance/ Complaint Workgroup to recommend the appeal and grievance data that M+C organizations should make available to beneficiaries.

GAO Recommendation #1

To help ensure that the appeal process provides adequate protection to Medicare beneficiaries, the HCFA Administrator should take the following actions:

- Provide more explicit denial notice instructions to plans. Denial notices should explain the coverage criteria and state the specific reason(s) why the beneficiary did not meet criteria.

HCFA Comment

HCFA concurs with the recommendation. In fact, HCFA has been planning to publish an operational policy letter (OPL) in early 1999 instructing M+C organizations that they must be explicit in their denial notices to beneficiaries. Plans should notify beneficiaries of any adverse coverage determination in writing and include a detailed explanation of the coverage criteria within the body of the notice. Model language for denial notices has been provided to M+C organizations and delegated providers. Portions of this model denial language may be used in other member materials as well.

GAO Recommendation #2

- Set specific timeliness standards for certain types of denial notices, such as discontinued skilled nursing facility (SNF) care services, to allow beneficiaries reasonable time to obtain an expedited appeal decision.

HCFA Comment

HCFA agrees that timeliness standards should be set for certain types of denial notices and that enrollees should receive such notices prior to discharge. HCFA has been exploring the need to establish timeliness standards for notices -- other than adverse organization determinations and inpatient hospital discharges for which there are already specific requirements. In particular, we have commenced a regulation team to develop a notice of proposed rulemaking (NPRM) addressing when M+C organizations should issue notice to beneficiaries in the case of service reductions or discontinuations (such as SNF care, home health, or physical therapy). Further, we have committed to work with members of the beneficiary advocacy community and industry representatives to obtain guidance on how best to operationalize any new requirement.

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GAO Recommendation #3

- Develop criteria for plans to use in determining when initial decisions and appeals should be expedited.

HCFA Comment

Under § 1852(g)(3)(B)(ii) of the Social Security Act, M+C organizations are required to expedite any request for a service "if the request indicates that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." The preamble to the April 30, 1997, Expedited Review final rule with comment that applies to grandfathered 1876 cost contracts provides that requests for reconsideration of noncoverage determinations for inpatient stays, other than hospital discharges for which immediate Peer Review Organization review is available, will be expedited. It also provides that requests for reconsiderations of determinations to discontinue a service (such as physical therapy) in the home or outpatient setting where a longer review time could jeopardize the enrollee's life, health, or ability to regain his or her maximum function, will be expedited.

HCFA has a concern that a further refinement of the criteria would inadvertently exclude unspecified standards. As a result,we are proceeding cautiously so as to avoid any unanticipated problems. HCFA will explore possible options regarding criteria that could be used for granting expedited requests for services.

GAO Recommendation #4

- Require each plan to collect sufficient information from its provider groups so that HCFA staff can, during the course of a normal biennial performance review, determine whether the plan and its provider groups satisfactorily implemented the required appeals process.

HCFA Comment

HCFA concurs with the recommendation. HCFA is implementing parts of the Part C regulation though the Quality Improvement System for Managed Care (QISMC).

Under this system, HCFA specifies the requirements for M+C organizations who elect to delegate functions to outside entities. These include making the M+C organization accountable for any function delegated to an outside organization. The requirements also call for written delegation agreements; pre-evaluation of the delegated entity's ability to

perform the delegated function, and monitoring. HCFA expects to complete revisions to its monitoring protocol, the Contractor Performance Monitoring System, in late Spring 1999. This protocol should include the Part C requirements. The Contractor Performance Monitoring System will also contain a new QISMC section.

HCFA also conducts sampling in order to determine compliance with some of the requirements for the appeals process. Samples are random and may, or may not, include files of beneficiaries who are receiving their appeals rights from a delegated provider group. Under HCFA's current policy, the M+C organization is responsible for the appeals function regardless of any delegated function. HCFA will focus its attention on ensuring that M+C organizations understand the delegation requirements as outlined in QISMC and that M+C organizations understand their continued accountability. HCFA will also review evaluation methods to provider groups when appropriate.

Regulations implementing the Balanced Budget Act of 1997 (BBA) gave HCFA additional authorities to enforce the managed care appeals process. The Part C regulation at 42 CFR 422.510(a) allows HCFA to initiate enforcement actions against an M+C organization that "substantially fails to comply" with the appeals and grievances requirements in subpart M. These enforcement actions include termination, nonrenewal of the M+C contract, and intermediate sanctions.

GAO Recommendation #5

- Require agency staff conducting performance reviews to sample a number of denied cases that were not appealed to determine whether beneficiaries were informed of their appeal rights.

HCFA Comment

HCFA concurs with the recommendation. Regional office staff currently review a sample of an M+C organization's claims denials as part of the Claims Processing review. HCFA staff must make a determination on HCFA's Review of Denied Claims worksheet (Form WS-CP2) as to whether a claims denial was proper and whether the correct appeals language was provided in the denial notice.

HCFA is currently updating the monitoring guide to incorporate the Part C requirements. HCFA intends to include a reference to the Medicare Organization Determinations and Appeals section in the Claims Processing Section, and on the Review of Denied Claims worksheet.

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GAO Recommendation #6

- Utilize the data the agency collects during plan performance reviews to assess the relative performance of plans and develop strategies for better plan monitoring and program management.

HCFA Comment

HCFA concurs with the recommendation. HCFA is embarking on an effort to analyze the data from the M+C organization monitoring database and has recently completed collection and validation of the FY 1998 data. Data collected from FY 1997 and FY 1998 is currently being analyzed to determine commonalities and trends that exist among the data collection periods at all levels: national, regional, market and M+C organization. Results from this data analysis will be used by the HCFA managers to more effectively focus agency monitoring efforts by providing relevant and timely information to their staff. In addition, results from this data analysis may be used by HCFA to inform M+C organizations of industry-wide areas of improvement.

As a long term project, HCFA will be developing strategies to enhance the uses of M+C organization data collected through the current M+C organization monitoring process as well as utilizing several additional relevant M+C organization data, such as CAHPS, and the Medicare Health Outcomes Survey. HCFA plans to analyze the different data sources and use this information to make changes in its overall M+C organization monitoring strategy, including the development of M+C organization performance measures.

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United States General Accounting Office

GAO

Report to Congressional Requesters

April 1999

MEDICARE+CHOICE

New Standards Could Improve Accuracy and Usefulness of Plan Literature

Printed copies of this document will be available shortly.

GAO/HEHS-99-92

B-282193

April 12, 1999

The Honorable Charles E. Grassley
Chairman
The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Jack Reed
United States Senate

Today, almost 7 million Medicare beneficiaries are enrolled in health plans offered by managed care organizations (MCO) that participate in the Medicare+Choice program, Medicare's alternative to its fee-for-service program.[1] Although Medicare managed care enrollment has nearly doubled in the last 3 years, approximately 32 million beneficiaries (83 percent) remain covered under fee-for-service. Many health care analysts believe that competition among MCOs can lead to enhanced benefit packages and lower out-of-pocket fees for Medicare beneficiaries. Analysts further believe that increased managed care enrollment may yield savings for the Medicare program. The potential of Medicare+Choice cannot be realized, however, unless beneficiaries are well-informed about their enrollment options.

Recently, the Health Care Financing Administration (HCFA), the agency responsible for administering the Medicare program, took steps to increase beneficiaries' awareness of their health care options. Beneficiaries can now obtain names of available plans and a summary of their benefit packages by calling a toll-free telephone number or logging onto HCFA's Internet Web site. The agency intends to include some of this information in the Medicare handbooks it will mail to all beneficiaries in October 1999. In spite of these new resources, however, MCOs' sales agents and member literature will remain beneficiaries' only source of detailed

[1]A plan is a package of specific health benefits, out-of-pocket costs, and terms of coverage. An MCO is an entity that offers one or more plans. The Medicare+Choice program also allows non-MCO plans, such as private fee-for-service plans and medical savings account plans, to participate. However, as of Mar. 1999, no non-MCO plans had joined the program.

information about plans' benefits and out-of-pocket fees.[2] HCFA, therefore, continues to review and approve all member literature and other marketing materials distributed by MCOs to help ensure that beneficiaries receive accurate information about their available health plan options.[3]

Because correct and useful information is vital to the success of the Medicare+Choice program, you asked us to assess (1) the extent to which MCOs' member literature provides beneficiaries with accurate and useful plan information and (2) whether HCFA's review process ensures that beneficiaries can rely on MCOs' member literature to make informed enrollment decisions. To address these issues, we assessed the accuracy, timeliness, completeness, and comparability of the member literature of 16 MCOs and studied HCFA's requirements and practices for reviewing and approving these materials. Our analysis focused on three benefits that vary in complexity: annual screening mammography, outpatient prescription drugs, and ambulance transportation. Our work was performed from August 1998 to April 1999 in accordance with generally accepted government auditing standards. Appendix II contains details on our methodology.

RESULTS IN BRIEF

Although HCFA had reviewed and approved the materials we examined, all 16 MCOs in our sample from four HCFA regions had distributed materials containing inaccurate or incomplete benefit information. Almost half of the organizations distributed materials that incorrectly described benefit coverage and the need for provider referrals. For example, materials from five MCOs stated that beneficiaries needed a physician's referral to obtain an annual screening mammogram. In fact, Medicare policy explicitly prohibits MCOs from requiring a referral for this service. In addition, one MCO marketed (and provided) a prescription drug benefit that was substantially less generous than the plan had agreed to provide in its Medicare contract. Moreover, some MCOs did not furnish complete information on plan benefits and restrictions until after a beneficiary had enrolled. Other MCOs never provided full descriptions of plan benefits and restrictions. Although not fully disclosing benefit coverage may hamper beneficiaries' decision-making, neither practice violates HCFA policy. Finally,

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[2]"Member literature" includes benefit summary brochures, policy booklets, member handbooks, and plan letters regarding benefit changes.

[3]"Marketing materials" include any material managed care plans distribute to Medicare beneficiaries. In addition to member literature, these materials include radio, newspaper, and television advertisements.

as we have reported previously,[4] it was difficult to compare available options using member literature because each MCO independently chose the format and terms it used to describe its plan's benefit package. In contrast, the Federal Employees Health Benefits Program's (FEHBP) plans are required to provide prospective enrollees with a single comprehensive and comparable brochure to facilitate informed enrollment choices.

