



National Association of Insurance Commissioners

July 15, 2008

Abby Block  
Director, Center for Beneficiary Choices  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4131-P  
PO Box 8016  
Baltimore MD 21244

Dear Ms. Block:

We respectfully submit our comments to CMS’s proposed revisions to the regulations governing the Medicare Advantage and Prescription Drug Benefit Programs (file code CMS-4131-P), which were published in the Federal Register on May 16, 2008.<sup>1</sup> This letter reflects the collective views of the National Association of Insurance Commissioners, as compiled by the NAIC’s Senior Issues Task Force. You may receive additional comments from individual state departments of insurance.

We would like to comment on the following items of interest to state insurance regulators:

Overall:

We appreciate CMS’s decision to strengthen and improve marketing guidelines. In doing so, we recognize and applaud areas where CMS has adopted, or moved towards, recommendations that the NAIC has made since enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). In particular, we note the new limitations on cross-selling, expanded definitions of cold calls, and strengthened provisions to assist states in their oversight of licensed producers. We also support CMS’s decision to codify the current patchwork of CMS guidance on marketing practices into federal regulation, as well as to impose several requirements for the first time. Because of the progress represented by the proposed regulation and the inadequacy of current sub-regulatory guidance, we urge CMS to enact it - modified as suggested here - into a final rule.

However, we continue to believe that a greater state role is necessary to ensure proper enforcement of the regulations and to provide timely responses to consumer complaints. Without the authority to oversee the marketing activities of plans, the ability of a state insurance department to properly oversee the activities of producers is severely compromised. We understand that current federal law would need to be amended in order to substantially address this concern and state regulators have strongly supported, and continue to support, legislation that would so amend current law.

As you know, the NAIC’s Medicare Private Plans Subgroup (of which CMS has been a part) is currently developing a White Paper on the regulation of Medicare Advantage and prescription drug plans. The current draft of the White Paper includes a number of recommendations made by state regulators which go beyond or enhance the items addressed in the proposed federal rule. Some of the following comments are based on the recommendations in the White Paper.

<sup>1</sup> 73 Fed. Reg. 28556-28604.

<b>EXECUTIVE HEADQUARTERS</b>	2301 McGee Street, Suite 800	Kansas City, MO 64108-2662	p   816 842 3600	f   816 783 8175
<b>GOVERNMENT RELATIONS</b>	444 N. Capitol Street, NW, Suite 701	Washington, DC 20001-1509	p   202 471 3990	f   202 471 3972
<b>SECURITIES VALUATION OFFICE</b>	48 Wall Street, 6th Floor	New York, NY 10005-2906	p   212 398 9000	f   212 382 4207

Non-Renewal Notification Timelines (§422.506):

We oppose the reduction of the beneficiary and public notice period for MA and Part D non-renewals, as contained in Section 422.506. The proposed regulation would reduce this critical notice period from 90 days to 60 days prior to the effective date in order to expand the period that plans and CMS have for the contract appeals process. This would reduce by one-third the number of days affected beneficiaries have to understand the impact of the non-renewal, evaluate their options, and make informed decisions about the subsequent plan year. Given the difficulty and significance of these steps, we urge you to maintain the current 90 day notice period.

CMS Civil Monetary Penalties (§422.760, §423.760):

We support the effort to clarify CMS's ability to levy civil monetary penalties, as contained in Sections 422.760 and 423.760. Current regulations simply state that CMS may impose civil monetary penalties of up to \$25,000 per determination of a violation, but does not provide guidance as to whether a series of related incidents, or a single event that impacts multiple enrollees, would constitute a single determination or multiple determinations. Due to the lack of precision in the current regulation, CMS has been unable to levy meaningful penalties against plans where violations affecting multiple beneficiaries were found, even though significantly higher penalties were levied by state regulators for the same or related violations. The proposed regulation clarifies that such penalties may be levied for each enrollee covered under the organization's contract that is adversely affected or substantially likely to be adversely affected by the deficiency. We agree that clarification in this area is warranted.

