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## **SECTION 1. EXECUTIVE SUMMARY**

In developing this white paper, the goal of the Medicare Private Plans<sup>1</sup> Subgroup was to outline the problems in the market and their underlying causes, and to suggest solutions to those problems. This is not a position paper. As the reader can well imagine, there are divergent interests and points of view of the participants in the Subgroup that will likely not be bridged. At the same time, there are some areas where there is consensus among the Subgroup. This paper attempts to gather the viewpoints of various participants into one document, and attribute those to the appropriate interest group, so that policy makers can make informed decisions on how to deal with these programs in the future. All participants agree that there have been problems in the market and that there are problems that need to be addressed in order to properly protect the Medicare-eligible population.

All participants agree that better cooperation and coordination between state regulators and the Centers for Medicare and Medicaid Services (CMS) would be in the best interests of all parties. This effort is already under way with the implementation of a Memorandum of Understanding (MOU) between CMS and the various states. However, some participants (industry and CMS) believe that the current regulatory structure should be maintained, while others (state regulators and consumer groups) believe that states should have greater regulatory authority over the plan sponsors than they do under current law.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) has been called the most significant change to the Medicare program since its inception in 1965. MMA established coverage of outpatient prescription drugs for all Medicare-eligible beneficiaries through Medicare Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug plans (MA-PDs). It changed the name of the Medicare+Choice program to Medicare Advantage (MA) and changed the payment structure to encourage participation of the private insurance industry in Medicare Part C. Proponents of the changes believed that competition among insurance carriers in providing coverage would result in lower costs to the program and more choices for Medicare beneficiaries. Other observers believed that Congress authorized generous payments to health plans and other providers in order to further the goal of moving Medicare

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<sup>1</sup> Medicare Private Plans are private insurance companies under contract with the federal government to provide Medicare benefits to enrollees. These plans are authorized under Medicare Parts C and D, and include Medicare Advantage (MA) Plans, Medicare Advantage Prescription Drug Plans (MA-PD), and Medicare Prescription Drug Plans (PDP).

from a social insurance program to a program run by the private sector.<sup>2</sup> As a result of the MMA, all Medicare beneficiaries now have a choice of an MA plan option in 2008, whereas only 25% of rural beneficiaries had a private plan choice in 1999. According to CMS, the cost of the Medicare prescription drug benefit is now roughly one-third less expensive than originally projected.

Another provision of the MMA expanded existing preemption of state law over plan sponsors. States now have regulatory responsibility only for the licensure and solvency of the plan sponsors, and all other aspects of regulatory responsibility were preempted and rest with CMS. However, states retained their regulatory authority over producers (agents and brokers).

Participation by the insurance industry in Medicare private plans was beyond what was expected. The competition in the new marketplace was fierce as plan sponsors worked hard to sign up both current Medicare-eligible beneficiaries and newly eligible beneficiaries. The newly implemented CMS systems used to enroll, disenroll, monitor and track enrollees experienced some problems that adversely affected beneficiaries.

CMS has worked to address the new challenges facing private plans in the Medicare market in a variety of ways. CMS has engaged in extensive policy development around the marketing of MA and PDPs, including proposing major revisions to the MA and PDP regulatory framework. CMS has expanded its monitoring of plan marketing through improved audits, “Secret Shopper” events, post-enrollment verification of calls, mandatory reporting of marketing and sales events. In addition, CMS has increased transparency around its compliance monitoring and enforcement actions by making information about these activities publicly available on its Web site. Many of these activities have been complemented by CMS’ collaboration with state insurance regulators through MOUs to facilitate information-sharing, regular meetings and trainings.

Marketing and sales abuses were and continue to be documented by state insurance departments, consumer groups and CMS. Because of the expanded preemption of state law by MMA, the ability of state insurance departments to assist consumers in Medicare private plans has been limited.