The errors we identified in MCOs' member literature went uncorrected because of weaknesses in three major elements of HCFA's review process. Limitations in the benefit information form (BIF), the contract form that HCFA reviewers use to determine whether plan materials are accurate, led some reviewers to rely on the MCOs themselves to help verify the accuracy of plan materials. Additionally, HCFA's lack of required format, terminology, and content standards for member literature created opportunities for inconsistent review practices. According to some regional office staff, the lack of standards also increased the amount of time needed to review materials, which contributed to the likelihood that errors could slip through undetected. Finally, the agency's failure to ensure that MCOs corrected errors identified during the review process caused some beneficiaries to receive inaccurate information. HCFA is working to revise the BIF and develop a standard summary of benefits for plans to use–steps that will likely improve the agency's ability to review member literature and other marketing materials–but other steps could be taken to improve the usefulness and accuracy of plan information.

BACKGROUND

Medicare is the national health insurance program for those aged 65 and older and certain disabled individuals. In 1998, Medicare insured approximately 39 million people. All beneficiaries can receive health care through Medicare's traditional fee-for-service arrangement, and many beneficiaries live in areas where they also have the option of receiving their health care through a managed care plan. Of the almost 7 million Medicare beneficiaries enrolled in managed care as of March 1999, nearly all are enrolled in plans whose MCOs receive a fixed monthly fee from Medicare for each beneficiary they serve. Total Medicare spending is expected to reach about $216 billion in fiscal year 1999, with managed care's portion reaching approximately $37 billion.

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[4]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

Balanced Budget Act Required Major Program Changes

The Balanced Budget Act of 1997[5] (BBA) established the Medicare+Choice program as a replacement for Medicare's previous managed care program. Medicare+Choice was intended to expand beneficiaries' health plan options by permitting new types of plans, such as preferred provider organizations and provider-sponsored organizations, to participate in Medicare. BBA also established an annual, coordinated enrollment period to begin in 1999 during which beneficiaries may enroll or change enrollment in a Medicare+Choice plan.[6] Previously, MCOs were required to have at least one 30-day period each year when they accepted new members, but most MCOs accepted new members throughout the entire year. Also, before BBA, Medicare beneficiaries could join or leave a plan on a monthly basis. Beginning in January 2002, Medicare beneficiaries will no longer be able to enroll and disenroll on a monthly basis. If they experience problems with a plan, identify a better enrollment option, or simply have second thoughts, beneficiaries will have a limited time each year to change the election they made during the coordinated enrollment period.[7] Afterwards, they will be "locked into" their health plan decision for the remainder of the year.

Contracting Process Establishes Plan Benefit Packages

Each plan's benefit package is defined through a contracting process that establishes the minimum benefits a plan must offer and the maximum fees it may charge during a calendar year.[8] After a benefit package is approved by HCFA, a plan may not reduce

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[5]P.L. 105-33.

[6]Individuals may enroll in a Medicare+Choice plan when they first become eligible for Medicare regardless of the time of year.

[7]Beneficiaries will have 6 months in 2002 and 3 months thereafter to change their enrollment choices. Exceptions to these limitations will be made if an organization materially misrepresents the plan or substantially violates a material provision of its contract.

[8]HCFA approves plan benefit packages though a process formally known as the adjusted community rate proposal process, which is intended to ensure that Medicare does not pay MCOs more than a commercial purchaser would pay for the same benefits, after adjusting for differences in Medicare beneficiaries' health status and use of services. If Medicare's payment is higher, the MCO typically adds benefits to offset the difference. MCOs cannot charge fees–in the form of monthly premiums,

benefits or increase fees until the next contract cycle. A BIF, which is included in an MCO's contract as an exhibit, describes in detail the services, copayments, and monthly premiums associated with each plan.

HCFA Reviews All Marketing Materials

HCFA's central and regional offices are involved in reviewing plans' marketing materials, which include member literature. The central office negotiates contracts and establishes national policy regarding marketing material review. HCFA's regional offices review marketing materials when submitted throughout the year and require MCOs to change the materials when they omit required information or are inaccurate, misleading, or unclear. While some regional offices may review materials that certain organizations distribute nationwide, generally each regional office is responsible for reviewing the materials to be distributed within its geographic jurisdiction. To verify the accuracy of benefit information, regional staff are instructed to check plan materials against the BIF. HCFA staff also verify that MCOs have included certain information in their materials, such as explanations of provider restrictions and beneficiary appeal rights. HCFA provides guidance for both developing and reviewing marketing materials through its contract manual, marketing guidelines, and operational policy letters. Despite HCFA's authority to do so, the agency does not require MCOs to use standard formats or terminology in their marketing materials.

According to HCFA regulations, if HCFA staff do not disapprove submitted materials within 45 days, the materials are deemed approved, and MCOs may distribute the materials to beneficiaries.[9] Review procedures established by several regional offices allow "contingent approval"; that is, the materials are approved on the condition that the MCOs make specific corrections. When contingent approval is given, procedures in three regions call for HCFA staff to verify that the MCOs have made the required corrections before the materials are published and distributed to beneficiaries. (See fig. 1.)

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copayments, or other cost-sharing–that are higher than what a beneficiary would likely pay under traditional Medicare.

[9]42 CFR, part 422.80.

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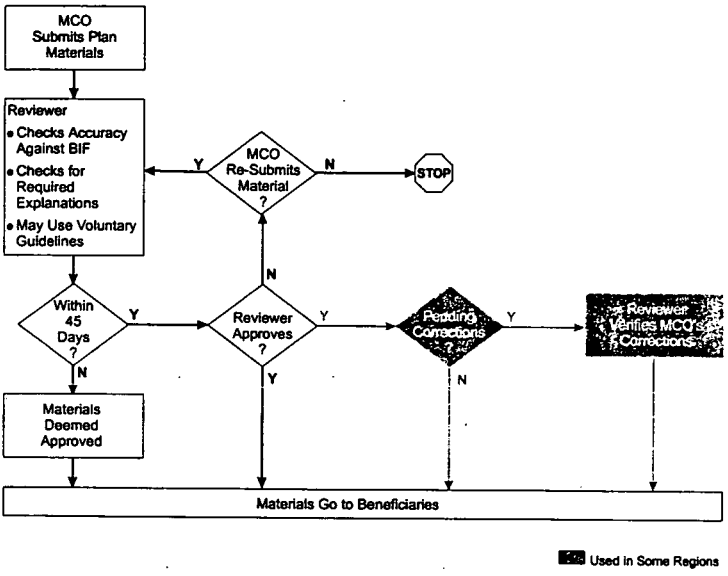
Figure 1: HCFA's Process for Reviewing and Approving Marketing Materials



Source: GAO analysis of HCFA's review policies and practices.

Plan Information Is Necessary for Informed Choice

Historically, HCFA has done little to address beneficiaries' need for comparable and unbiased information about Medicare managed care plans. In 1996, we reported that beneficiaries received little or no comparable information on Medicare health maintenance organizations and that the lack of information standards made it difficult

for beneficiaries to compare plans' member literature.[10] At that time, we recommended that HCFA produce plan comparison charts and require plans to use standard formats and terminology in key aspects of their marketing materials.

BBA mandated that HCFA undertake a number of activities to provide Medicare beneficiaries with information about their health plan options. Beginning in November 1998, HCFA was required to provide an annual national educational and publicity campaign to inform beneficiaries about the availability of Medicare+Choice plans and the enrollment process. Also, each fall starting in 1999, HCFA must distribute to beneficiaries an array of general information about the traditional Medicare program, supplemental insurance, appeal and other rights, the process for enrolling in a Medicare+Choice plan, and the potential for Medicare+Choice contract termination. At the same time, HCFA must provide each Medicare beneficiary with a list of available Medicare+Choice plans and a comparison of plan options. All of these activities are designed to coincide with and support the coordinated open enrollment period slated to occur each November starting in 1999.

HCFA's goal is to make beneficiaries aware of their health plan options and to provide some summary information to help beneficiaries compare those options. According to HCFA officials, in 1999 each beneficiary will receive a Medicare handbook that contains some comparable information about available health plans.[11] Beneficiaries who want more information may call HCFA's toll free telephone number (1-800-MEDICAR) or log onto the Internet Web site (www.medicare.gov). All of these resources--the Medicare handbook, toll-free telephone number, and Web site--are designed to help beneficiaries identify enrollment options and compare selected aspects of benefits. To obtain detailed information about specific plans, however, beneficiaries must continue to rely on MCOs' sales agents and member materials. (See fig. 2.)

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[10]GAO/HEHS-97-23, Oct. 22, 1996.

[11]During the fall of 1998, HCFA included this information in the Medicare handbook distributed to beneficiaries in five states.

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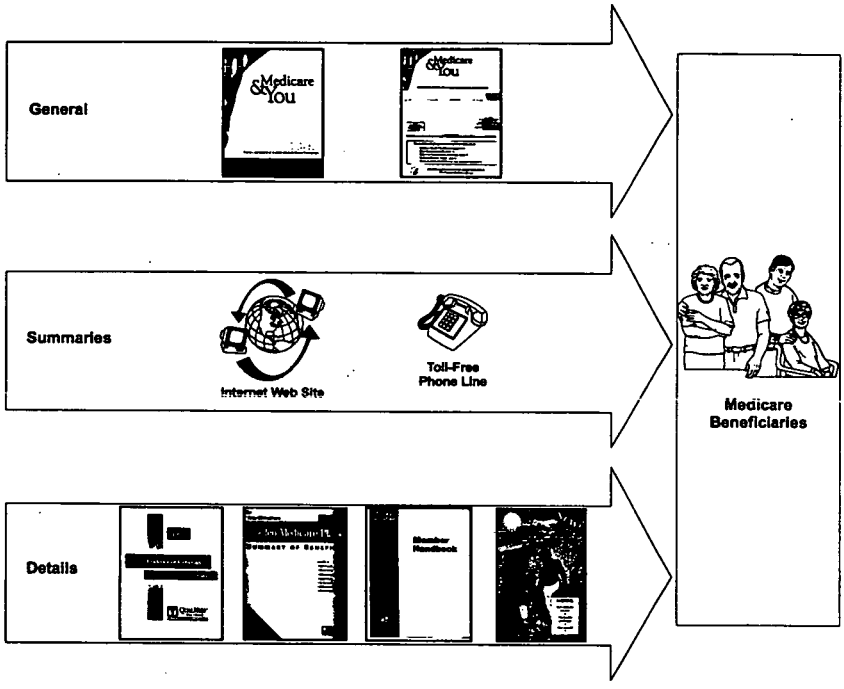
Figure 2: Plan Information Available to Medicare Beneficiaries



Sources: For general information, HCFA; for summary information, HCFA and MCOs; for detailed information, various MCOs' marketing materials.