In addition, we would suggest that no upper limit on total monetary penalties be specified. There may be situations where monetary penalties should clearly be significant enough to avoid recidivism. We would suggest CMS have the flexibility to impose an appropriate monetary penalty without the constraint of an arbitrary cap.

CMS Expedited Marketing Material Approval Process (§422.2262, §423.2262):

Under current CMS procedures, MA plan sponsors considered by CMS to have a good track record are permitted to bypass the traditional 45 day period of CMS review and instead utilize a file and use system where marketing materials are deemed approved within five days with no CMS review. The proposed revisions at Sections 422.2262 and 423.2262 would eliminate this expedited system based on an organization's track record, and instead rely upon a file and use system only for sponsors who choose to use materials containing CMS model language, or for materials otherwise identified by CMS as not containing substantive content warranting review.

We support CMS's move towards greater use of model language, which would reduce the potential for problematic marketing materials. In doing so, however, we would urge you to clarify, or limit the scope of, materials that CMS would consider to not contain substantive content warranting review.

Additionally, we suggest that you consider an additional requirement that plan sponsors file their marketing materials with state regulators, so that we may be aware of the marketing materials that have been approved for sale in the states and so that we are able to respond when unapproved materials are distributed.

Cash Rebates / MA Supplement Plans (§422.2268(a)):

While we support the limitation proposed in Section 422.2268(a) to prohibit cash or other monetary rebates as an inducement for enrollment, we strongly urge you to strike the second sentence which states that "[t]his does not prohibit explanation of any legitimate benefits the beneficiary might obtain as an enrollee of the MA plans, such as eligibility to enroll in a supplemental benefit plan that covers deductibles and coinsurance..."

We are greatly concerned that this second sentence creates ambiguity to an otherwise clear prohibition on the provision of cash or other money to induce the enrollment in an MA plan. We believe that this second sentence

inadvertently legitimizes plans that are being marketed to supplement Medicare Advantage plans, but do not comply with state and federal Medicare supplement laws.

Promotional Items and Prohibition on Meals (§422.2268(b), §423.2268(b)):

Sections 422.2268(b) and 423.2268(b) would limit gifts to potential enrollees, unless of nominal value (as established by CMS), offered to all eligible members, and are not in the form of cash or other monetary rebates. Meals may not be provided regardless of value, although refreshments such as coffee, soft drinks, and snacks would be permitted.

While we support the goal of decreasing the use of incentives as a way to increase enrollments, we believe that prohibiting “meals” is somewhat ambiguous and is subject to interpretation. We would suggest clarifying the term “meals”.

Unsolicited Direct Contact (§422.2268(d), §423.2268(d)):

Sections 422.2268(d) and 423.2268(d) would expand the current prohibition on door-to-door solicitation to include other unsolicited instances of direct contact, such as outbound calling without the beneficiary initiating contact. The discussion of the proposed regulation also mentions other examples of prohibited behavior such as approaching beneficiaries in parking lots or outside of educational events.

We strongly support this effort to expand current prohibitions to include other such unsolicited contacts. In doing so, we suggest that you clearly define and prohibit “cold calls” as any unsolicited telephone call without the beneficiary initiating the contact, including calls to follow up to plan mailings when no other contact by the beneficiary has been made.

We also continue to remain concerned about CMS’s ability to adequately enforce these provisions. State regulators, State Health Insurance Assistance Programs (SHIPs), and consumer groups have already reported a high number of complaints about practices already prohibited under CMS guidelines. It is unclear how CMS would effectively enforce these additional requirements.

Cross-Selling (§422.2268(f), §423.2268(f)):

We are pleased that CMS has recognized and addressed the problem of cross-selling, which state regulators have consistently raised. As you know, state regulators are concerned that current CMS Marketing Guidelines permit unscrupulous sales tactics where a producer makes an appointment with a beneficiary to discuss one type of plan and then proceeds to try to sell them another type of plan, which may be unsuitable. This problem is exacerbated by the fact that the open enrollment period for these plans is so short and the financial incentives to enroll beneficiaries in certain plans are such that improper marketing and sales activity will likely continue to occur without addressing the root causes of the improper activity. Sections 422.2268(f) and 423.2268(f) would prohibit the cross-selling, in any MA or Part D sales activity or presentation, of non-health care related products.