Because of the problems with marketing and enrollment in the MA and PDP market during the implementation of these programs, Congress held several hearings on the program, some of which focused on the marketing and sales problems in the market. The National Association of Insurance Commissioners (NAIC), through its Senior Issues (B) Task Force, established the Medicare Private Plans Subgroup (Subgroup) consisting of state insurance regulators, CMS, consumer groups, insurance industry representatives and other experts to review the Medicare market established under MMA, document the state of the market and provide suggested solutions to the problems in that market.

Since implementation of the MA and Medicare Prescription Drug programs, and increased scrutiny over marketing practices associated with these plans, there already have been efforts to address some of the problems in these markets. These efforts are documented in the paper.

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<sup>2</sup> Thomas L. Greaney, *Forward: The New Infrastructure of Medicare*. St. Louis University Journal of Health Law & Policy 1 (2007).

However, there are some fundamental differences of opinion as to causes of the problems and how they should be addressed. And, as indicated above, problems continue despite efforts that have already been made to address some of the marketing abuses.

State insurance regulators and consumer groups firmly believe that limiting the states' regulatory authority over plan sponsors to licensure and solvency has resulted in consumer harm and has negatively impacted states' ability to protect their Medicare-eligible consumers because states are preempted from applying their unfair trade practices laws to plan sponsor activity. States are therefore unable to address, in many cases, the root causes of the marketing and sales problems because they cannot hold the plan sponsors responsible for the acts of their producers, nor can they properly assist consumers when they file a complaint about a plan sponsor. They believe that the federal government does not have sufficient resources, insurance enforcement expertise or knowledge of the local Medicare marketplace to properly assist consumers with problems in a timely manner.

State insurance regulators and consumer groups also believe that plan sponsors should be required to appoint their producers in the states that require appointment. This would assist states in knowing exactly who is writing for the plan sponsors should problems arise with a particular producer. The insurance industry also supports appointment for producers selling MA plans.

State insurance regulators and consumer groups strongly recommend that the state regulatory preemption contained in MMA be amended so that states have the ability and thereby the regulatory authority to enforce appropriate state laws on all marketing practices of insurance companies that are MA and Part D plan sponsors. States are quick to point out that they do not want to be involved, in any manner, in the contractual relationship between CMS and plan sponsors. States **do not** want to be included in the following:

1. The bid process.
2. The review and approval of benefits, benefit plan designs and cost shares.
3. The filing and approval of plan sponsor marketing and sales material.
4. Coverage determinations.
5. Determination and enforcement of CMS' marketing and sales guidelines other than those in a state's unfair trade practices act.

On the other hand, plan sponsors and CMS firmly believe that the regulatory structure as currently contained in federal law should be maintained. Because these programs are completely funded with federal dollars, CMS believes that shared regulatory authority over the plans with states is improper. Plan sponsors believe that since these are national programs, giving states regulatory authority over the plans would result in inconsistent regulatory oversight and enforcement, with state and regional variations to the program that could lead to confusion, delays and inconsistency regarding oversight issues and result in increased costs to the plans, beneficiaries and the program in general. CMS is working to address marketing and sales abuses through increased oversight, new guidance and the promulgation of regulations governing MA and Part D marketing and sales activities. Therefore, industry believes that a change to federal preemption is not the best approach to address these issues, but instead supports increased federal regulation and oversight and increased federal and state collaboration.

State insurance regulators and consumer groups also believe that the current financial structure is one of the root causes for the marketing and sales abuses in the Medicare private plan market. MA plans receive payments that are, on average, higher than Original Medicare.<sup>3</sup> State insurance regulators and consumer groups believe that the level of compensation to plan sponsors provides an incentive to sell as many MA plans as they can, resulting in some of the high-pressure and fraudulent marketing and sales practices being experienced in the marketplace. The compensation to plan sponsors has also translated, in some cases, into high compensation to their producers in the form of high commissions and lucrative bonus packages as compared to other types of insurance products, encouraging them to sell as many MA products as they can. These types of financial incentives usually can result in marketing and sales tactics that cause consumer harm and unsuitable sales. To address these concerns, state insurance regulators and consumer groups make a number of recommendations outlined in the paper.

