

**America's Health
Insurance Plans**

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May 12, 2008

Mr. Guenther Ruch, Chair
NAIC Senior Issues Task Force, Medicare Private Plans Subgroup
c/o Jane Sung, Health Policy and Legislative Analyst & Counsel
National Association of Insurance Commissioners
444 N. Capitol Street, NW, Suite 701
Washington, DC 20001

Dear Mr. Ruch:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments on the NAIC Medicare Private Plans Subgroup Draft White Paper. AHIP is the national trade association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. The work of the NAIC Medicare Private Plans Subgroup on the draft White Paper is of significant interest to AHIP's member organizations, many of which participate in the Medicare Advantage (MA) and Part D programs.

General Comments

We value the collaboration and discussion of ideas and recommendations that have occurred since September in developing the draft White Paper. While we have expressed concerns about the direction of the document in certain areas, we have shared the common goal of recommending strategies that strengthen protections for beneficiaries. However, the April 29, 2008 draft of the White Paper contains new sections that have not been developed in a collaborative manner and recommendations that are inappropriate and pose potential harm to beneficiaries. We have serious concerns about Section 2- Background, Section 5- Financial Incentives, and Section 6- Benefit Design.

Section 2 —Background. This section is intended to provide the reader with an introduction to the paper, and to the Medicare Advantage and Part D programs. Instead, it makes pejorative and slanted statements about the Medicare Advantage and Part D programs that do not reflect the view of the subgroup as a whole, do not present any varying views, and as such misses the important opportunity to be an informational and factual document. We are concerned about the tone of this section and question why this nonobjective course is being pursued. We have offered some proposed changes to the background section under our specific comments.



Section 5 — Financial Incentives and Section 6 — Program Design. These new sections added to the White Paper appear to fall outside of the scope of the Subgroup’s hearings and ongoing discussions and move well beyond recommendations intended to address specific regulatory and marketplace marketing issues. These sections advocate certain policy positions without taking into consideration Congressional intent for the current policy and the impact of the recommendations on coverage options for beneficiaries in states impacted by the proposed changes. These sections also advocate policy positions that are not reflective of the viewpoints of a subset of Subgroup members. Additionally, we have concerns about the technical accuracy of some of the statements in these sections. Finally, the statements and recommendations in these two sections were drafted in the absence of any meaningful discussion about these issues by the Subgroup.

We recommend removal of Section 5 and Section 6 from the White Paper. Merely adding a counterpoint position from those who do not agree, when these sections stridently call for affirmative legislative and policy changes that overwhelmingly reflect a political view of a segment of the Subgroup, is insufficient to maintain the White Paper’s position as a balanced document. Therefore, at this time we would like to reserve the opportunity to offer comments on the specific language in these sections pending the outcome of discussions at the upcoming meeting of the Subgroup in Washington, D.C. on May 20th and 21st. However, we have highlighted several key areas of concern below.

Specific Comments

Below please find our specific comments in response to the April 29, 2008 draft of the White Paper.

Section 1. Executive Summary

We recognize that the NAIC is currently in the process of drafting the Executive Summary for the White Paper and offer a recommendation for inclusion in that section of language similar to the explanation that appears in Section 2.C. regarding the process for developing the White Paper and the recommendation contained therein. The language would serve to inform the reader at the beginning of the paper of the process undertaken for development of the recommendations in the paper. Below please find our suggested language.

Executive Summary

The paper attempts to gather the viewpoints of various participants and attribute those to the appropriate interest groups. As the reader of this paper will see, there



are some fundamental differences between the various interested parties that will likely not be bridged. At the same time, there are some areas where there is consensus among most of the Subgroup.

Section 2.A. The Need for Action: Problems in the Medicare Private Plan Marketplace — Marketing and Sales Abuses.

AHIP recommends deletion of the last paragraph in the subsection on marketing and abuses, because the assertion that plan payment levels drive compensation arrangements for agents is unfounded. Broader issues of plan funding are not relevant to the principal issues addressed in the White Paper. Furthermore, including mention of these issues is likely to undermine the effectiveness of the paper.

