

March 8, 2008

Mr. Guenther Ruch  
Chair, NAIC Medicare Private Plans Subgroup  
c/o Ms. Jane Sung  
NAIC  
701 Hall of the States  
444 North Capitol St, NW  
Washington, DC 20001



**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

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Re: NAIC Medicare Private Plans Subgroup – White Paper Working Draft

Dear Chairman Ruch:

The Blue Cross and Blue Shield Association (BCBSA) appreciates the opportunity to comment on the NAIC's Medicare Private Plans Subgroup draft white paper dated 4/29/2008 to address issues in the Medicare private plan marketplace. BCBSA represents the 39 independent, locally owned and operated Blue Cross and Blue Shield companies (Plans) that collectively provide health coverage to more than 100 million people – nearly 1 in 3 Americans. Plans collectively serve several million Medicare beneficiaries that have enrolled in Medicare Advantage (MA) or Part D plan options sponsored by our Plans.

We would like to thank the subgroup for reaching out to all stakeholders as it examines the marketing of Medicare Advantage. Medicare Advantage is a valuable program that has a current enrollment of more than 9 million Medicare beneficiaries who rely upon this program for comprehensive health coverage.

As presented in previous BCBSA comments and Blue Cross and Blue Shield of Michigan (Attachment I) and Blue Cross Blue Shield of Minnesota (Attachment II) testimony during the subgroup's hearing last September, BCBSA supports continued federal oversight of MA plans while allowing the continuation of state regulation of agents and brokers. We continue to be concerned that any changes to the federal preemption provisions established under the Medicare Modernization Act (MMA) would return Medicare Advantage to the confusion that existed under the Medicare+Choice program with both federal and state regulation of plans.

We believe the best approach to addressing marketing issues is to improve communications between CMS, state regulators and/or the NAIC so that all parties can work together in their respective areas of oversight to improve issues as needed.

Our comments provide feedback on the 4/29/08 draft of the white paper, make recommendations for incorporation into the next draft and for discussion at the May 20-21 meeting of the Subgroup. Our comments are categorized into two groups:

1. General comments on the paper; and
2. Specific comments on recommendations detailed in the paper; including the recently drafted sections.

## 1. General Comments

### *General Tone*

BCBSA believes that the white paper would benefit by reflecting a more balanced description of the MA program's development and its popularity as an option for Medicare beneficiaries. We are concerned that the white paper has diverted from its original charge of reporting on marketing practices to one that is an indictment of the MA program as a whole. The new Sections 5 and 6 make broad generalizations about the Medicare Advantage program that we do not believe are supported by evidence. We suggest that NAIC's explanation of changing the program design and/or CMS' plan reimbursement in Medicare Advantage would best be detailed outside this white paper.

### *Scope of the Report*

As indicated, BCBSA is concerned that the scope of the current draft white paper goes beyond the original objective of the workgroup which was to assess issues with marketing and sales in the Medicare Advantage marketplace. Moreover, we believe that many statements are speculative and are not supported by facts or evidence which detract from the credibility and usefulness of the report.

For example, there is no evidence to support the paper's claim that, "aggressive marketing and sales tactics...are the result of high payments that Medicare Private Plans receive..." or that, "these financial incentives appear to drive the sales practices..." as asserted on Page 3. We are not aware of any documentation of a causal relationship between the Medicare Advantage bidding and payment system and the abuses in the marketplace under review currently being addressed by CMS, state regulators and NAIC.

### *State regulation of MA plans*

While BCBSA encourages the NAIC to provide recommendations to CMS on marketing for MA plans, we continue to oppose any federal legislation that would subject MA plans to problematic dual federal-state regulation. As a program financed by federal funds, MA plans are best regulated at the federal level, just as with other federal programs, including TRICARE and the Federal Employees Health Benefit Program (FEHBP). Allowing states to enforce requirements for MA plans would return Medicare Advantage to the confusion that existed under the M+C program with both federal and state regulation of plans. This would result in increased confusion for beneficiaries as well as for plan sponsors.

The Medigap model is not applicable to Medicare Advantage since Medigap is a state-based, privately financed insurance product with no federal funds and the only tie to federal oversight is for plan design. Medigap is a distinct supplemental insurance product purchased by individuals in the private market. Medicare Advantage is a federal program and funded primarily by federal dollars.