Both CMS and the insurance industry strongly disagree with state regulators and consumer groups on their financial compensation concerns. Industry has stated that it does not believe that payments to plan sponsors drive marketing and sales abuses. They contend that there have not been any studies that show a causal relationship between the compensation received by the plan sponsors and their producers and the marketing and sales problems documented in the Medicare marketplace. However, all parties agree that marketing abuses are of serious concern and that the most effective and appropriate way to address these abuses is directly through regulation of sales and marketing practices.

In addition, requiring plan sponsors to meet a set loss ratio for the plans they offer and requiring the plans to be guaranteed renewable is contrary to the way the MA program has been designed. They argue that costs to the program would increase significantly if such requirements were put on the plan sponsors. They also argue that such requirements would likely significantly harm the program to the detriment of the Medicare population.

State insurance regulators, consumer groups and some industry also strongly believe that the vast number of plan options available to Medicare consumers has resulted in the inability of consumers to make an informed buying decision. With the seemingly unlimited number of plans available—all with different coverages, cost shares, formularies for PDPs, providers and plan sponsors—consumers are overwhelmed by their choices to the point where they are unable to make a good comparative and informed buying decision. These groups believe that choice is good, but too many choices result in confusion and the risk of making a bad choice. It also increases the risk of inappropriate marketing and sales practices by plan sponsors and producers.

To address this problem, state insurance regulators, consumer groups and some from the industry recommend that plan sponsors be limited in the number of plans they can offer by type of plan. In addition, they recommend that strong consideration should be given to standardize MA plans so that consumers have the ability to compare plans. They suggest that the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) NAIC Medigap model be used as a template and guide for standardizing MA plan benefits and benefit plan designs.

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<sup>3</sup> Original Medicare may also be referred to as traditional, or fee-for-service, Medicare, and is composed of Medicare Part A and Medicare Part B.

CMS, as well as most of the insurance industry, strongly disagree with the state regulator and consumer group conclusion and proposals. They believe that the current MA program offers not only consumer choice but also encourages competition among plan sponsors that ultimately saves both the beneficiary and the program money. Also, while there were concerns about the number of choices available under Part D when people were first able to enroll and the late enrollment penalty applied, most of the industry asserts that those concerns have been addressed through education, improved decision-making tools, beneficiary assistance, and experience with the program. Moreover, they believe that satisfaction with this program is very high.<sup>4</sup> Most of the industry also opposes standardization because it would lock benefits into an inflexible structure that would be difficult and slow to change.

Further, they state that there are no data or studies that show the number of plans and plan sponsors in the market are harmful to consumers. In fact, they report that consumers are saving significant money by participating in an MA plan versus Original Medicare.<sup>5</sup> They believe that the problems in the market should be addressed directly through strengthening of the federal regulation of the program (including prohibition of certain marketing activities and increased consumer protections) and increased partnership between CMS and states. However, industry does not believe that vast changes to the current MA and Part D program structure—which in and of themselves could cause consumer confusion—would serve the best interest of beneficiaries and address the marketplace issues.

The problems in the Medicare marketplace are real. The solutions to those problems vary depending upon whose perspective one takes. It is the hope that this paper will provide a meaningful perspective for policymakers as they address these significant issues.

## **SECTION 2. BACKGROUND**

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

#### The Medicare Private Plans Marketplace and the Medicare Modernization Act

Medicare private plans are private insurance organizations under contract with the federal government to provide Medicare benefits to enrollees. Medicare private plans are authorized under Medicare Parts C and D, and include Medicare Advantage (MA) plans, Medicare Advantage Prescription Drug plans (MA-PD), and Medicare Prescription Drug plans (PDP) (offered to enrollees in Original Medicare). Through these plans, the private insurance sector now plays an increasing role in the provision of insurance coverage to the Medicare-eligible population.

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<sup>4</sup> 2008 National Survey of Senior Regarding Medicare Advantage, Conducted jointly by Ayres, McHenry & Associates and the Feldman Group on behalf of America's Health Insurance Plans (AHIP).