A. The Need for Action: Problems in the Medicare Private Plan Marketplace

Marketing and Sales Abuses

~~Aggressive marketing and sales practices, especially in the MA-PFFS market are likely the result of the high payments that Medicare Private Plans receive under the CMS bid process that translates to large compensation arrangements paid to agents. Some plans have been reported to offer a bonus of up to \$10,000, in addition to a commission, for high levels of beneficiary enrollment in MA products. These financial incentives appear to drive the sales practices, choices offered and advice given to Medicare beneficiaries.~~

Section 2.A. The Need for Action: Problems in the Medicare Private Plan Marketplace — Many Types of Coverage Options.

AHIP recommends inserting language that clarifies that this statement reflects the opinion of state regulators and consumer groups. Our recommended language is shown below in underscore.

Many Types of Coverage Options

State regulators and consumers groups believe that ~~the~~ sheer number of Medicare Private Plans being offered to beneficiaries has led to confusion. For instance, in 2007, the State of Florida reported thirty-seven insurance carriers marketing and selling over 300 different Medicare Advantage (MA) plans, all of which have different coverages, cost-shares and premiums, not including fifty-



seven standalone Medicare Prescription Drug Plans (PDPs), all of which have different coverages, cost-shares, premiums, and, in many instances, different formularies.¹ State regulators and consumer groups believe that because of the many plans available to beneficiaries and the complex nature of these plans, it has been very difficult, if not impossible, for beneficiaries to make informed buying choices.

Section 2. D. — Current Efforts.

AHIP recommends inserting language that provides additional information about Medicare Private Plan Industry Initiatives. Our recommended language is shown below in underscore and overstrike.

Medicare Private Plans Industry Initiatives

The insurance industry has taken steps to address recent issues that have arisen in ~~the recognized some of the problems~~ in the market and, individually and through its associations, has also made efforts to address these problems. In March 2008, America's Health Insurance Plans' (AHIP) Board of Directors adopted a statement on strengthening the oversight and regulation of Medicare marketing activities to provide additional federal consumer safeguards.² The proposal calls for more stringent Medicare marketing regulation by CMS including prohibitions on door-to-door sales, cross-selling of non-health related products, cold calls, and any inducements for beneficiaries to enroll in a plan. The statement also recommends the adoption of additional safeguards to protect beneficiaries, and recommendations to improve agent training, and testing, and addressing agent compensation structures.³ The statement recommends the establishment of an advisory panel and providing additional tools to states to monitor sales activities and address market conduct issues. These tools include appointment of agents and brokers by MA plans, requiring MA and Part D plans to comply with state information requests about brokers and agents, and establishing a process for states to trigger CMS targeted audits.

¹ Senkewicz testimony, p. 1.

² It should be noted that America's Health Insurance Plans (AHIP) represents a large majority of, but not all, Medicare Advantage plans.

³ The March 2008 statement by the Board included recommendations to require consumer disclosures, verification calls to confirm that beneficiaries intended to enroll in a specific MA plan, limitations on the scope of products marketed during an appointment, limitations on promotional activities, improvements to marketing materials, and plan type designations to assist beneficiaries in easily identifying the plan type as they compare plan offerings.



Previously, Earlier, in May 2007, AHIP's Board adopted a set of industry principles for protecting beneficiaries as they consider enrolling in the MA and Part D programs and ensuring that brokers, agents and plan marketing staff meet new qualifications and requirements.⁴ Individual companies also have ~~also~~ expressed a commitment to improve consumer safeguards and protections. AHIP also developed comprehensive training for brokers and agents with a required passing score of 90 percent of questions answered correctly. This training is offered jointly by AHIP and the agent-broker industry.

Section 4. Agent Oversight

We are offering recommendations for revision to the specific language in this section in several areas described below. Additionally, with respect to the format of this section, we recommend that it be consistent with Section 3 in order to reflect comments and differing viewpoints of Subgroup members on the proposed recommendations.