We continue to recommend that the paper acknowledge that Medicare Advantage and the Part D prescription drug benefit are also largely organized on a regional or multi-state level, not as a single state product. Dual federal-state regulation over multi-state products would create complex regulatory issues for those regional plans with a single set of benefits and premiums. We encourage the NAIC to review the excellent testimony provided by BCBS of Minnesota on this issue and the complexities of a regional MA or Part D plan at the NAIC subgroup hearing in 2007 (Attachment II).

### *Enhanced Reporting on Efforts Underway*

The draft white paper catalogs issues in the Medicare marketplace over the past few years but presents only limited details on the steps that have been taken to increase oversight of marketing the MA program and ensure that the issues of the 2006 and 2007 open enrollment period have been addressed.

BCBSA has provided to the NAIC staff and others a listing of the steps that have been taken by CMS and others to address marketing issues. We believe NAIC staff should coordinate with CMS to provide a more complete explanation of improved regulatory requirements, including items detailed in the 2009 “call letter.” The paper also should acknowledge that CMS has recently issued updated draft regulations for comment for the 2009 plan year. A complete analysis of the CMS proposed rule released today (May 8) and the resulting final regulation will need to be undertaken prior to finalizing the NAIC white paper. We are also attaching the chart comparing Medigap rules to MA marketing rules that has been shared with NAIC staff as well as Congressional committees which we hope is helpful (Attachment III).

One example where CMS’ efforts could be included is on page 20 in Section 4. The draft paper notes the new training requirements CMS has implemented for agents selling PFFS products while stating that, “these requirements are sub-regulatory guidance and do not have the same legal effect as the Medicare statute and regulations.” The CMS proposed rule released May 8, 2008 is intended to codify previously issued guidance as formal regulation as well as codify new areas of regulation anticipated to be in place for the 2009 open enrollment season. And while we are not able to provide a full analysis of the extensive draft rule CMS has released today in time for the white paper comment deadline, the white paper should include acknowledgement of CMS’ ongoing efforts to codify guidance into regulation.

## **2. Specific comments or recommendations detailed in the paper**

### **Specific comments on Section 3 include:**

- **B.5.b, p.1: Cold Calls:** Suggest combining comments 2 and 3.
- **B.6, p.16: Inducements to Enroll:** The use of inducements should be in accordance with CMS guidelines.
- **B.7.a, p.17: In-Home Sales:** In-home enrollment of individuals in congregate living arrangements is necessary in certain circumstances. For example, banning all congregate living enrollments would prohibit a nursing home that is approved by CMS to offer a Special Needs Plan for institutionalized beneficiaries from enrolling its residents. CMS guidelines currently provide protections for congregant living facilities.
- **B.8.a, p.18: Improved Suitability Standards:** We are concerned with the lack of a clear definition of “suitability.” We recommend this section be deleted. If this section is retained and suitability standards are to be included, we recommend that suitability standards be clearly defined at the federal level and uniformly applied. Standards should not be implied to require one-on-one counseling with each beneficiary and plans should not have the responsibility for making income and asset determinations for enrollment.

We are concerned with the proposal to single-out and differentially treat dual eligible beneficiaries. Plans should not be responsible for making income and asset determinations

prior to engaging a beneficiary. Mandating differential treatment of dual eligible individuals by MA plans could be harmful and discriminatory. We believe the suggestion as written actually would be detrimental to dual eligible populations and could impose barriers in access to potentially valuable MA plan options for dual eligible beneficiaries.

- **B.8.b, p.18: Enrollment Forms:** We are concerned that this section, which recommends changes to enrollment forms, fails to take into account the many enrollments that are internet based or through SHIPs without any one-on-one agent or broker contact.

We disagree with the comment (1) that MA plans are not suitable for dual-eligible beneficiaries. In reality, many duals benefit from enrolling in a MA plans. Most MA plans provide coordinated care with a focus on prevention, disease and chronic care management: benefits not found in traditional Medicare. In addition, many MA plans also contract with state Medicaid agencies to coordinate Medicaid coverage and are in a much better position to coordinate care for their enrollees than the fragmented coverage beneficiaries would receive in the FFS Medicare program in addition to Medicaid coverage.

