

## **Plans Suspend PFFS Marketing: Plans adopt strict guidelines in response to deceptive marketing practices**

The Centers for Medicare and Medicaid Services (CMS) announced today that in response to concerns about marketing practices, seven health care sponsors have signed an agreement to suspend voluntarily the marketing of Private-Fee-For-Service (PFFS) plans. This suspension for a given plan will be lifted only when CMS certifies that the plan has the systems and management controls in place to meet all of the conditions specified in the 2008 Call Letter and the May 25, 2007 guidance issued by CMS. The signatories include: United Healthcare, Humana, Wellcare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee.

The agreement is effective five business days from today and will continue to apply to individual plans until they have demonstrated to CMS that they have the systems and management controls in place to ensure that they can meet all the CMS requirements. CMS review will begin as soon as plans indicate they are ready. Plans signing the agreement will be actively monitored to ensure they do not engage in marketing while the voluntary suspension is in place. Violations will be subject to a full range of available penalties, which can include suspension of enrollment, suspension of payment for new enrollees, civil-monetary penalties, and termination of the plan's involvement in the Medicare program.

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[San Francisco Chronicle](#)

Insurers agree to back off on Medicare plans

### **Sales tactics used for fee-for-service policies under fire**

[Victoria Colliver, Chronicle Staff Writer](#)

Saturday, June 16, 2007

Seven large insurers on Friday agreed to suspend marketing of a form of Medicare policy after complaints were made about questionable sales tactics and outright fraud associated with the plans.

The companies, including UnitedHealth Group, Humana and WellCare, said they will stop marketing the policies, known as private fee-for-service plans, until they can prove to Medicare officials that sales materials are accurate, agents understand the policies and consumers intend to enroll.

The action comes in response to consumer complaints and a Senate committee hearing last month that looked into abuses. The plans are sold by private insurers as alternatives to traditional Medicare.

Some agents violated Medicare rules by showing up uninvited at senior citizens centers, misleading beneficiaries about the products and, in a few cases, forging signatures to increase sales, according to government officials and consumers. In some cases, the agents erroneously assured new enrollees that their doctors would accept the policies.

"This voluntary agreement demonstrates the plans are stepping up to assure deceptive marketing practices end and beneficiaries fully understand what they are purchasing," said Abby Block, director of beneficiary choices for the Centers for Medicare and Medicaid Services.

About 1.3 million senior and disabled Medicare beneficiaries are enrolled in Medicare fee-for-service policies, the fastest growing form of Medicare managed-care plans. They differ from traditional Medicare because they are managed by private companies and sometimes offer more benefits than straight Medicare, such as dental and vision coverage.

Under the agreement, the seven insurers -- which together sell about 90 percent of Medicare fee-for-service plans -- will test sales representatives on their product knowledge and register them with the government.

The insurers agreed to put disclaimers in marketing materials and telephone new enrollees to make sure they understand the policies and genuinely intend to enroll. Failure to comply could lead to suspension or fines. While they agreed to suspend their marketing activities, the insurers can continue to sell the policies.

Other companies that signed on to the temporary suspension include Coventry Health Care Inc., Universal American Financial Corp., Sterling Life Insurance Co. and Blue Cross/Blue Shield of Tennessee.

America's Health Insurance Plans, the industry's trade group, supported the agreement but stressed that the vast majority of agents and brokers are ethical and knowledgeable about their products.

Health advocates said the action is a good start but fails to address what they say is the root cause of the abuse -- the fact the federal government reimburses private insurers for fee-for-services policies at a higher rate than other types of Medicare plans. Sales agents, in turn, receive higher commissions.

"Money is a driving force for both the plans and agents, and that is driving a lot of the marketing misconduct we're seeing," said David Lipschutz, staff attorney for California Health Advocates.

Lipschutz said changes to reimbursement levels would require congressional authority.

"This will do virtually nothing to protect Medicare beneficiaries and is a pathetic attempt to preempt Congressional action," Rep. Pete Stark, D-Fremont, a longtime critic of Medicare fee-for-service plans, said in a statement.

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## MEDICARE NEWS

For Immediate release  
Affairs  
June 15, 2007

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The Centers for Medicare and Medicaid Services (CMS) announced today that in response to concerns about marketing practices, seven health care sponsors have signed an agreement to suspend voluntarily the marketing of Private-Fee-For-Service (PFFS) plans. This suspension for a given plan will be lifted only when CMS certifies that the plan has the systems and management controls in place to meet all of the conditions specified in the 2008 Call Letter and the May 25, 2007 guidance issued by CMS. The signatories include: United Healthcare, Humana, Wellcare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee.

“While we note that most health insurance agents are helpful and responsible in describing and explaining choices to beneficiaries, there are a few bad actors that need to be removed from the system for good,” said Leslie V. Norwalk, Esq., Acting Administrator of CMS. “This voluntary agreement demonstrates that CMS and the plans are stepping up to ensure that deceptive marketing practices end immediately, and that beneficiaries understand what they are purchasing.”

“Through a variety of methods, including our ‘secret shopper’ program that uses trained individuals to attend marketing events and report back on the insurance agents’ activities, and the eyes and ears of our thousands of partners throughout the nation, CMS is proactive in protecting beneficiaries from rogue agents. Although the 2700 agent complaints we logged from December 2006 to April 2007 represent less than one half of one percent of the 1.3 million members enrolled in individual PFFS plans, we can always do better,” added Norwalk.

The agreement is effective five business days from today and will continue to apply to individual plans until they have demonstrated to CMS that they have the systems and management controls in place to ensure that they can meet all the CMS requirements. CMS review will begin as soon as plans indicate they are ready. Plans signing the agreement will be actively monitored to ensure they do not engage in marketing while the voluntary suspension is in place. Violations will be subject to a full range of available penalties, which can include suspension of enrollment, suspension of payment for new enrollees, civil-monetary penalties, and termination of the plan’s involvement in the Medicare program. The full range of updated conditions will be in effect for all sponsors of PFFS plans beginning October 1, 2007, and violations of those conditions will be subject to the same types of penalties.

Primary provisions that the plans signing the agreement must meet to have the suspension lifted (and that all PFFS must meet beginning October 1, 2007) are summarized below:

- All materials, including but not limited to advertisements, enrollment materials, and materials used at sales presentations by employees or contracted representatives of a health insurance company will include the model disclaimer language provided by CMS in its May 25, 2007 guidance.
- All representatives selling the product to beneficiaries on behalf of the plan sponsor will pass a written test that demonstrates their thorough familiarity with both the Medicare program and the product they are selling.
- A provider outreach and education program will be in place to ensure that providers have reasonable access to the plan terms and conditions of payment, and that provider relations staff are readily accessible to assist providers with questions concerning the plan.
- Outbound education and verification calls will be made to all beneficiaries requesting enrollment to ensure that they understand the plan rules.
- Lists of planned marketing and sales events provided to CMS will include events sponsored by delegated brokers and agents as well as those sponsored by the plan.
- When asked by CMS, plan sponsors will provide a complete list of all representatives marketing a PFFS product and authorize CMS to make that list available to State Insurance Departments on request.

“We want to underscore that Corrective Action Plans already in place will remain in effect until full compliance is attained and investigations underway involving fraud or criminal activity will continue to their appropriate conclusion,” added Norwalk. “In addition, once marketing resumes, CMS will actively monitor performance. Any violations of the requirements set forth in CMS guidance will be subject to immediate remedial action in accordance with standard procedures.”