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MEMBER LITERATURE FREQUENTLY WAS NOT ACCURATE, TIMELY, COMPLETE, OR COMPARABLE

Our investigation of 16 MCOs uncovered flaws in their plans' member literature, beneficiaries' only source of detailed benefit information. Much of the MCOs' plan literature contained errors or omissions about mammography and prescription drug benefits, ranging from minor oversights to major discrepancies. While we found no errors about ambulance services, some MCOs' member literature omitted information about the benefit. Moreover, beneficiaries frequently did not receive important information until after enrollment. Even then, beneficiaries in some plans received member literature that was incomplete and did not fully disclose plan benefits, exclusions, and fees. The lack of full disclosure in member literature leaves the beneficiary vulnerable to unexpected service denials and additional out-of-pocket fees. Making comparisons among health plans' benefits remains challenging because of the use of nonstandard formats and terminology. In contrast, FEHBP participants received plan brochures that contained relatively complete benefit descriptions presented in a standard format.

Beneficiaries Were Not Assured Accurate Plan Materials

We found significant errors and omissions in the plans' member literature that MCOs distributed to beneficiaries. For example, effective January 1998, HCFA required organizations to cover annual screening mammograms and to permit beneficiaries to obtain this service without a physician's referral. Also, MCOs were required to notify beneficiaries of this new Medicare benefit.[12] Materials from five MCOs, however, explicitly stated that beneficiaries must obtain physician referrals to obtain screening mammograms. (See fig. 3 for three examples.) Member literature from five other organizations failed to inform beneficiaries of their right to self-refer for this service.

[12]BBA revised Medicare coverage for annual screening mammography, ensuring that beneficiaries enrolled in managed care plans have access to the same benefit available in Medicare fee-for-service. HCFA Operational Policy Letter #57 implemented 42 CFR section 422.100 (h)(1).

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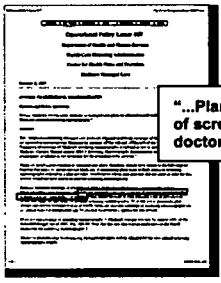
Figure 3: Plan Referral Requirements for Screening Mammography Contradict Medicare Coverage

HCFA Operational Policy Letter #57



"...Plans are required to provide coverage of screening mammography without a doctor's prescription or referral..."

Excerpts From Medicare 1998 Plan Materials

- **MAMMOGRAMS.** One (1) baseline mammographic examination for women between the ages of 35 and 39. One (1) routine mammographic examination per calendar year for women age forty (40) or more. The Member must obtain a Referral from her Primary Care Physician before receiving this service. Other mammographic examinations will be covered only when recommended by the Primary Care Physician or a Referred Specialist.

	osteoporosis.	monthly/$3600 annual limit.
Mammograms	X-ray screening to detect breast cancer. One provided per year for women age 35 and older.	Must be ordered by your HEALTHCARE physician.
Medical Supplies	Provided as medically	Must be ordered by your [illegible]

prior to surgery	
• Chemotherapy • Diagnostic tests • Medical supplies and equipment • X-rays • Mammograms • Laboratory services • Pap Smear screening	No charge. Services must be authorized by your Primary Care Physician.

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Note: Emphasis added.

Sources: For requirements, HCFA Operational Policy Letter #57; for examples, various MCOs' member literature.

Much of the MCOs' member literature provided incorrect or inconsistent information about prescription drug coverage. For example, the member literature for a large, experienced Medicare MCO specified an annual dollar limit for prescription drugs that was lower than the amount required by the organization's Medicare contract. The contract required the provision of unlimited generic drugs and coverage of at least $1,200 for brand-name drugs. This MCO's materials, which varied by county, understated the brand-name drug coverage, listing annual dollar limits as low as $600. When we contacted the MCO officials, they confirmed that they were providing the lower benefit coverage. On the basis of the MCO's enrollment for 1998, we estimated that about 130,000 members could have been denied part of the benefit that Medicare paid for and to which they were entitled under the MCO's contract. Another MCO provided conflicting information about its prescription drug benefit. In one document, the MCO alternately described its prescription drug benefit as having a $200 monthly limit and a $300 monthly limit. (The correct limit was $300.) In another case, an MCO used the same member literature for four separate plans, emphasizing that all members were entitled to prescription drug benefits. Actually, however, only two of the four plans offered a prescription drug benefit.

The member literature we reviewed did not contain errors regarding ambulance services, but the documents often omitted important information about the benefit. One MCO did not include any reference to the benefit in its preenrollment member literature. Three other MCOs stated that ambulance services were covered "per Medicare regulations" but did not define Medicare's coverage. Most of the remaining MCOs provided general descriptions of their ambulance coverage but did not give details of the extent of the coverage, such as whether the MCOs would pay for out-of-area ambulance service in an emergency.

Up-to-Date Plan Information Was Not Always Available When Beneficiaries Made Enrollment Decisions

Officials from several MCOs told us that their organizations typically issue a member policy booklet–a document that discloses the details of a plan's benefit coverage, benefit restrictions, and beneficiary rights–after a beneficiary enrolls. Moreover, MCOs often provided enrollees with outdated member policy documents. For example, one MCO failed to provide enrollees with a current member policy document until August 1998–8 months after the start of the new benefits year.

Distributing outdated information can be misleading. HCFA allows MCOs to use outdated plan member materials as long as the organizations attach an addendum indicating any changes to the benefit package. HCFA officials believe that this policy is reasonable because beneficiaries can determine a plan's coverage by comparing the changes cited in the addendum with the prior year's literature. However, some MCOs distributed outdated literature without the required addendum. When MCOs did include the addendum, the document did not always clearly indicate that its information superseded the information contained in other documents. In addition, some MCOs did not provide dates on their literature, which obscured the fact that the literature was outdated.

Adequate preenrollment benefit information will become even more crucial in 2001, as BBA's annual enrollment provisions begin to take effect in 2002 and Medicare beneficiaries are no longer able to disenroll on a monthly basis. To help beneficiaries make informed choices, BBA requires HCFA to provide beneficiaries with summary plan information before the annual November enrollment period. Furthermore, new regulations now require MCOs to issue letters by mid-October each year describing benefit changes that will be effective January 1 of the following year. MCOs must send these annual notification letters to all enrollees, and to any prospective enrollees upon request. However, HCFA has not required MCOs to provide more complete member literature prior to enrollment. As a result, beneficiaries still might not have the information they need to make sound enrollment choices.

Additionally, beneficiaries enrolling in plans before 2002 may be unaware that their plans may be terminating services shortly after the beneficiaries have enrolled. A plan must notify its members at least 60 to 90 days before it ends services.[13] However, there is no requirement that a terminating plan stop advertising and enrolling new members, with the result that in 1998, some beneficiaries unknowingly joined plans that soon exited the Medicare program. For example, one MCO notified its members in May 1998 of its intent to end services in several Ohio counties. The MCO continued to advertise and enroll new beneficiaries without informing them that plan services would end on December 31, 1998. After inquiries from beneficiaries, the MCO ceased marketing activities in July. Although these marketing activities angered many beneficiaries, the MCO was operating within HCFA's notification requirements.[14]

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[13]An MCO may terminate plan services through a modification, termination, or nonrenewal of its contract with HCFA.

[14]Until Jan. 2002, MCOs may market to and enroll beneficiaries throughout the year. Beginning in Nov. 2001, however, beneficiaries will have to select a plan during the open enrollment season. Consequently, primarily those individuals who become

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Member Literature May Not
Fully Describe Plan Benefits

Some beneficiaries do not receive important information about plan benefits and restrictions even after they have enrolled in a plan. Because HCFA's instructions regarding benefit disclosure are vague, MCOs vary in the amount of information they provide to beneficiaries.[15] Some organizations we reviewed provided relatively complete descriptions of plan coverage in a member policy booklet or similar document. However, other MCOs did not disclose important restrictions in any member literature.

In fact, MCOs that adopt HCFA's suggested disclosure language will send beneficiaries to an information dead end. In the guidelines it provides to MCOs, HCFA suggests that a plan's "evidence of coverage," a document frequently referred to as a member policy booklet, direct beneficiaries to the MCO's Medicare contract to obtain full details on the benefit package. According to HCFA, a member policy booklet should state that "[it] constitutes only a summary of the [plan] . . .. The contract between HCFA and the [MCO] must be consulted to determine the exact terms and conditions of coverage." HCFA officials responsible for Medicare contracts, however, said that if a beneficiary requested a contract, the agency would not provide it because of the proprietary information included in an MCO's adjusted community rate proposal. Furthermore, an MCO is not required, according to HCFA officials, to provide beneficiaries with copies of its Medicare contract. MCO officials we spoke with differed on whether their organization would distribute copies of its contract to beneficiaries. By establishing an MCO's Medicare contract–a document that is not usually available to beneficiaries–as the only document required to fully explain the plan's benefit coverage, HCFA cannot ensure that beneficiaries are aware of the benefits to which they are entitled.

Vague or incomplete benefit descriptions leave beneficiaries vulnerable to unexpected service denials. For example, disputes sometimes arise when beneficiaries are told they do not have the coverage they believed they would have when they enrolled. An official from the Center for Health Dispute Resolution (CHDR), HCFA's contractor that adjudicates managed care appeal cases, told us that CHDR uses the information in MCOs' member literature to determine whether plan members are entitled to specific benefits that are not covered by Medicare fee-for-service. When an MCO's literature is

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eligible on or after Jan. 1, 2002, may be affected by mid-year marketing.