- **B.9.a, p.18: Marketing material requirements:** This section is not needed because CMS guidelines already include a requirement that the listed items be included in marketing and education materials. As an alternative, this section could be redrafted to describe how CMS guidelines require these items in educational materials.
- **B.12, p.19: Limiting advertisements to one particular product:** We strongly disagree with this proposal as it would put beneficiaries at a disadvantage by limiting the information necessary for beneficiaries to make plan comparisons and the most knowledgeable coverage decisions. In addition, it would seem to be in direct conflict to the previous proposal (B.9) to include explanations of how a particular MA plan is different from others. Finally, this proposal could have the unintended consequence of significantly increasing the amount of advertising and marketing of individual plans and thus significantly increasing administrative costs and adding to beneficiary confusion.
- **B.14, p.19: Apply all new CMS marketing and sales guidance on PFFS to all Medicare private plans:** BCBSA believes that this is inappropriate as some CMS guidance is applied to specific product types and some is designed to correct particular problems that have not been seen across the entire MA program. For example, CMS issued a new requirement requiring out-bound calls to verify enrollment in PFFS plans to address what was a perceived issue in the marketplace. Requiring verification calls for all MA plans is unnecessary because similar enrollment issues was not an issue with HMO and PPO plan options. Implementing this new requirement program-wide would be costly, from both an administrative and resource perspective. Consequently, we urge caution when considering expansion of costly new requirements to all MA plans in the marketplace where there have been no issues raised to be addressed. We believe that CMS should impose out-bound enrollment verification call requirements on plans that are placed on corrective action plans for marketing/enrollment issues or on those that CMS has determined to have problematic enrollments; not all MA plans.

#### **Specific comments on Section 4 include:**

As indicated previously, we believe that CMS has taken numerous steps, some in coordination with the NAIC and the states, to deal with issues in this marketplace. The white paper should accurately describe the efforts made by CMS, both to date and anticipated later this year, to address agent and broker oversight.

Moreover, we believe that Section 4 could be revised to provide a more objective examination of agent and broker oversight while removing some of the subjective statements. Specific comments on Section 4 include:

- Page 21, fourth paragraph: In no line of business are carriers required to report on the “activity” of agents. Insurance carriers instead are required to report on complaints received regarding agents. We believe this section could be revised to tailor reporting requirements to complaints rather than activity.

Additionally, we believe the process laid out in the text is correct and should be enhanced rather than deemed as deficient. MA plan sponsors report complaints to CMS, which oversees this federal program. In turn, CMS communicates with states about agent and broker complaints. The agreement on the MOU and increased communication between the states and CMS as the appropriate communication channel, rather than establishing a system which would result in dual federal-state regulation of this program. CMS has rigorous monitoring activity which leads to corrective action plans.

- Page 21, fifth paragraph: We recommend deleting the last sentence beginning, “CMS seems to have ignored...” as a subjective statement not backed up by clear evidence and implying bad intent.
- Page 21, sixth paragraph: We recommend deleting the last sentence beginning, “However, it would be much easier...” as subjective and contradictory to paragraph 4. The appropriate process is for CMS and the states to communicate rather than adding duplicative federal and state reporting requirements on plan sponsors.
- Page 21, seventh paragraph: We recommend revising this paragraph to present a more balanced tone. The current wording takes the position that the MOU is only effective “to the extent that CMS decides to share” information, implying that CMS actively decides to withhold information from states. We recommend deleting the phrase, “but only to the extent that CMS decides to share the information” as being overly subjective.
- Page 22, number 1: CMS already can require plans to ensure agents meet certain criteria and state regulators also can require their own continuing education requirements so we believe this recommendation is unnecessary.
- Page 22, number 2: We support approved training programs but oppose standardizing the method for providing the training. Standard methods of training would limit the educational opportunities to train agents should new technologies or methods arise (i.e. in addition to in-person, web-based, correspondence or other training methods currently utilized).
- Page 22, number 4: We disagree and believe that requiring all MA plans to complete duplicative reporting requirements to both CMS and the states is onerous and inappropriate. Instead, we believe it would be more appropriate and efficient for MA plans to supply information regarding agent and broker complaints to CMS and that states and CMS should be in regular communication about the complaints that each receives. MA plans should be required to comply with state information requests for information about individual agents or brokers as part of a state’s investigation into conduct of individual agents or brokers.
- Page 22, number 6: CMS currently has the authority – and has exercised that authority -- to take corrective measures against plans in response to agent and broker misconduct.

- Page 22, number 7: We believe it is not CMS or the plan's responsibility to ensure that agents and brokers are trained on all state-specific programs. This authority regarding agent and broker continuing education requirements currently resides in state insurance departments and no new authority is needed.