However, we believe that the marketing of all non-Medicare related products should be prohibited in this section, not just health care-related products. This would ensure that beneficiaries would be able to fully consider the Medicare-related products such as Medicare Prescription Drug Plans, Medicare supplement insurance plans, and the range of Medicare Advantage plans. This would also ensure that beneficiaries are not subject to cross-selling of other unrelated products such as long-term care insurance policies, dread disease policies, and limited benefit health care plans, which would otherwise be permitted by the proposed language.

Scope of Appointments and Cooling-Off Period (§422.2268(g), §423.2268(g), §422.2268(h) and §423.2268(h):

Sections 422.2268(g) and 423.2268(g) would limit the types of Medicare products to be offered during an appointment to the scope agreed upon by the beneficiary. In the discussion of the proposed regulation, the NPRM indicates that, in advance of any marketing appointment with a beneficiary, the beneficiary must have the opportunity to agree to the range of choices that will be discussed, and that agreement must be documented by the plan sponsor. Sections 422.2268(h) and 423.2268(h) would require that additional lines of plan business not identified prior to the in-home appointment would require a separate appointment that could not be re-scheduled until 48 hours after the initial appointment.

While we strongly support the intent of these provisions, we urge you to carefully consider beneficiary protections in crafting specific procedures so that the signed agreement does not become protection for the plan sponsor and the producer without providing meaningful protection for the beneficiary. We urge you to work with state regulators and consumer groups to develop such procedures, and to more clearly define the type of information that must be documented by the plan. In doing so, CMS should consider that if a producer is already in the home when documentation is requested, a beneficiary is likely to feel pressured to sign any document that is presented, even if the individual is not truly interested in the products. In that case, the signed agreement simply becomes a protection for the plan sponsor and the producer, not the beneficiary.

Sales Activities in Health Care Settings (§422.2268(k), §423.2268(k)):

Sections 422.2268(k) and 423.2268(k) would prohibit sales presentations, or the distribution or acceptance of plan applications in provider offices or other places where health care is delivered. The discussion of the proposed regulation states that sales activities would be prohibited in areas where patients primarily intend to receive health care services such as waiting rooms and pharmacy counter areas, and states that sales activities would only be permitted in common areas of health care settings, such as hospital cafeterias or conference rooms.

We support this clarification. Again, we are concerned with CMS's ability to adequately enforce this provision. We also suggest that you clarify the phrase "other places where health care is delivered" and instead prohibit such activities "in provider offices, pharmacies, or other places where a health care provider delivers health care services to a Medicare beneficiary."

Additionally, we are opposed to efforts by plan sponsors to co-brand with pharmacies, and the sales of products within proximity to pharmacy counters. States may be interested in enacting restrictions on producers to prohibit such arrangements, if they are determined to be in violation of state laws. We would like to know CMS's position on whether such a state prohibition would be permitted or otherwise preempted.

Sales Activities at Educational Events (§422.2268(l), §423.2268(l)):

Sections 422.2268(l) and 423.2268(l) would clarify that plans may not engage in sales presentations or distribute or accept plan applications at educational events. The discussion includes an explanation that such educational events would include health fairs, conference expositions, and state-or community-sponsored events.

We support this requirement, and would encourage further clarification of the difference between "educational" and non-educational events in order to minimize confusion. However, we continue to remain concerned about CMS's ability to adequately enforce these provisions.