Agent Training

CMS, as a result of the problems in the MA-PFFS market has implemented additional agent and broker training requirements upon companies for agents and brokers selling PFFS products. These requirements, according to CMS, may be expanded to all Medicare private plans at some later date. However, these requirements are sub-regulatory guidance and do not have the same legal effect as the Medicare statute and regulations.

The training platform being used was developed by AHIP and reviewed by CMS and is entitled "Marketing Medicare Advantage and Part D Prescription Drug Plans: Understanding Medicare Basics, Plan Options, and Marketing and Enrollment Requirements."⁵ CMS also requires the MA plans and PDPs to document training, and have internal monitoring and auditing procedures in place.

Agent Tracking and Oversight

Under the discussion of state appointment laws, AHIP recommends inclusion of language that acknowledges industry's support for the adoption of a requirement

⁴ The May 2007 statement by the Board included provisions on agent training, annual recertification and targeted retraining, enrollment safeguards, monitoring of compliance, investigation and response to complaints, agent compensation, and provider outreach.

⁵ This training program can be accessed at www.MedicareOnlineTraining.com



that MA plan sponsors appoint agents under applicable state laws. Our recommended language is shown below in underscore.

Agent Tracking and Oversight

CMS has taken the position that state agent appointment requirements -- state law requirements which require companies to appoint their agents -- are pre-empted and unenforceable. This inability to tie improper agent activity to plans is a major shortcoming of the current MA and PDP regulatory system.

MA plan sponsors have expressed their support for the adoption of a requirement for the appointment of agents that are marketing MA plans, consistent with state law, where applicable and report for-cause agent and broker terminations and the reasons for these terminations.⁶ Additionally, some MA plan sponsors currently voluntarily appoint agents in states that have such requirements.

CMS Medicare Marketing Requirements essentially state that it is the plan sponsor's responsibility to monitor and act on agent activity. CMS only specifically requires that plans verify state licensure of agents and brokers as required by state law, and requires that the plan have a process in place to address agent and broker problems. Yet, it does not appear to require plan sponsors to report improper agent activity to state insurance regulators. CMS also requires that plans monitor its agents and brokers for marketing violations and signs that may indicate problems (such as rapid disenrollment, complaints, etc) and requires plans to withhold or withdraw payment for rapid disenrollments.

Suggestions for Improving Agent Training and Agent Tracking and Oversight

AHIP would like to offer comments on several of the suggestions for improving agent training and agent tracking and oversight that have been offered by state regulators and consumer groups. Our comments are shown below.

Suggestion # 6. Require plans to take responsibility for the acts of their agents and take corrective measures when an agent engages in misconduct while selling a plan's product. Such measures would include the imposition of monetary sanctions against the plan sponsors and

⁶AHIP Board Statement on Strengthening the Oversight of Medicare Advantage and Part D Marketing (03-03-08)



agents, and holding harmless individuals who have been harmed. (*Consumer groups; state regulators*)

AHIP Comment:

It should be noted that CMS guidance already requires plans to take responsibility for the acts of their agents and take corrective measures when the agent engages in misconduct while selling a plan's product. Under current CMS guidance, Medicare private plans are held responsible for the conduct of individuals who are "directly employed by an organization, with which an organization contracts to perform marketing or a downstream marketing contractor"⁷ CMS takes into consideration the acts of agents when conducting oversight of MA plan compliance with CMS Marketing Guidelines. Where there are findings of inappropriate sales practices MA plan sponsors are subject to the full range of sanctions including corrective action plans, cessation of marketing, and civil monetary penalties. Therefore, we do not believe that this recommendation provides any additional consumer protection.

Suggestion # 8. Establish standards for subcontracting agents/agencies, including training requirements and monitoring processes. (*State regulators*)

AHIP Comment:

Under current CMS guidance, MA and Part D plan sponsors are required to implement agent training programs and monitor agent compliance. Therefore, we do not believe that this recommendation provides any additional consumer protection.