[15]HCFA advises MCOs to provide information sufficient for beneficiaries to make informed enrollment choices.

vague, CHDR allows the MCO to submit internal plan memorandums that clarify its benefit coverage. But beneficiaries generally do not receive these internal memorandums. Consequently, beneficiaries who must rely on incomplete member literature and sales agents' verbal interpretations of this literature are likely to be unaware of important benefit limitations or restrictions.

Meaningful Plan Comparisons Were Difficult to Achieve

Inconsistent formats and terminology made comparisons among plans' benefit packages difficult. We generally had to read multiple documents to determine each plan's benefit coverage for mammography, prescription drugs, and ambulance services. Answering a set of basic questions about three plans' prescription drug benefits, for example, required a detailed review of twelve documents: two from plan A, five from plan B, and five from plan C (see fig. 4). It was not easy to know where to look for the information. For example, we found the answer to the question of whether a plan used a formulary in plan A's summary of benefits, plan B's Medicare prescription drug rider, and plan C's contract amendment.[16] Plan C's materials required more careful review to answer the question because the membership contract indicated the plan did not provide drug coverage. However, an amendment–included in the member contract as a loose insert–indicated coverage for prescription drugs and the use of a formulary.

[16]In general, a formulary is a list of drugs that MCOs prefer their physicians to use in prescribing drugs for enrollees. The formulary includes drugs that MCOs have determined to be effective and that suppliers may have favorably priced for the MCO. Any drug not included on a formulary is considered a nonformulary drug, which may cost the beneficiary more or may not be covered at all.

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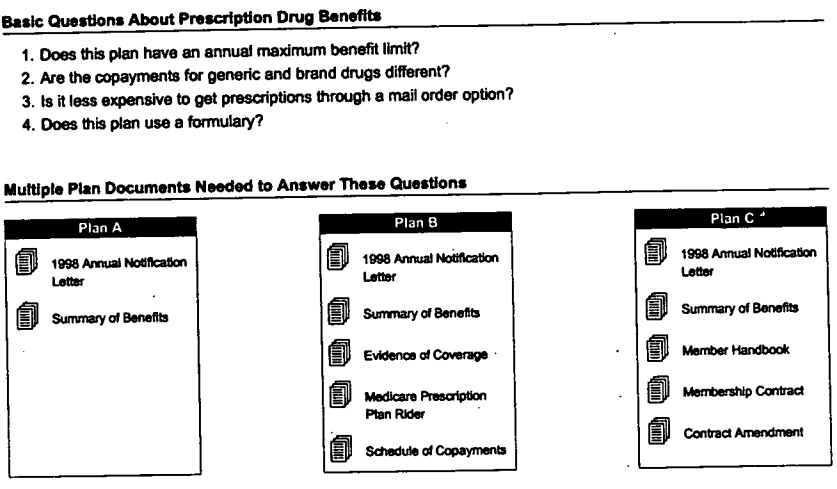
Figure 4: Multiple Plan Documents Needed to Answer Basic Drug Benefit Questions



[a]Plan documents contradict each other regarding covering nonformulary drugs.

Source: GAO analysis of MCO member literature.

As in previous studies, we found plans' materials did not use comparable terms or formats.[17] For example, it was difficult to determine whether the three plans offered by one MCO covered nonemergency ambulance transportation, because each plan's materials used different terms to describe the benefit. The lack of clear and uniform benefit information almost certainly impedes informed decision-making. HCFA officials in almost every region noted that a standard format for key member literature, along with clear and standard terminology, would help beneficiaries compare their health plan options.

[17]GAO/HEHS-97-23, Oct. 22, 1996, and Medicare Managed Care: Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices (GAO/T-HEHS-98-162, May 6, 1998).

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Each FEHBP Plan Distributes a Single, Complete Member Policy Brochure

FEHBP, administered by the Office of Personnel Management (OPM), is similar to the new Medicare+Choice program in that it serves a large and diverse population, allows participation of different types of health care organizations, and allows plans' benefit packages to vary. Unlike HCFA, however, OPM requires FEHBP plan materials to follow standard formats and terms. OPM officials believe this requirement helps FEHBP members make informed decisions. FEHBP health care organizations produce a single, standard brochure for each plan that is the "contractual document" between the member and the organization. This brochure is a complete description of the plan's benefits, limitations, and exclusions. The 1999 FEHBP brochure explicitly states the following objective: "This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure."

OPM officials said that the brochures must describe what each plan's coverage includes, as well as what it excludes, so that there is less chance for misunderstanding. The benefit information must be listed in a prescribed format and language to facilitate members' comparisons among plan options, but OPM's standards allow variation in some language to accommodate differences in plans' benefits and procedures. Each plan's brochure must include a benefit summary presented in OPM's prescribed format. OPM officials update the mandatory brochure language every year to reflect changes in the FEHBP's requirements and organizations' requests for improvements to the language. Finally, OPM requires organizations to distribute plan brochures prior to the FEHBP annual open enrollment period so that prospective enrollees have complete information on which to base their decisions. OPM officials told us that all participating organizations publish brochures that adhere to OPM's standards.

Although OPM's process for reviewing and approving member literature is generally similar to HCFA's, it differs in important ways. The process begins when FEHBP organizations submit benefit coverage information to OPM in standard brochure format. OPM contract specialists then review the brochures to verify compliance with mandatory terminology and format requirements and to ensure that nonstandard information is presented appropriately, given the plans' benefit packages and organizational structures. For example, organizations offering fee-for-service (indemnity) plans would use different language in describing plan procedures and restrictions than MCOs would. Organizations are then responsible for printing and distributing the brochures. To verify the accuracy of the final documents, OPM

obtains 20 brochures from each plan's first print run.[18] According to an OPM official, if OPM contract reviewers identify errors, they can require organizations to attach an addendum, reprint the brochures, or pay a fine. The official said that any errors identified are generally minor and are corrected through an addendum attached to the brochures.

WEAKNESSES IN HCFA'S REVIEW PROCESS ALLOWED PROBLEMS IN PLAN MATERIALS TO GO UNCORRECTED

Although HCFA approved all the member literature we reviewed, weaknesses in three critical elements of the agency's review process allowed errors to go uncorrected and important information to be omitted. Our review showed that the structure of HCFA's contracting documents has created problems in determining the accuracy of plan materials and has resulted in the omission of important benefit details by several organizations. Additionally, HCFA's lack of consistent standards has contributed to inconsistent reviews and extra work and may have increased the chance of errors slipping through the review process undetected. Moreover, MCOs have failed to correct plan materials as required by HCFA staff. HCFA has begun to address some, but not all, of the issues we have identified.

HCFA's Standard for Gauging Accuracy in Plan Materials Is Faulty

MCOs' Medicare contracts, which include the BIF, establish the foundation for HCFA's review of marketing materials. HCFA reviewers are instructed to use the BIF to check that plan member literature accurately reflects the contracted benefits and member fees. Reviewers told us, however, that the BIFs often do not provide the required detail, and our work revealed that the BIFs did not provide consistent or complete benefit descriptions. For instance, the BIFs did not always specify whether a plan's prescription drug benefit covered only specific drugs. Restricting coverage to a list of specific drugs, or a formulary, is a common element of plans' benefit packages. Yet of our sample of 16 MCOs, 14 used formularies in one or more of the plans they offered, but only 8 disclosed this restriction in their BIFs.

Because BIFs are often incomplete, reviewers sometimes rely on benefit summary sheets provided by MCOs to verify the accuracy of plan materials. This practice is contrary to HCFA policy, which requires an independent review of the MCOs' plan

[18]We did not review OPM's processes or validate the accuracy of plan brochures.

literature. The reviewers who approved the erroneous materials cited earlier explained that some of the errors might have occurred because the MCOs' summary sheets incorrectly described plans' benefits. This was the explanation given by the reviewer who approved the plan member literature advertising a $600 annual benefit limit for brand-name prescription drugs instead of the contracted $1,200 annual limit.

Lack of Standards Hampered Review of Important Member Literature

The lack of detailed standards for plans' member literature can result in misleading comparisons and put some MCOs at a competitive disadvantage. Without detailed standards, HCFA reviewers have wide discretion in approving or rejecting plan materials. The MCO representatives and HCFA officials we spoke with said that this latitude leads to inconsistent HCFA decisions. An MCO official told us that, while several plans in a market area required a copayment for ambulance services if a beneficiary was not admitted to a hospital, not all plans were required to disclose that fact. The HCFA reviewer responsible for one plan's materials required the plan to disclose the fee, yet different HCFA staff in the same regional office who reviewed other plans' materials did not require similar disclosure. These inconsistent review practices caused one plan's benefits to appear less generous, even though several other plans had similar benefit restrictions.

The lack of mandatory format and terminology standards for key member literature, such as benefit summary brochures and member policy booklets, increases the amount of time and effort needed to review and approve plans' member literature. Moreover, unlike many government programs, Medicare does not require MCOs to use standard forms for such typical administrative functions as enrollment, disenrollment, and appeals. Instead, each organization creates its own forms. Consequently, HCFA staff spend a great deal of time reviewing disparate documents that could be routine forms. Several reviewers commented that the volume and complexity of MCOs' member literature contributed to the likelihood that errors would pass through the review process undetected. Agency staff said that they could spend more time reviewing important member documents, such as member policy booklets, if HCFA required the use of standard forms for administrative functions.

HCFA officials recognize that standardizing key documents and terms would facilitate their review of plans' marketing materials and reduce the administrative burden on both HCFA and MCOs. Some agency officials expressed concern, however, that MCOs might resist efforts to standardize the way information is presented. In fact, many of the MCO officials we spoke with said they would welcome some standardization because it could save them time and money. One MCO official commented that MCOs

may not be using HCFA's current guidelines and suggested standards because they are voluntary and use language that is legalistic and confusing to beneficiaries. Several MCO officials stressed that any mandatory standards should be developed with industry input and with the advice of professional marketing specialists.

Reviewers Did Not Ensure That Final Materials Incorporated Required Corrections

MCOs are responsible for correcting errors in their marketing materials and distributing accurate information. Some HCFA reviewers told us that they do not approve marketing materials until the MCO has corrected all identified errors. Other HCFA reviewers told us that they give contingent approval–that is, they approve the material if the MCO agrees to make specific corrections. The MCO is required to send a copy of the print-ready document to HCFA so the reviewer can verify that the corrections were made. Reviewers often did not have copies of the print-ready or final documents in their files, however. Several reviewers admitted that it was difficult to get the final documents from MCOs and that they generally trust the organizations to publish materials as approved or to make the corrections outlined in approval letters. Moreover, reviewers noted that the contingent approval practice was adopted to expedite reviews when materials required only minor corrections.