<sup>5</sup> Presentation by Abby Block before the National Medicare Education Panel (October 24, 2007). (CMS has reported that MA enrollees are saving an average of almost \$90 per month because of the improved benefits and lower out-of-pocket costs provided by Medicare Advantage plans.)

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established outpatient prescription drug coverage through the Medicare program to the Medicare-eligible.<sup>6</sup> The MMA created a new market for the insurance industry through the provision of outpatient prescription drug coverage and significantly modified private coverage options.

Among other things, the MMA changed the name of the old Medicare+Choice program to Medicare Advantage (MA), and changed the payment system for these plans. MA plans provide Medicare benefits to enrollees in the place of Original Medicare. MA plans include: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) (both regional and local), Private Fee-For-Service plans (PFFS), Special Needs Plans (SNP), Medical Savings Accounts (MSA) and Provider Sponsored Organizations (PSO). By the end of 2007, the number of beneficiaries enrolled in MA plans since enactment of the MMA has increased 34% to compose 19% of all Medicare beneficiaries.<sup>7</sup>

In addition to the above, the MMA expanded preemption of state law relating to MA plans and established the same preemption for PDPs.<sup>8</sup> Only state laws concerning licensure and solvency are preserved. The MMA also permitted CMS to grant special, temporary waivers from state licensing requirements for PDPs under certain circumstances.<sup>9</sup>

#### Marketing and Sales Abuses

State departments of insurance, State Health Insurance Assistance Programs (SHIPs), consumer advocacy organizations and others have reported patterns of overly aggressive, deceptive and abusive marketing and sales practices in the Medicare private plan marketplace since implementation of the MMA. State insurance departments have consistently reported that they have received a disproportionately high number of complaints related to Medicare private plans, as compared to other insurance products.<sup>10</sup>

Recent surveys of state departments of insurance conducted by the NAIC also showed that states have received complaints from consumers showing patterns of aggressive and deceptive or

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<sup>6</sup> Public Law 108-173 (enacted December 8, 2003).

<sup>7</sup> Marsha Gold, *Medicare Advantage in 2008*, Kaiser Family Foundation, June 8, 2008.

<sup>8</sup> 42 U.S.C. §1395w-26: “The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.” 42 U.S.C. § 1395w-112: “The provisions of sections [1854\(g\)](#) and [1856\(b\)\(3\)](#) shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sections apply to MA organizations and MA plans under part C.”

<sup>9</sup> 42 U.S.C. §1395w-112.

<sup>10</sup> Testimony of Wisconsin Insurance Commissioner Sean Dilweg: Hearing Before the Subcommittee on Health of the House Ways & Means Committee, 110<sup>th</sup> Congress (May 22, 2007); Testimony of North Dakota Insurance Commissioner Jim Poolman: Hearing Before the Subcommittee on Oversight & Investigations of the House Energy & Commerce Committee, 110<sup>th</sup> Congress (June 26, 2007); Testimony of Illinois Insurance Director Michael McRaith: Hearing Before the Senate Finance Committee, 110<sup>th</sup> Congress (February 7, 2008); Testimony of Special Agent Sherry Mowell, Georgia Office of the Commissioner of Insurance: Hearing Before the Senate Special Committee on Aging, 110<sup>th</sup> Congress (May 16, 2007).

abusive marketing practices.<sup>11</sup> These complaints include reports of producer<sup>12</sup> and/or company misrepresentations in the marketing and sales of MA plans, particularly Private-Fee-For-Service (MA-PFFS) plans, including misrepresentations about provider networks, provider acceptance of plans, reimbursements, benefits, premiums and other features.<sup>13</sup> In some cases, for example, beneficiaries were enrolled without a clear explanation that, unlike with Original Medicare, their access to providers (including doctors and hospitals) may be restricted, or that their provider may not accept the MA plan's payment terms.