Suggestion #10. Require plan agents to disclose the commissions they pay for the sale of Medicare Private Plans. (*State regulators*)

AHIP Comment:

The information that is being recommended for disclosure is proprietary. Additionally, current CMS Marketing Guidelines require sales representatives to disclose to potential enrollees that they may be compensated by the MA plan sponsor for the sale of the product. Disclosure of additional information beyond what is currently required does not provide an additional consumer safeguard. If the goal is to protect beneficiaries from inappropriate sales tactics that state regulators believe are encouraged by agent commissions, then we believe the recommendation should focus on the agent commission structure. AHIP's Board Statement on Strengthening Oversight of MA and Part D Marketing contains a

⁷ CMS Marketing Guidelines, published Aug. 15, 2005, updated July 25, 2006.



recommendation for CMS to consult with the NAIC, MA and Part D plans, and other key stakeholders on new requirements for agent compensation. Compensation structures should encourage agents to fully inform beneficiaries about the products and plan rules and discourage marketing misconduct, such as churning and high-pressure sales tactics.

Suggestion # 11. Expand current NAIC disclosure requirements to include Medicare Advantage and Medicare Prescription Drug Plans so that consumers can better understand the differences between Medicare Supplement and Medicare Advantage. (*State regulators*).

AHIP Comment:

We agree that consumer disclosure is important. The AHIP Board Statement on Strengthening the Oversight of MA and Part D Marketing supports requirements that MA plan sponsors, as part of the application process, must receive the signature of a beneficiary on certain information disclosures included in the MA application that address the beneficiary's understanding of the plan structure and benefits prior to submission of the application. However, we believe that such disclosure should not be limited to, or based solely upon, the current NAIC disclosure requirements. We believe if there are to be requirements for additional disclosures, they should be developed by CMS in consultation with a broad group of stakeholders, including the NAIC, plan sponsors, and consumers groups to ensure the inclusion of necessary and appropriate information.

Section 5. Financial Incentives

As previously stated, AHIP recommends removal of this section from the White Paper as we believe that it goes beyond the scope of the discussions of the Subgroup and undermines the recommendations to strengthen oversight of marketing. It is not directly related to the marketplace issues that prompted the NAIC to form this Subgroup and we believe that to date, the Subgroup has not engaged in any significant discussion about this issue. Additionally, as currently drafted some of the content is technically inaccurate and would require substantial revision to present accurate information.

While we would like to reserve the opportunity to offer comments on the specific language in these sections pending the outcome of discussions at the upcoming meeting of the Subgroup, we have highlighted several key areas of concern below.

1. **Unfounded Assertion that MA Plan Payment Levels are Directly Related, or have an Impact on Medicare Marketing Abuses** — This assertion is unfounded as there are



no data to support a causal relationship between plan payment level and Medicare marketing abuses.