Plan Names (§422.2268(m), §423.2268(m)):

Sections 422.2268(m) and 423.2268(m) prohibit the use of plan names that suggest that a plan is not available to all Medicare beneficiaries. However, the proposed regulation fails to address the larger problem of vague and highly confusing plan names. In many cases, a plan sponsor may offer multiple plans of the same type, using

similar names, which can be very confusing to the beneficiary. The use of words such as “value”, “reward”, “gold”, “silver” in plan names, or the absence of a reference to the plan type (HMO, PPO, PFFS, etc) could mislead consumers as to the type of plan, or the availability of providers affiliated with a plan. Therefore, we urge you to consider new requirements for plan names, including the prohibition of vague or potentially misleading terms in plan names, and/or a requirement that plan sponsors add a parenthetical plan type designation at the end of the plan name in written materials (e.g. ABC Plan [HMO]) unless the name already includes this information.

While it may be temporarily confusing for beneficiaries if there are new requirements for plan names, the benefits of consumer protection in the long run outweigh any temporary confusion. After implementation of the standardized nomenclature for Medigap policies under OBRA 1990, many Medigap plan names needed to be changed, but these requirements benefited consumers in the long run because plan names for Medigap policies were comparable and consumers could easily distinguish between the various types of policies.

#### State-Licensed Marketing Representatives (§422.2272, §423.2272):

We support the codification of the requirement at Sections 422.2272 and 423.2272 that plan sponsors employ only state-licensed individuals to conduct marketing activities. While this has long-been a CMS requirement, as you know, state market conduct examinations and other reports from state regulators have demonstrated numerous instances where plan sponsors have failed to adhere to this requirement.

The discussion of this requirement in the Notice of Proposed Rulemaking (NPRM) includes a clarification that plan customer service representatives (who disseminate information, answer factual inquiries from beneficiaries, and take demographic information for the purposes of completing an enrollment application) would not have to be state-licensed. We support this clarification, so long as these customer service representatives are not providing advice about plans, making buying recommendations, and are not compensated according to the number of applications submitted in which they had a role.

#### State Agent Appointment Laws (§422.2272, §423.2272):

Sections 422.2272 and 423.2272 of the proposed regulation would require that plan sponsors employ only agents whom they have reported to states that have been appointed, “consistent with the appointment process provided for under State law, except that any fees required under such appointment process do not apply.” We appreciate that CMS has finally acknowledged the importance of appointment laws in ensuring that states can properly identify, monitor, and share information about producers selling in our states. However, we would like to raise significant concerns with the construction of this section.

First, while the discussion of the proposed regulation acknowledges the importance of state appointment laws, it also states that, “...State laws requiring compliance with an appointment law with respect to Medicare Part C and Part D marketing are pre-empted...” and therefore fees charged in connection with state appointment laws may not be applied. We continue to disagree with CMS’s interpretation that state appointment laws are pre-empted by the MMA, and believe that state appointment laws are critical to states’ responsibility to regulate insurance producers (agents and brokers).

Second, by requiring that plans only report to states that they are acting “consistent with the appointment process”, and preventing the application of any state fees required under the appointment process, significant questions are raised about the state’s ability to enforce these requirements. If plan sponsors were to fail to adhere to this requirement, it is unclear whether a state would be able to take action under state law.

Instead, we urge CMS to revise this section to clearly state that state agent appointment laws are enforceable. In subsection (c), we urge you to replace the phrase “consistent with” and insert in its place the phrase “as required by”. Also in subsection (c), we urge you to strike the phrase “do not” and insert “shall”, and after the word “apply” insert “because such fees are not considered a premium tax or similar tax on payments to an MA plan”.

We also urge CMS to require that all enrollment applications include the producer's National Insurance Producer Registry (NIPR) number. The NIPR maintains a central repository of producer licensing information, which is used by participating state insurance departments to screen and track producers.

Guidelines for Agent Compensation (§422.2274(a)(1)-(2), §423.2274(a)(1)-(2)):

We are pleased that CMS imposes new limitations in compensation paid by plans to producers, to reduce some potentially harmful incentives for producers to steer beneficiaries towards certain types of products without the best interests of the beneficiary in mind. The proposed regulation would require plans to pay a first year commission that is no greater than the commission earned in all subsequent years, and requires that the commission must be the same for all plans and all plan product types offered by the organization's or sponsor's parent. The description of these provisions indicate that CMS intends to require that organizations offering MA and MA-PD products must establish a single commission, and PDP sponsors must establish a single commission.