**Specific comments on Sections 5 and 6 include:**

We strongly recommend that these sections be deleted as we believe they are beyond the scope of the original intent of the white paper on marketing and sales of Medicare plans. Section 5.A uses anecdotes that are misleading to indict the Medicare Advantage program as a whole. Moreover, the points raised in this section replicate earlier assertions made in the background section and do not warrant rehashing in a new section. We recommend removing Section 5 and incorporating a more balanced and objective discussion of the Medicare Advantage program in the background section. Some examples of subjective and inflammatory language that we recommend removing include:

- Page 23, third paragraph under section 5.A: We disagree that the bidding and payment system under Medicare Advantage is a "primary driver" of marketing and sales abuses. The MMA was designed to create new options and choices for all Medicare beneficiaries. Industry responded by providing many new options and choices and for the first time, all Medicare beneficiaries have access to a private plan option. Agents and brokers responded by joining in the marketing effort of these new options. CMS, NAIC, regulators and the industry are responding to marketing and sales regulatory issues that have arisen in launching this new effort to bring expanded options to beneficiaries.
- Page 23, last paragraph: The draft white paper describes MA "overpayments" and attributes the statement to the March 2008 MedPAC report to Congress. This is incorrect because the MedPAC report to Congress does not use the word "overpayment."
- Page 23, last paragraph: The paragraph states that the additional compensation received by MA plans is, "without a corresponding level of coverage to the beneficiary." In reality, MA plans provide many additional benefits and reduced cost sharing -- \$86 per month on average according to CMS -- when compared to traditional FFS Medicare.
- Page 24, first paragraph: We believe that it is incorrect to state that "CMS argues that plan sponsors are required to return excess profits back to beneficiaries in the form of additional benefits or reduced premium." **By law** plans are required to return 75% of the savings from bidding below the benchmark to beneficiaries in the form of additional benefits or reduced premium and the government retains the remaining 25%. This sentence should be revised to indicate that it is in statute and not an argument. Moreover, the use of the term "profits" is incorrect. The correct statutory term for savings returned to the beneficiary is "rebate".
- Page 24, third paragraph: We believe that one example of one plan sponsor in Oklahoma providing high commissions for a particular plan type should not be used to assume the entire industry has a similar compensation system.
- Page 24, fourth paragraph: The use of anecdotal stories does not accurately depict the entire industry. Moreover, the example defines certain parameters and inputs arbitrary enrollment figures that are not substantiated. We recommend this paragraph be deleted or revised to indicate that it does not depict specific instances of actual commissions received by actual agents.

- Page 24, fifth paragraph: The white paper has provided no evidence to justify the statement that, “plan sponsors are still earning substantial income on their sales of MA plans” and we recommend this statement be removed.
- Page 25, first paragraph: The statement that plan sponsors are “expending significant sums” to advertise is unsubstantiated and includes no comparisons to other industries and products and we suggest it be stricken as outreach to beneficiaries is key to the MA program efforts. We also disagree with the paragraphs inference that development of product choices is bad for beneficiaries and the program.
- Page 25, second paragraph: Providing additional benefits through MA is required by law for plans that bid below the benchmarks and we believe it is inappropriate to discuss them in context of abusive incentives to sell MA products. The MA bidding and payment methodology provides a clear incentive for plans to drive down costs and bid below the benchmarks. MA plans that bid below the Congressionally specified benchmarks are required to use 75% of the difference for additional benefits and reduced cost sharing for beneficiaries and return the remaining 25% to the government treasury. Plans that use the savings dollars for extra benefits such as “health club memberships, nurse call lines, vision care or dental care” are providing valuable additional benefits not provided under traditional Medicare. Including these benefits in the discussion of improper financial incentives devalues these important health care benefits that also have been regarded by beneficiaries as highly valuable.

The inclusion of the anecdote of a plan sponsor that held sales lunches -- and only discussed the PFFS product out of the array of products available -- as a bad practice should be deleted as it is in direct contradiction to recommendation 3.B.12 on page 19 that would limit advertising to a single product. To remain credible, the white paper should not recommend a mandatory sales practice in one section while condemning the same practice in another section.

- 5.B, p.25, fourth paragraph: We do not believe that the two anecdotes described in Section 5.B provide solid evidence to warrant the statement, “agent compensation for MA plans, especially for MA-PFFS plans is substantially greater than for other Medicare-related health insurance products.”
- 5.B, p.26, second full paragraph: We request state insurance regulators provide data or evidence to justify the statement that complaints, “have not significantly decreased.” Otherwise, we recommend that this statement be stricken.