However, MCOs did not always correct the errors HCFA identified during the review process. We reviewed one plan's summary of benefits that incorrectly commingled 1997 and 1998 benefit information. The document we received from the MCO official contained several handwritten notations correcting inaccurate benefit information. For example, the copayment for prescription drugs was listed as $5, but a handwritten note indicated that there was no copayment for generic drugs. The HCFA staff member responsible for approving the material showed us a working copy of the document on which she had indicated the need for numerous changes. The published document we observed, however, did not incorporate many of these corrections. The reviewer had been unaware that the published document contained errors because she had never received a print-ready copy from the MCO.

New HCFA Efforts Hold Promise and Challenge

HCFA has undertaken several efforts to address some of the problems we identified during our review. The agency is developing a new plan benefit package (PBP) that it hopes will replace the BIF. The PBP's new format improves upon the BIF by standardizing the information collected from each plan. The PBP includes detailed checklists that make it easier to obtain consistent benefit information from plans. However, the PBP is flexible enough to capture benefit features that do not fit neatly

into a predetermined checklist. Using the PBP should also facilitate efforts to standardize member literature. HCFA intends to pilot test the PBP with a few MCOs this year for contract submissions effective in 2000. HCFA officials estimate that the PBP proposal will need to begin the Office of Management and Budget's clearance process no later than August 1999 to achieve full implementation by 2000. Otherwise, full implementation could be delayed.

Agency officials also recognize the importance of more uniform member literature and have articulated their intent to standardize key documents in future years. As a first step, HCFA established a work group to develop a standard format and common language for all plans' benefit summaries. HCFA hopes to establish the benefit summary by May and plans to use it in the fall 1999 benefit summary brochures. Achieving this goal will require HCFA's work group to reach consensus on standards for clear and accurate information and to avoid imposing burdensome requirements on MCOs. HCFA's long-term goals include establishing standards for other key documents, but the agency has not yet developed a coordinated strategy for its long-term efforts or decided whether such standards will be voluntary or mandatory.

CONCLUSIONS

Beneficiaries who enrolled or considered enrolling in the plans we reviewed were not well-served by plans' efforts to produce member materials or HCFA's review of them. The information that plans distributed was often confusing and hard to compare. Some plans distributed inaccurate or incomplete information or provided the information after beneficiaries had made their enrollment decisions, when it was less useful. These problems significantly limited beneficiaries' ability to make informed decisions about their health plan options. Moreover, some beneficiaries may have been denied health care coverage to which they were entitled or required to pay unexpected out-of-pocket fees. In contrast, each FEHBP plan must provide prospective enrollees with a single, comprehensive brochure to facilitate comparisons and informed enrollment choices.

Revisions to HCFA's current review process and procedures could greatly improve the quality of plans' member literature. For example, full implementation of HCFA's new contract form for describing plans' benefit coverage, the PBP, could help ensure that approved member literature is accurate and fully discloses important plan information. Similarly, standard terminology and formats for key member literature would facilitate full disclosure and provide beneficiaries with comparable plan information. Moreover, new standards for the distribution of key member literature would enable beneficiaries to have the information they need when they need it. The required use of standard forms for routine administrative functions, such as member enrollment, could reduce

HCFA's workload and allow staff to spend more time reviewing important member literature. Finally, efforts to standardize review procedures would help ensure consistent application of the agency's marketing material review policy.

RECOMMENDATIONS TO THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

In October 1996, we recommended that the Secretary of Health and Human Services direct the HCFA Administrator to (1) require standard formats and terminology for important aspects of MCOs' marketing materials, including benefits descriptions, and (2) require that all literature distributed by organizations follow these standards. Although HCFA has taken initial steps toward this end, significant work remains. Therefore, we are both renewing our previous recommendations and recommending that the HCFA Administrator take the following additional actions to help Medicare beneficiaries make informed health care decisions and reduce the administrative burden on agency staff and MCOs.

- Require MCOs to produce one standard, FEHBP-like document for each plan that completely describes plan benefit coverage and limitations, and require MCOs to distribute this document during sales presentations and upon request.
- Fully implement HCFA's new contract form for describing plans' benefit coverage, the PBP, for the 2001 contract submissions to facilitate the collection of comparable benefit information and help ensure full disclosure of plans' benefits.
- Develop standard forms for appeals and enrollment.
- Take steps to ensure consistent application of the agency's marketing material review policy.

AGENCY COMMENTS

HCFA agreed with our findings that the agency's review process and procedures need to be strengthened in order to ensure that beneficiaries receive accurate and useful information. The agency also concurred with our recommendations to improve the oversight of Medicare+Choice organizations' marketing materials and to require the use of standardized formats and language in plans' member materials. HCFA has steps under way that may help correct some of the problems we found. For example, the agency is developing a standardized summary of benefits document and intends to

require Medicare+Choice organizations to use the document beginning in November 1999.

While HCFA's efforts may standardize important aspects of plans' materials, such as information about appeal rights, these efforts stop short of requiring Medicare+Choice organizations to provide a single standard and comprehensive document that describes plan benefits and beneficiaries' rights and responsibilities as plan members. HCFA believes that Medicare+Choice organizations should retain the flexibility to develop materials that differentiate their services from those provided by other Medicare+Choice organizations. We agree that MCOs should be able to differentiate their plans. However, requiring MCOs to provide an FEHBP-like brochure, in addition to other plan materials, would preserve the MCOs' flexibility and provide Medicare beneficiaries with more complete and comparable information than they may currently receive. In fact, these standard brochures may encourage plans to compete on real differences in plan features. The full text of HCFA's comments appears in appendix I.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 1 day after the date of this letter. At that time, we will send copies of this report to The Honorable Donna E. Shalala, Secretary of Health and Human Services; The Honorable Jacob Lew, Director, Office of Management and Budget; The Honorable Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration; and other interested parties. We will also make copies available to others upon request.

This report was prepared under the direction of James Cosgrove, Assistant Director, by Marie James, Keith Steck, and George Duncan. If you or your staff have any questions about this report, please contact Mr. Cosgrove at (202) 512-7029 or me at (202) 512-7114.

William J. Scanlon
Director, Health Financing
and Public Health Issues

COMMENTS FROM THE HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

APR 6 1999

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare+Choice: Revised Standards and Procedures Could Improve Accuracy and Usefulness of Plan Information"

TO: William J. Scanlon, Director
Health Financing and Systems Issues, GAO

We appreciate the opportunity to review your draft report to Congress concerning Medicare+Choice plan marketing materials. We agree that HCFA should continue efforts to ensure that beneficiaries receive useful information from managed care organizations, and to improve the effectiveness and efficiency of the Medicare+Choice program.

We are enclosing our comments to the specific recommendations. We look forward to working with GAO and the Congress as we further our commitment to provide beneficiaries with the information they need in order to make informed health care decisions.

Enclosure

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

Overview

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

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

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

HCFA will continue to work closely with the Congress, GAO, beneficiary groups and other interested parties to assure that beneficiaries have complete, accurate and understandable information both to understand and compare their health plan options. We will continue to examine instances where current marketing policies could be better

implemented and areas where policies should be clarified or expanded.

GAO Recommendation

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

- Require standard formats and terminology for important aspects of MCO's marketing materials, including benefit descriptions.
- Direct the HCFA Administrator to require that all literature distributed by organizations follow these standards.

We recommend that the Administrator of HCFA:

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

HCFA Comment

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

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

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

The type of documents M+C organizations have used to describe their benefits varies widely. M+C organizations have used their own structure, format, and language in providing benefit information. But this flexibility has made it difficult for beneficiaries to make comparisons when choosing among Medicare+Choice organizations. Thus, beginning in contract year 2000, HCFA will require M+C organizations to use a standardized Summary of Benefits and provide them to all prospective and current members, beginning with the November 1999 open enrollment period.

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

Phase II: Standardize Remaining Documents

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

GAO Recommendation

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

HCFA Comment

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

The description of plan benefits is the foundation of the marketing review process. For the 1998 and 1999 contract years, the BIF was used to approve benefits in the Adjusted Community Rate (ACR) and to review M+C organization marketing material. Following a comprehensive review of the 1998 BIF, it became clear that a standard, more detailed reporting format system was needed. For 2000, the BIF has been modified as part of the transition to the PBP. The BIF 2000 reduces the need to have a separate data collection

effort for Medicare Compare data for plan year 2000, thereby saving HCFA staff valuable time and effort and reducing the need for duplicative data validation. For 2001, the PBP will be used to perform these functions and will improve the reliability and accuracy of managed care organization contract documents.

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

Now on p. 9.

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

Now on p. 11.

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

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

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APPENDIX I

Now on p. 13 .

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

GAO Recommendation

- Develop standard forms for appeals and enrollment.

HCFA Comment

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

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

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GAO Recommendations

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

HCFA Comment

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

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

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

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

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

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SCOPE AND METHODOLOGY

To do this work, we reviewed relevant policies and procedures at Health Care Financing Administration (HCFA) headquarters and regional offices. We also interviewed HCFA officials at headquarters and at all regional offices and spoke with representatives of industry and beneficiary groups. We visited four regional offices (Atlanta, Chicago, Philadelphia, and San Francisco) that cover high managed care penetration areas. In addition, we analyzed 1998 member literature and Medicare contracts for 16 of the 346 MCO contracts effective in 1998 (4 from each region we visited). Our sample included MCOs that varied in enrollment levels, structure, location, and years of Medicare experience. Because each MCO can offer more than one plan–for example, a standard option and a high option–we reviewed key materials for a total of 26 plans. We considered key member literature to include benefit summary brochures, member policy booklets,[19] member handbooks, and plan letters related to benefit changes. The plans we reviewed used various combinations of these key documents to disclose the details of their benefit packages, including benefit restrictions and members' rights. Finally, we compared the Federal Employees Health Benefits Program and Medicare's standards for plans' member literature.