However, we would urge CMS to consider additional clarification to these provisions. First, we urge CMS to more clearly define "plan product types" in the regulation, so as to clearly state that plan sponsors may not set different commissions for one type of MA plan than another (i.e., so that plan sponsors may not set one commission for MA-PPOs and another for MA-PFFS plans).

Second, we urge CMS to clearly define "commission or other compensation", or otherwise consider how bonuses (including production bonuses to promote high volumes of sales) would be factored into the first year commission limitation requirement. We have seen plans offering tremendous bonuses for volume sales in this market, leading to a strong incentive for some producers to steer beneficiaries to certain products. We suggest that the term "commission" be defined as "any compensation paid to an agent or broker for the sale, enrollment, or renewal of a Medicare beneficiary in an [MA plan / PDP], including any production bonus, prize, or other incentive amount paid to the agent or broker". We suggest that you define "production bonus" to mean any bonus schedule or payment to a marketing representative that is labeled as a "production bonus" or that provides a payment to a marketing representative that may be a bonus in addition to any base commission amount, and that provides added or increasing increments of payment per beneficiary that applies or who enrolls in an MA plan.

Third, we urge you to clarify how these provisions would be administered in practice, considering the lack of stability in benefits and cost-sharing from year-to-year. Currently, plans are permitted to change benefits, cost-sharing, and formularies on an annual basis.

Producer Training and Testing (§422.2274(b)-(d), §423.2274(b)-(d)):

We strongly agree with CMS that it is critical that producers are properly trained for these products and support provisions in the proposed regulation to require that all plan sponsors train and test all agents selling these products. Sections 422.2274(b) and (c) and 423.2274(b) and (c) would codify CMS's requirement that plan sponsors train and test producers on Medicare rules and regulations. In addition, Sections 422.2274(d) and 423.2274(d) would require plans to provide information to CMS as necessary to conduct oversight.

We understand from the discussion of the proposed regulation that CMS will continue to review plan sponsored training and testing platforms during "routine or focused monitoring visits", but the NPRM does not indicate that such materials will be reviewed prior to use or will be approved by CMS. We believe that this random review is inadequate to ensure that producers are receiving appropriate training for the products they are selling.

In addition, given the expertise and long history of state departments of insurance in regulating producers, we would welcome the opportunity to participate in the development, review and approval of such training and testing programs.

We also urge you to consider requiring state-specific information into training and testing platforms, where appropriate. In many instances, beneficiaries have not been made aware of state-specific information important to their buying decisions, such as interaction with a state’s Medicaid program, state pharmacy assistance program, or state Medicare savings program.

State Requests for Information (§422.2274(e), §423.2274(e)):

Sections 422.2274(e) and 423.2274(e) require plan sponsors to comply with state requests for information about the performance of licensed agents or brokers as part of a state investigation into the individual’s conduct. While we appreciate CMS’s efforts to reduce impediments to the states’ ability to fulfill their oversight responsibilities over agents and brokers, we are disappointed with the very narrow scope of this requirement. Instead, we urge you to require plans to collect and routinely report, in a timely manner, producer complaints to state regulators. This would ensure that states routinely receive information that is highly relevant to state oversight authority, and would allow states to identify problems in a proactive manner.

We appreciate the opportunity to submit comments to the proposed federal regulation. We look forward to our continuing cooperation as we work together to protect our Medicare beneficiaries.

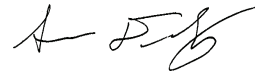
Sincerely,



Sandy Praeger, President  
NAIC  
Commissioner of Insurance  
State of Kansas



Joel Ario, Chair  
Health Insurance and Managed  
Care (B) Committee  
Commissioner of Insurance  
Commonwealth of Pennsylvania



Sean Dilweg, Chair  
Senior Issues (B) Task Force  
Commissioner of Insurance  
State of Wisconsin