Many states also reported complaints about inappropriate or confusing marketing practices leading beneficiaries to enroll in MA plans without adequately understanding the coverage into which they were enrolling. In some cases, beneficiaries believed they were signing up for a PDP or a Medicare Supplement (Medigap) Plan, rather than an MA plan, and they did not understand they were disenrolling from Original Medicare.<sup>14</sup>

States reported that, in some instances, consumers inquired about a Medigap plan or a stand-alone PDP, only to be signed up for an MA plan without their knowledge nor their understanding of the limitations of such a plan. Also, when beneficiaries requested disenrollment from the MA plan, it often took months to have Original Medicare reinstated.

States reported complaints regarding fraudulent activity, including beneficiaries who were enrolled without any contact with a producer, forged signatures, misrepresentations by producers, or improper use of personal information.<sup>15</sup> For example, producers used signatures of consumers who thought they were attesting to the producers' MA sales presentations by signing a "form," but ended up being enrolled in an MA plan. In addition, beneficiaries who had indicated that they had not reached a decision about enrollment were asked to sign an application for an MA plan. The producer promised to hold the applications, but enrolled them anyway.<sup>16</sup>

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<sup>11</sup> Summary of First State Survey on Medicare Marketing Issues, NAIC Senior Issues (B) Task Force (updated 6/1/07, conducted in April 2007); Summary of Second State Survey on Medicare Marketing Issues, NAIC Senior Issues (B) Task Force (updated 02/05/07, conducted in January 2008). Both survey summaries can be accessed at [www.naic.org/committees\\_b\\_senior\\_issues\\_medicare\\_private\\_plans.htm](http://www.naic.org/committees_b_senior_issues_medicare_private_plans.htm).

<sup>12</sup> An insurance "producer" is defined as a person required to be licensed under state law to sell, solicit or negotiate insurance. This term broadly includes entities which may be commonly referred to as insurance "agents" or "brokers," or referred to in CMS guidance as "marketing representatives."

<sup>13</sup> In the first NAIC survey, 41 out of 46 states reported that they had received complaints about such producer or company misrepresentations; in the second NAIC survey, 34 out of 36 states reported that they had received such complaints.

<sup>14</sup> In the first NAIC survey, 39 out of 46 states reported that they had received complaints about inappropriate or confusing marketing practices leading beneficiaries to enroll in MA plans without adequate understanding of what they were signing up for; in the second NAIC survey, 32 out of 36 states reported that they had received such complaints.

<sup>15</sup> In the first NAIC survey, 24 out of 46 states reported that they had received complaints about fraudulent activity; in the second NAIC survey, 19 out of 36 states reported that they had received such complaints. Testimony of Deputy Commissioner Lee Harrell, Mississippi Insurance Department: Hearing of the Subcommittee on Oversight & Investigations of the House Energy & Commerce Committee (4-5), 110<sup>th</sup> Congress (June 26, 2007); Mowell testimony.

<sup>16</sup> Summary of First State Survey, NAIC Senior Issues (B) Task Force; Testimony of Deputy Commissioner Mary Beth Senkewicz, Florida Office of Insurance Regulation: Public Hearing Before the NAIC Medicare Private Plans Subgroup (p. 5)(September 11, 2007).

States reported complaints of aggressive sales practices such as cross-selling, whereby producers used access to beneficiaries afforded under the MMA, which allows producers to explain PDPs, to pressure beneficiaries into other types of insurance products such as annuities, funeral expense insurance policies or life insurance policies.<sup>17</sup>

States reported improper enrollment into these plans of individuals with Alzheimer's disease or dementia, mentally incapacitated individuals, or beneficiaries with limited English proficiency who did not understand the products they were buying.<sup>18</sup> Dual-eligible beneficiaries have also been enrolled into plans that are unnecessary or inappropriate.<sup>19</sup>