2. **Failure to take into Consideration Congressional Intent with Respect to the Current Medicare Payment Policy** — Congressional intent to expand coverage and beneficiary choices to all areas in the country, including rural counties, is evidenced by evolution of MA plan payments. In 1997, a floor rate was established to ensure that a minimum level of payment would be maintained. In 2000, Congress established two separate floor rates (one for counties within a metropolitan statistical area with a population of more than 250,000 and one for all other counties) to encourage plan participation in areas where the floors would be the prevailing rates. For example, states such as Wisconsin, Nebraska, Utah, and New Jersey are almost entirely supported by the MSA and/or rural floors, which were intentionally designed to take into consideration provider and payment issues beyond fee-for-service expenditures in determining payment policy. In 2003, the Medicare Modernization Act (MMA) retained a floor rate as one of the five payment “prongs” that were used to calculate payments in 2004. Floors continue to serve as the basis of rates in more than half of the counties. Congress also created the MA regional plan program and established a stabilization fund to encourage plans to stay in underserved areas and ensure that choices would be stable into the future. As a result of these policy decisions, Medicare Advantage plans are now available in all counties nationwide, providing high quality, affordable health plan options to nearly all beneficiaries.
3. **Inaccurate Assertions Regarding MA Plan Payments and Beneficiary Coverage Levels** — Assertions about the relationships among plan payments, beneficiary coverage, and incentives to offer products throughout the country are unfounded.
4. **Mischaracterization of Features of the MA Benefit Package** — This section inappropriately refers to items such as vision care, dental care, and nurse call lines as “incentives” for enrollment. Vision care and dental care are generally not considered “incentives” for enrollment, but rather are additional benefits offered under the plan that many beneficiaries value. Additionally, nurse call lines are not “incentives,” instead they are a part of a plan’s care management program. The use of nurse call lines are common within comprehensive medical plans both in the commercial market as well as in the senior market. It is also important to note that some of these additional benefits are provided in conformance with CMS’s rebate rule that 75% of any payment above the bid must be returned to the beneficiary in the form of reduced premiums or additional benefits and 25% must be returned to the government. Labeling of these items as “incentives” is misleading.



5. **Failure to Provide a Comparison between Commission Differentiations and Bonus Arrangements Between Product Types in the MA Program and State Regulated Products** — This section failed to acknowledge that differences in agent commission structures between types of MA and PDP products is similar to the difference between comprehensive medical plans and limited benefit plans (i.e. pharmacy only coverage) subject to state insurance regulation. Additionally, with respect to the discussion on the use of incentives and bonuses, it should have been noted that insurers are permitted to use incentives and bonus programs, in addition to commissions, for the sale of state-regulated health insurance products.
6. **Failure to take into Account Industry Efforts in Certain Areas Such as Inducements for Enrollment (e.g. reference to sales lunches)** — In March 2008, the industry recommended adoption of a prohibition of offering meals to potential enrollees.
7. **Failure to Consider the Impact of Recommendations for MA Funding Cuts on Beneficiary Coverage Options Across the Country** — This section recommends cuts to MA plan payments without thorough consideration of the impact of proposed cuts on beneficiaries throughout the country. The Subgroup has not engaged in the detailed policy analysis and discussion that would render such recommendations credible.

Additionally, we have concerns about some of the suggestions listed at the end of this section.

Section 6. Program Design

As previously stated, AHIP recommends removal of this section from the White Paper as we believe that it goes beyond the scope of the discussions of the Subgroup and undermines the recommendations to strengthen oversight of marketing. It is not directly related to the marketplace issues that prompted the NAIC to form this Subgroup and we believe that to date, the Subgroup has not engaged in any significant discussion about this issue. Additionally, as currently drafted some of the content is technically inaccurate and would require substantial revision to present accurate information.

While we would like to reserve the opportunity to offer comments on the specific language in these sections pending the outcome of discussions at the upcoming meeting of the Subgroup, we have highlighted several key areas of concern below.

1. **Recommending to Arbitrarily Limit the Number of Plan Types Available by Plan Sponsor to No More than Two Per Plan Type** — This recommendation is not based on a study of the existing market, impact on beneficiary benefit options, or beneficiary preference.



Plan differences are designed to provide choice and convenience to meet the varying health care needs and preferences of the diverse beneficiary population.

2. Recommendation of Standardization of Benefits for MA-PFFS Plans — This recommendation would limit beneficiary choices and stifle innovation in this market. CMS provides sophisticated tools for beneficiaries, caregivers, family members, and advocates to readily compare plan options based on a beneficiary's health care needs

We appreciate the opportunity to comment on the April 29, 2008 draft of the NAIC White Paper on Medicare Private Plans. If you have questions or would like additional information about our comments, please feel free to contact me at (202) 861-1472 or ajackson@ahip.org.

Sincerely,

A handwritten signature in black ink that reads "Alethia Jackson". The signature is written in a cursive, flowing style.

Alethia Jackson