Our analysis focused on three benefits that vary in complexity: ambulance transportation, annual screening mammography, and outpatient prescription drugs. We selected ambulance transportation and screening mammography because these benefits must be provided by all Medicare plans and are relatively simple to describe and understand. We selected the outpatient prescription drug benefit because it is complex, not covered by traditional Medicare, and an important consideration in many beneficiaries' enrollment decisions.

[19]MCOs typically use a member policy booklet as the agreement between the plan and the beneficiary. This document may also be referred to as a member contract, evidence of coverage, or subscriber agreement.

Senator Breaux [presiding.] Senator Grassley has gone to vote. They tell me we are going to have four votes in a row, so I think we are going to try to get our questions in, and then we will submit written questions rather than keep all of you here until midnight.

I have just a couple of quick things. In the example in the chart that you have up here, Dr. Scanlon, on the left is the HCFA operational policy as to how the plans should be presented; is that correct?

Mr. SCANLON. That is correct.

Senator BREAUX. Is the thing on the right an actual example of one Medicare+Choice plan?

Mr. SCANLON. An actual example of three Medicare+Choice plans.

Senator BREAUX. And they are all absolutely, totally wrong on the first thing, about mammographies; correct?

Mr. SCANLON. That is correct.

Senator BREAUX. How does that not get caught? Did it just slip by?

Ms. CRONIN. It should have gotten caught. It absolutely should have gotten caught.

Senator BREAUX. Maybe we need a Spell-Check or something like that.

Ms. CRONIN. Well, as has been pointed out, what will happen in the future is that the words will be standardized so that there will not be a lot of options to add extra things, and you can quickly——

Senator BREAUX. Or to hide it somewhere else in their proposal.

Ms. CRONIN. That is right.

Senator BREAUX. It is not only going to help the beneficiary understand; it is going to also help HCFA to be able to monitor it a lot more easily.

Ms. CRONIN. That is right. So it will be much easier to capture errors when you are comparing a standardized description against a template.

Senator BREAUX. OK. Where are we on the timing of the new way of doing this?

Ms. CRONIN. This piece that we have seen, we want to focus group test and get public comment, because this has been informed by both the industry and beneficiary advocates, but we want to make sure that end-users can understand these words.

Senator BREAUX. I asked the question before about the cancellation policy.

Ms. CRONIN. Yes. I made a note of that.

Senator BREAUX. Do you think that is something that could be put in here?

Ms. CRONIN. Yes.

Senator BREAUX. Do you think that what I asked about makes sense?

Ms. CRONIN. Yes. Also, the other place where we need to make sure that it is more understandable—it was in the "Medicare and You" handbook that was in the pilot States, including Ohio, actually, but if Mr. Stringer did not see it, we need to make sure that it is much clearer. And in the context of thinking about doing our "Medicare and You" handbook which is sent to every Medicare ben-

eficiary, that is another place where we need to make it clearer that in fact the plan contract is really just for a year.

Senator BREAUX. And my final question is in the new way of outlining it, can we spell out the appeals rights? Is that something that can fit in the side-by-side comparison in some way?

Ms. CRONIN. Well, we have the one bullet that says "You have the right to appeal a denial of service. If the service is denied, you will receive a detailed explanation from us."

Senator BREAUX. Where is that?

Ms. CRONIN. That is at page 2, the last bullet, right above "Service Area." "You have the right to appeal a denial of service. If the service is denied, you will receive a detailed explanation from us."

Senator BREAUX. That is such an important part of it, I think it almost ought to be highlighted—I am just making a suggestion—but I would like to see that appeal thing highlighted in the brochures that are submitted. I think that is something that would be helpful.

Thank you all very much.

Senator Collins.

Senator COLLINS. Thank you, Senator Breaux.

I want to follow up on the question that Senator Breaux asked you about the information being just plain wrong, contradicting HCFA's policy. You have conceded that HCFA should have caught it. Well, now you know about it, so what do you do now? Are there sanctions?

Ms. CRONIN. We want to find out who the plans are. First, we need to investigate it and verify it, although we have no reason to doubt that this is not accurate. Then we will take some type of action. The options are that we can do a corrective action plan in terms of closely monitoring the plans and looking at all of their marketing materials, so there will be increased scrutiny. If we find additional problems, I think we have options in terms of requiring the plan to cease and desist enrolling and marketing. And ultimately, we have civil monetary penalties.

Senator COLLINS. You do have civil monetary penalties that can be applied.

Ms. CRONIN. Yes.

Senator COLLINS. So you could fine a plan for this kind of error or misleading statement.

Ms. CRONIN. Yes.

Senator COLLINS. Can you bar them from participating in Medicare if it were a more egregious or repeated violation?

Ms. CRONIN. I would imagine so, but I probably should check on the answer to that question.

Senator COLLINS. Mr. Scanlon, again, I want to thank you for the work that GAO has done, not only in this area but for my subcommittee as well in the area of Medicare fraud. It has always been of very high quality.

You note that the variation in Medicare plan literature contrasts very sharply with the uniformity of plan information distributed by managed care plans participating in the Federal Employees Health Benefits Plan. Indeed, as all of us have talked about, we get a very easy-to-understand booklet once a year during open season, which has a standard format and standard terminology. Are you aware of

any problems that either OPM or managed care plans participating in the Federal employees' program have had in complying with the requirement for uniformity?

Mr. SCANLON. We have not heard any, and we have had considerable contacts with OPM about the FEHBP program and the type of information that they require. In addition, we have worked closely with plans in terms of the Medicare work that we have been doing. They have not volunteered anything to us that it is difficult to produce this information for FEHBP.

We selected FEHBP as a model partly because it is very familiar to all of us here, but many corporations are also in a leadership position in terms of trying to standardize information and make it as user-friendly as possible for their employees. These corporations recognizing that this is an incredibly important but incredibly complicated choice. So we think that their experience, too, is relevant here.

Senator COLLINS. So you do not see any reason why the HMOs that are participating in Medicare could not provide the same sort of easy-to-understand information that the HMOs participating in the Federal employees' plan or the better corporate plans provide to their participants?

Mr. SCANLON. We see no barriers, and in fact many of them are the same plans.

Senator COLLINS. I was going to ask that. I would imagine many of them are the same.

Mr. SCANLON. That is right. There is significant overlap.

Senator COLLINS. In your testimony, you also noted that the managed care plans submit the beneficiary information to HCFA, which in turn has 45 days to conduct its review. But as I understand it based on your testimony, the plans are free to distribute the materials if HCFA does not disapprove the materials within the timeframe.

Seeing the information you uncovered makes me wonder whether HCFA is really reviewing the materials or whether in fact the 45-day timeframe simply expires, and the materials are used. Did you look at that?

Mr. SCANLON. We did not look directly at the number of times the 45 days expired. We did find examples where there was an actual review, and in these cases, it involved instances where there was a review and still the plan literature was wrong when distributed. We also found cases where the plan literature review revealed that there was a problem and that it was not corrected when the plan was given notice of that problem.

Senator COLLINS. Unfortunately, a vote is in progress, and there is very little time left. I get to be chairman right now, and with my new, enhanced power, I am going to actually adjourn the hearing at the direction of the chairman. But we do all have a lot of additional questions that we will be submitting them for the record, so in my new role as Chairman Collins of the Aging Committee, this hearing is adjourned.

Thank you for your participation.

[Whereupon, at 4:29 p.m., the committee was adjourned.]

APPENDIX

GAO Responses to Committee Questions on Oversight of Plan Information and Appeal Reports

Question. In your estimation, why does the review process vary among the regions and what can be done to provide greater consistency?

Answer. Regional office reviewers have wide discretion to approve or reject managed care organizations' (MCO) member literature because HCFA has not required a common set of format and terminology standards for this literature. This discretion results in inconsistent HCFA decisions, unnecessary delays, and extra costs for the agency and the MCOs. While HCFA has some guidelines related to marketing materials, both plan officials and HCFA staff have questioned their usefulness because the guidelines are voluntary and often suggest legalistic and confusing language. Moreover, some HCFA regional offices follow these guidelines, while others do not, thereby creating another source of inconsistency among the regions' review processes.

We made several recommendations to HCFA that could help ensure a more consistent review process and standardize the information provided to Medicare beneficiaries. First, we suggested that HCFA develop standard formats and terminology for important aspects of MCOs' member literature, including benefits descriptions. Second, we recommended that HCFA require all MCOs' member literature follow these standards. Both of these recommendations would add structure and consistency to HCFA's review process. Third, we recommended that HCFA take steps to ensure consistent application of the agency's review policy.

Question. In your recommendation, you suggest that HCFA should require each plan to produce one standard, FEHBP-like document that fully discloses benefit coverage and limitations. Can you comment on how difficult this would be to produce and what is a realistic time frame for HCFA and the plans?

Answer. While developing a standard FEHBP-like document is not a simple task, it is also not an impossible one. HCFA is currently designing a standard benefit summary document and intends to require MCOs' to use it beginning in November 1999 to coincide with the Medicare+Choice open enrollment period. This effort is a good first step, but will not result in a comprehensive document that fully describes plan benefits and beneficiaries' rights and responsibilities as plan members.

If HCFA used the standard benefit summary document as the starting point, a more comprehensive FEHBP-like document likely could be developed in time for MCOs to use in 2000. Producing such documents should not impose too great a burden on MCOs, as they provide similar documents for FEHBP and others.

Question. As a follow-up to my last question, do you think requiring an FEHBP-like brochure would help facilitate beneficiaries' ability to choose a plan, and would it have any impact on plans and their ability to compete?

Answer. Currently, plan comparisons are very difficult because MCOs do not use the same language to describe the same benefits and they do not use the same format in presenting information. Setting language and format standards for MCOs' member literature would facilitate plan comparisons. A single comprehensive document from each plan that describes its benefits and restrictions would help ensure that beneficiaries have full, accurate, and comparable information about their health plan options and would enhance their ability to make informed decisions.

Requiring each MCO to provide an FEHBP-like brochure may encourage greater competition because beneficiaries could more readily focus on differences in plan features. Moreover, each MCO could distribute additional plan materials to differentiate its plans from those provided by other MCOs. MCO officials we spoke with said that they would welcome some standardization because it could save them time and money by facilitating a more expedient and efficient review of their marketing materials. However, several MCO officials stressed that any mandatory standards should

be developed with industry input and with the advice of professional marketing specialists.