#### **Specific comments on Section 5 conclusions:**

- **5.C.1, p.26: MA funding reductions:** We disagree with the assumption that cutting MA payments will reduce or eliminate abusive marketing and sales tactics. Improved training and oversight, which has been put in place, is the proper way to address marketing issues. Reducing MA funding will increase member premiums, reduce benefits and reduce or eliminate altogether health plan options for beneficiaries.
  - According to the 2007 study by Adam Atherly, Ph.D. and Kenneth Thorpe, Ph.D. (Attachment IV) proposed MA funding cuts similar to those in the white paper would cause roughly one-third of MA enrollees -- more than 3 million people -- to lose their MA coverage and return to traditional Medicare. (According to the Congressional Budget Office, such cuts would cause half of all MA enrollees to lose their coverage.)

Beneficiaries who disenroll from Medicare Advantage would face an estimated increase in costs of \$825 per year.

- Thorpe and Atherly found that in half the states more than 50,000 Medicare Advantage enrollees would lose their coverage if the proposed cuts were enacted:
- 11 states would lose more than 100,000 MA enrollees each: Pennsylvania, Ohio, Michigan, Texas, California, Colorado, Oregon, Washington, Massachusetts, Wisconsin and Illinois
- 13 states would lose between 50,000 and 100,000 MA enrollees each: Missouri, North Carolina, New Jersey, Alabama, Georgia, Minnesota, Florida, New York, Louisiana, Kentucky, Virginia, Indiana and Tennessee
- **5.C.2, p.26: *Guaranteed renewable requirements:*** MA products cannot be made guaranteed renewable without predictable funding from the federal government. Every year Congress enacts Medicare legislation to change priorities and, in turn, change the amount of funding available to the MA program. Closed blocks cannot be managed when Congressional action to change funding levels and covered benefits changes the landscape annually.
  - For example, in 2003, Congress enacted the MMA with additional funding to foster private plan choices in Medicare and add a prescription drug benefit. Then in years 2005 – 2007, Congress enacted legislation cutting \$14.5 billion from MA. Forcing plans to renew products indefinitely when Congress alters the available funding year-to-year would be unsustainable.
- **5.C.5, p.27: *Minimum loss ratio (MLR) requirements:*** We would oppose requiring MA plans to meet defined MLRs as they are inconsistent with the competitive design of the MA program and requirements for other providers in Medicare. In addition:
  - *MLRs are a misleading indicator of the value provided by MA plans.* The medical loss ratio is a poor and misleading indicator of plan quality because it fails to account for the fact that many administrative functions – such as care coordination, quality improvement, network management and investment in information technology – often reduce costs and improve outcomes for beneficiaries.
  - *Definition of MLRs could discourage care management.* Activities such as care coordination, utilization review, quality reporting and case management are sometimes considered administrative expenses and mandating MLR levels would create a disincentive for health plans to invest in these important initiatives.

#### **Specific comments on Section 6:**

- **Section 6:** We recommend that this section be removed because it is beyond the original scope of the white paper project set forth by the NAIC Medicare Private Plans Subgroup. Promoting broad changes in program design will lead to significant beneficiary confusion and do little to address the abuses in marketing and sales that were identified in the 2006 and 2007 plan years. If this issue area is to be explored, we recommend undertaking an additional examination of the consequences of MA program restructuring before making

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broad recommendations. For example, 6.C.5 recommends multiple-year contracts for MA plan sponsors. Under the current system of Congressionally controlled funding and benefit-levels, MA plans cannot be required to remain in the program if Congress cannot guarantee adequate levels of funding over multiple years.

Again, thank you for the opportunity to provide input on this white paper working draft. We look forward to discussing these and other comments at the May 20-21 meeting of the Subgroup and on subsequent conference calls. If you have any questions or would like further information, please do not hesitate to contact me at (202) 626-4802 or [joan.gardner@bcbsa.com](mailto:joan.gardner@bcbsa.com).

Sincerely,

Joan Gardner  
Executive Director, State Services

- Attachment I: Testimony of BCBS Michigan before the NAIC, September 11, 2007
- Attachment II: Testimony of BCBS Minnesota before the NAIC, September 11, 2007
- Attachment III: Chart detailing current CMS marketing guidelines (dated March 18, 2008 which does not include detail on the CMS proposed rule dated May 8, 2008)
- Attachment IV: Atherly, Adam, Ph.D and Thorpe, Kenneth, Ph.D, "The Impact of Reductions in Medicare Advantage Funding on Beneficiaries." April 2007