Question. How difficult would it be for HCFA to develop other standard forms like you suggest for enrollment and appeals that would be considered user-friendly?

Answer. Again, while developing standard, user-friendly forms is not an impossible task, it requires some effort. Such an effort could involve consultation with professional communication experts, MCOs, consumer representatives, as well as many other activities. However, HCFA has not explicitly committed to developing standard forms, indicating instead that it will standardize certain language for use in plan notices.

Question. What is your reaction to requiring the plans to include in their denial notices a brief explanation of the appeals process in Medicare and numbers of who beneficiaries can call besides the plan?

Answer. Currently HCFA suggests that plans include in their denial notices the names and telephone numbers of local organizations that could assist beneficiaries with their appeals. Some plans follow this guidance, but others do not. We believe that HCFA should ensure that the appeals process provides adequate protection to Medicare beneficiaries. Requiring plans to include the names and telephone numbers of relevant local agencies would help beneficiaries understand and navigate the appeals process.

Question. Does GAO have plans to evaluate HCFA's "Medicare & You" handbook and the Medicare Compare database so that necessary improvements can be identified before the November 1999 annual open enrollment period?

We intend to look at how HCFA is conducting the 1999 information campaign. While our work will not be completed in time to affect HCFA's handbook or database before the 1999 open enrollment period, our results may suggest improvements that HCFA could adopt in 2000.

Question. One major deficiency GAO pointed in its report on Medicare+Choice plan information was the difficulty some beneficiaries may have in getting detailed information about benefits and restrictions. It is my understanding that HCFA's instructions in this area are rather vague and, in fact, may actually lead beneficiaries to a dead end. HCFA's guidelines suggest that managed care plans refer beneficiaries to the Medicare contract for full details of the benefit package. However, since the plan's contract with Medicare contains proprietary information, it is fully within the plan's discretion not to release that information to the requesting beneficiary.

(A) Did GAO offer any recommendations to HCFA as to how this situation could be corrected?

Answer. We recommend that HCFA require MCOs to produce one standard, FEBBP-like document for each plan that completely describes plan benefit coverage and limitations, and require MCOs to distribute this document during sales presentations and upon request. If this recommendation is adopted, beneficiaries would have no need to obtain a copy of the MCO's contract.

(B) Has HCFA taken action to change its guidelines?

Answer. HCFA is reviewing its guidelines, but the agency has not made a commitment to requiting MCOs to produce a comprehensive and standard FEHBP-like document.

HCFA Responses to Senator Grassley's Questions Regarding Oversight of Medicare+Choice Plan Marketing and Appeals

Question. I am curious to know why HCFA cannot implement similar guidelines to programs such as FEHBP where plans have to send a complete description of benefits every year that reflect current benefits and any changes that may have occurred along with a letter? I realize we are in a transition phase to an open enrollment process, but what does HCFA have in place to ensure beneficiaries receive this coverage document and any changes in benefits? And if you don't intend to require plans to provide full disclosure both prior to enrollment and after enrollment, why not?

Answer. The Medicare+Choice regulation published on June 26, 1998 does include guidelines similar to FEHBP that require all Medicare+Choice plans to provide enrollees with a complete description of benefits at the time of enrollment and annually thereafter. Plans fulfill the annual notification requirement by providing beneficiaries enrolled in the plan with a document called the Evidence of Coverage. We have model language for this document, but plans often use their own language. We will soon begin work on standardizing the Evidence of Coverage and plan on requir-

ing Medicare+Choice plans to use a standardized Evidence of Coverage by the November 2000 open enrollment period.

This Fall, all plans will be required to provide both current and prospective enrollees a standardized Summary of Benefits. The Summary of Benefits, while not as detailed as the Evidence of Coverage, provides beneficiaries with general information about the plan (e.g., appeal rights, using network providers) and also includes a table comparing plan coverage and cost sharing to original fee-for-service Medicare. The table must include all Medicare-covered benefits, and must also contain information on certain additional benefits (such as prescription drugs or vision care) if the plan provides these services. Attached is a sample of the Summary of Benefits.

In addition to providing enrollees with an annual description of benefits, Medicare+Choice plans are required to inform enrollees of any changes in the plan's benefit package 30 days before such a change takes effect. In the case of benefit changes that are effective on January 1, enrollees must be notified by October 15 (in time for the November open enrollment period). Plans typically fulfill this requirement by sending their enrollees a letter describing the change.

Question. I know HCFA is undertaking measures to standardize the summary of benefits and the terms to describe benefits. I recognize standardizing information requires some flexibility to allow plans to describe their own unique benefits, and I support that. However, benefits covered by Medicare fee-for-service should not vary in Medicare+Choice so these benefits should be easier to describe in a standardized way. Would you agree with this statement?

Answer. Yes, the basic Medicare benefit descriptions are easier to standardize because Medicare+Choice plans are required to offer all the benefits covered by Medicare. However, plans also have flexibility to lower cost-sharing that they require from beneficiaries relative to the fee-for-service cost sharing requirements. For example, a Medicare+Choice plan may either require a beneficiary to pay 20 percent cost-sharing for a service just like Medicare fee-for-service, or a Medicare+Choice plan may also eliminate the cost sharing responsibility for the beneficiary. Even given these differences, however, we are still able to provide information about these benefits in a standardized way.

Question. I understand that states are getting more involved in review of Medicare marketing materials because these managed care plans are licensed in the state. Can you tell me from your perspective how much this is happening and if it causes your agency, the plans, or beneficiaries any problems since it is another layer of review?

Answer. We do know that several states, through the Department of Insurance, Department of Health, or Departments of Corporations, are highly involved in the review of marketing materials. We have heard from several plans that state involvement does lengthen the review process. For example, complications may arise when language mandated by the state is inconsistent with Medicare requirements. Under Federal preemption, state laws or standards that are in conflict with Medicare+Choice standards are preempted by Federal law. These Federal preemption principles, which have been restated in the Balanced Budget Act of 1997 (BBA), can thus be used if there is conflict between state and Federal requirements for marketing materials. However, no plans have requested use of Federal preemption authority to date.

Question. The appeals notices, in my estimation, should clearly state your rights under the program, who to call, and numbers for assistance besides just the plan's number. Why can't HCFA streamline these notices in a more user-friendly way and require plans to include the local SHIP program, which is paid for by taxpayer dollars, along with the Social Security office if they have questions?

Answer. Prior to the Balanced Budget Act of 1997 (BBA), Medicare regulations required health plans to (1) provide denial notices stating the specific reasons for an adverse determination, and (2) inform the enrollee of his/her right to a reconsideration, including an expedited reconsideration, by the plan. HCFA elaborated on this regulation in a Program Memorandum (issued July 22, 1997, still prior to the BBA), which required plans to provide appeals information upon denial of a payment or service, and provided model language for plans to use in informing enrollees of their appeal rights. The model language included the following information:

- the conditions under which enrollees may appeal, and who may request an appeal;
- the appeal process (including circumstances in which the enrollee may request an expedited appeal of a service denial);
- the opportunity to submit additional information with the appeal;
- the opportunity for an extension if it would benefit the enrollee; and

• the right to contact a Peer Review Organization (PRO) in the case of a quality complaint.

The model language also informed enrollees about outside organizations that could help respond to their questions about appeals. These organizations included the Medicare Rights Center, the State Long-Term Care Ombudsman, the Area Agency on Aging, and the State Health Insurance Assistance Program.

These provisions were further refined by the BBA and HCFA's Medicare+Choice regulation published on June 26, 1998, which requires more detailed and understandable denial notices than those previously used by many plans. These notices must explain (1) the specific reasons for the denial in understandable language, and (2) the enrollee's right to both reconsideration by the plan and to several levels of external review beyond reconsideration by the plan (including both standard and expedited appeal processes).

In a forthcoming Operational Policy Letter (OPL) to Medicare+Choice organizations, HCFA will provide new model language for denial notices that will reflect the new requirements of the BBA. HCFA will require the notice to be written in plain language, in a culturally competent manner, and contain telephone numbers for external assistance organizations.

Initially, Medicare+Choice organizations will be able to choose whether to follow the model language or use their own language while the model language undergoes consumer testing and subsequent revisions. However, our goal is to require mandatory use of final, standardized appeal notices by M–C organizations in 2000.

Question. How do beneficiaries rind out about the different time frames and what their rights are under Medicare+Choice?

Answer. Beneficiaries are notified of their appeal rights in several different documents, and at multiple points in the process, as described below:

Annual Notices: Rights are summarized annually in the Medicare Handbook and in the health plan's Evidence of Coverage, the document provided annually to beneficiaries that summarizes benefits, rights, and protections. The Evidence of Coverage includes detailed information concerning time frames within which an enrollee must request an initial coverage decision (i.e., an organization determination) and an appeal, as well as time frames within which the M–C organization must render its decision.

Notice Upon Discharge: Enrollees must be issued a written notice of appeal rights upon discharge from an inpatient hospital. This notice provides information concerning an enrollee's right to immediate review by a Peer Review Organization (PRO), the time frames within which an enrollee must request a review, and the time frames within which a decision must be rendered. M–C organizations must also issue a notice of appeal rights to enrollees upon discharge from a skilled nursing facility.

Notice Upon Denial: M–C organizations are required to provide enrollees with a written notice of appeal rights whenever the organization denies a payment or service, in whole or in part. The written notice includes the specific reasons for the denial in understandable language, notification of the enrollee's right to an appeal (including the circumstances in which the enrollee may request an expedited appeal of a service denial), information concerning the time frames within which an enrollee must file an appeal, and the time frames within which the M–C organization must render its decision.

Question. Regarding the appeals process, why has HCFA not provided plans with clear guidelines on what should be considered urgent for expedited appeals?

Answer. Prior to the Balanced Budget Act (BBA), HCFA published a regulation creating an expedited review process for managed care organizations. On July 22, 1997, HCFA issued a Program Memorandum to all Medicare-contracting managed care plans that required the plans to develop a system for identifying and handling expedited cases. The regulation and Program Memorandum instructed organizations to grant all requests for expedited review that are either made or supported by a physician. Enrollee requests for expedited review, without physician support, must be expedited if the plan determines that the enrollee's life, health or ability to regain maximum function could be jeopardized by waiting for a standard determination.

This standard for expedited appeals was subsequently codified in the BBA. We believe the statutory standard for deciding whether to grant a request for an expedited appeal——if "the organization determines that application of the normal time frame for making a determination (or a reconsideration concerning a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function," -provides sufficient information to guide M–C organizations in operationalizing the expedited review process. However, HCFA plans to re-

view whether it would be appropriate to specify expedited criteria in further instructions to M–C organizations.

HCFA RESPONSES TO SENATOR SANTORUM'S QUESTIONS REGARDING OVERSIGHT OF MEDICARE+CHOICE PLAN MARKETING AND APPEALS

Question. What initiatives has HCFA undertaken to ensure the consistency with which HCFA regional offices review and provide guidance to health plans regarding their marketing materials?

Answer. We are aware of the issues regarding uniform application of marketing review regulations and guidelines across the 10 HCFA Regional Offices. We will continue to expand our existing effort to address the complex issue of uniformity of review. This effort includes the following activities:

(a) Final Verification of all Marketing Materials. HCFA central office has issued requirements for the regional offices that all final marketing documents must be reviewed before they are used to ensure that HCFA's required changes are incorporated.

(b) Pilot Study on Centralization. We are pursuing options regarding the feasibility of centralized marketing review. We will initiate a nationally representative, 6-month pilot study on the efficacy of a private sector contractor performing the review of marketing materials.

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

(d) Use of Standardized Forms. We are moving toward the use of standardized forms that will preclude plan variation in a number of areas. This Fall, we will require plans to use a standardized Summary of Benefits. In the future, we will require plans to use standardized beneficiary notification materials and enrollment forms.

Question. What initiatives has HCFA made to improve the "beneficiary friendliness" of the required language in notices to beneficiaries regarding their appeal rights?

Answer. To help ensure that notices are understandable and useful to beneficiaries, HCFA provides model language to Medicare-contracting organizations. On July 22, 1997, HCFA issued a Program Memorandum with model language, including an explanation of enrollee appeal rights, for use by all Medicare-contracting plans upon denial of payment or services. HCFA is currently developing new model language incorporating simplified language that will permit enrollees to better understand their appeal rights upon denial. In preparing that new language, HCFA contracted with an external organization to translate the existing language into a more user-friendly format (i.e., "plain English"). HCFA has also worked closely with industry groups and advocacy groups to redesign the notice of appeal rights provided to beneficiaries upon discharge from an inpatient hospital. All model language will be consumer tested in an attempt to ensure that beneficiaries will be able to clearly understand their appeal rights.

Question. What efforts has HCFA made to correct errors in the"Medicare & You" handbooks? I understand that in a major Oregon market only one Medicare+Choice plan was listed whereas there are actually four available. In addition, in parts of Washington and Florida, brochures were mailed with a statement that the information presented is incorrect and that the beneficiaries should call a toll-free-number if they had any questions. What activities is HCFA undertaking to ensure greater accuracy in its educational materials, particularly in preparation for the November 1999 annual open enrollment period?

Answer. The print production process for the 1999 handbook began in June 1998. All information included in the handbook had to be finalized by that time. When the 1999 Medicare & You handbooks were printed, the information was correct. However, in October, some plans decided to leave the Medicare program or reduce the area they served which caused some of the information in the handbooks to be incorrect. Such errors will not occur this year because plans must notify us earlier (July 1) if they plan to leave the Medicare program.

The 2000 Medicare & You handbooks will contain limited plan information, such as Medicare+Choice plan names, telephone numbers, ranges of premiums for plans available, and a note if prescription drugs are offered. The handbooks will refer

beneficiaries to the 1-800-MEDICAR(E) number and the www.medicare.gov website for up-to-date and accurate specific information about the plans available to them in their area, along with a detailed description of the plans' benefits.

In Oregon, however, some plans were inadvertently omitted from the 1999 Medicare & You handbook. These errors were the result of proposed health plan mergers that were never completed and problems in our verification process. Since we have simplified the handbook's contents and have modified the verification process, we do not expect that these problems will reoccur in the future.

Question. Some beneficiary confusion may stem from lack of understanding of important managed care concepts such as using physicians, hospitals, or other providers that are in a plan's network, or using primary care physicians as gatekeepers. I understand that the Medicare Compare database did not accurately convey some of these important concepts. Has HCFA taken steps to fix these inaccuracies and improve the beneficiary friendliness of the Medicare Compare database?

Answer. Medicare Compare does provide some information on managed care concepts. For example, the database includes a section called "Doctor and Hospital Choice." Under this section a plan's description includes language such as "You must go to plan doctors, specialists, and hospitals. You need a referral to see specialists."

We are continually evaluating the comments we receive and working to improve the Medicare Compare database. In the process of standardizing the Summary of Benefits that health plans provide to enrollees, we have developed better language for describing plan benefits. We will use this improved language in future revisions to Medicare Compare, including revisions made this Fall.

Other parts of the www.medicare.gov website, such as the general Medicare+Choice plan Questions and Answers and Glossary of Terms, are being updated to provide more information on key managed care concepts. Beneficiaries can also obtain general information from the Medicare & You handbook.

HCFA RESPONSES TO SENATOR REED'S QUESTIONS REGARDING OVERSIGHT OF MEDICARE+CHOICE PLAN MARKETING AND APPEALS

Question. The GAO report discussed several oversight problems related to health plan materials distributed to Medicare managed care beneficiaries and prospective beneficiaries. One notable example in the report was the inaccurate statement made in several plans' marketing materials that beneficiaries required physician referrals to obtain screening mammograms. As we all know, this directly contradicts Medicare policy which allows beneficiaries to obtain this service without a referral.When HCFA institutes a change in policy regarding Medicare benefits or coverage, what process does the agency undertake to ensure that contracting plans are aware of this change and understand what they need to do to conform appropriately?

Answer. Every January 15, we provide Medicare+Choice plans with advance notice of changes in the payment methodology. As part of this notice, we highlight any benefit changes to Medicare that are due to recently enacted legislation or changes in regulation. In addition, we often issue Operational Policy Letters that clarify current HCFA policy or advance new policies based on current law and regulations. These letters also highlight changes in Medicare benefits. These letters are posted on our website and are also sent to the major health plan associations, who in turn distribute them to the plans. An Operational Policy Letter was issued on October 2, 1997, clarifying that beneficiaries do not need a referral for screening mammogram.

We are also changing the way that Medicare+Choice plans provide us with information about their benefits, which will help us catch errors in plan materials. This new method for capturing plan information will address one of the problems found by the GAO—that some plans incorrectly stated that preauthorization was needed for screening mammography. Because the mammography service category is predetermined by HCFA policy, the new system does not allow a Medicare+Choice plan to enter different authorization rules for this benefit.

Question. Do fee-for-service plans exhibit similar problems in implementing policy changes to their marketing materials?

Answer. If you are referring to private fee-for-service plans, thesetypes of plans would be notified about policy changes in the same manner as other Medicare+Choice plans, as discussed above. However, we do not currently have any private fee-for-service plans contracting with Medicare. If your question is referring to original fee-for-service Medicare, there are no contracting plans in original fee-for-service and no marketing materials that are reviewed. Under original fee-for-service Medicare, organizations that process claims from physicians and hospitals

receive funding from Medicare for education and training of providers. This training may include bulletins and newsletters, seminars, teleconferences, and computer-based training modules to give providers information about billing or coverage changes, including the addition of new Medicare benefits.

Question. In instances where a health plan is in violation of HCFA practices, what types of penalties or other action is HCFA authorized to take against the plan?

Answer. We have the authority to impose sanctions on plans for violating HCFA marketing policies. Two practices are specified as violations: health screening by plans of potential enrollees and misrepresenting or lying to beneficiaries about plan benefits.

The statutory sanction authority allows us to suspend a plan's ability to market to and/or enroll new members, and, through the Inspector General's office, impose civil monetary penalties on plans. Also, instead of sanctions, we can issue corrective action plans to managed care organizations when we find violations. A corrective action plan may instruct the plan to take steps to ensure that all sales representatives are trained appropriately and may include HCFA monitoring of the plan's sales training classes or materials.

HCFA RESPONSES TO SENATOR CRAIG'S QUESTIONS REGARDING OVERSIGHT OF MEDICARE+CHOICE PLAN MARKETING AND APPEALS

Question. What initiatives has HCFA undertaken to ensure the consistency with which HCFA regional offices review and provide guidance to health plans regarding their marketing materials?

Answer. We are aware of the issues regarding uniform application of marketing review regulations and guidelines across the 10 HCFA Regional Offices. We will continue to expand our existing effort to address the complex issue of uniformity of review. This effort includes the following activities:

(a) Final Verification of all Marketing Materials. HCFA central office has issued requirements for the regional offices that all final marketing documents must be reviewed before they are used to ensure that HCFA's required changes are incorporated.

(b) Pilot Study on Centralization. We are pursuing options regarding the feasibility of centralized marketing review. We will initiate a nationally representative, 6-month pilot study on the efficacy of a private sector contractor performing the review of marketing materials.

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

(d) Use of Standardized Forms. We are moving toward the use of standardized forms that will preclude plan variation in a number of areas. This Fall, we will require plans to use a standardized Summary of Benefits. In the future, we will require plans to use standardized beneficiary notification materials and enrollment forms.

Question. What initiatives has HCFA made to improve the "beneficiary friendliness" of the required language in notices to beneficiaries regarding their appeal rights?

Answer. To help ensure that notices are understandable and useful to beneficiaries, HCFA provides model language to Medicare-contracting organizations. On July 22, 1997, HCFA issued a Program Memorandum with model language, including an explanation of enrollee appeal rights, for use by all Medicare-contracting plans upon denial of payment or services. HCFA is currently developing new model language incorporating simplified language that will permit enrollees to better understand their appeal rights upon denial. In preparing that new language, HCFA contracted with an external organization to translate the existing language into a more user-friendly format (i.e., "plain English"). HCFA has also worked closely with industry groups and advocacy groups to redesign the notice of appeal rights provided to beneficiaries upon discharge from an inpatient hospital. All model language will be consumer tested in an attempt to ensure that beneficiaries will be able to clearly understand their appeal rights.

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