Since aggressive marketing and sales practices—especially in the MA-PFFS market—have increased dramatically since implementation of the MMA, state regulators and consumer groups believe that these practices are linked to the substantial payments Medicare private plans now receive under the CMS bid process. These payments allow for significant compensation for producers. Some plans reportedly offer bonuses of up to \$10,000, in addition to commissions, for high levels of enrollment into MA products. Arguably, such substantial financial incentives drive sales practices, plan choices offered, and advice given to Medicare beneficiaries. However, the insurance industry asserts that there is no documentation of a causal relationship between the MA bidding and payment system and the abuses in the marketplace. The insurance industry believes that the reported rise in marketplace abuses could be attributable to several differences in the marketplace post-MMA that are unrelated to payment rates to MA and Part D sponsors. For example, lack of familiarity among over 40 million consumers and caregivers with new Medicare offerings in 2006, the introduction of a new sales force that lacked experience with these products and/or the needs of Medicare beneficiaries, and the unscrupulous actions of a limited group of individuals who are not representative of the broker and agent industry as a whole.

### Many Types of Coverage Options

State regulators and consumer groups believe that the sheer number of Medicare private plans offered has led to confusion among beneficiaries, despite the widespread availability of resources available to assist beneficiaries in their decision-making. For example, in 2007 the state of Florida reported that 37 insurance carriers marketed and sold over 300 different MA plans. All of these plans had different coverage levels, cost-share amounts and premium rates. Additionally, there were 57 stand-alone PDPs, all with different coverage levels, cost-share amounts, premium rates and drug formularies.<sup>20</sup> Because of the variety of 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.

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<sup>17</sup> In the first NAIC survey, 33 out of 46 states reported that they had received complaints about cross-selling; in the second NAIC survey, 21 out of 36 states reported such complaints.

<sup>18</sup> Testimony of Senior Health Insurance Assistance Program Director Alan Heumann, Louisiana Department of Insurance: Public Hearing Before the NAIC Medicare Private Plans Subgroup (p. 2)(September 11, 2007).

<sup>19</sup> Mowell testimony, p. 3.

<sup>20</sup> Senkewicz testimony, p. 1.

Finally, as a result of the recent changes in the Medicare private plans market, new products have been developed that some state regulators have questioned. For example, there have been problems with the marketing of Special Needs Plans (SNP) that provide coverage to only certain categories of at-need individuals. Also, state regulators and consumer groups are alarmed by reports that some insurance companies are marketing a new form of supplement insurance to wrap around MA plans—such plans violate federal and state Medicare supplement requirements.

#### Jurisdiction for Consumer Complaints Confusing

States and consumers have also reported problems with complaint resolution. In some cases, these problems are a direct result of the split regulation between states and the federal government in this market.<sup>21</sup> Additionally, because of the broad preemption of state law under the MMA and limited state regulatory authority, states have experienced significant problems assisting Medicare-eligible consumers.

As noted earlier, states have received a disproportionately high number of complaints concerning MA plans. Complaints made to state insurance departments suggest that CMS and plans are providing conflicting information concerning a beneficiary's current enrollment status.<sup>22</sup> Because of the bifurcated regulatory system, states are unable to directly assist beneficiaries with such problems and can only refer the individuals to CMS.

Even where beneficiaries are able to find solutions to such problems, the final resolution may be delayed for months and may involve disenrollment, halting automatic premium deductions, and unexpected out-of-pocket costs for the beneficiaries. Beneficiaries who incur unexpected medical expenses resulting from improper marketing may not be made whole even when the issues are resolved. Some beneficiaries have been required to pay higher premiums for the Medigap policies that were dropped. Other beneficiaries were unable to recover employer-sponsored retiree health coverage that was lost when they enrolled in an MA private plan.

As a result of these and other problems, such as the lack of access to providers, complaints to state insurance departments about this program have increased dramatically. While states have different complaint-tracking methods, and state insurance departments that house SHIP offices typically report significantly higher numbers of complaints, it is clear that all states have seen a major influx in complaints relating to Medicare private plans. For example, the Florida Office of Insurance Regulation reported that investigations of Florida producers selling MA plans have increased 515% from 2006 to 2007.<sup>23</sup>

#### Congressional Action on Marketing Abuses

Several congressional hearings were held concerning the Medicare private plan marketplace. The testimony at these hearings brought out the problems in the marketing and sales of these products as highlighted above.

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<sup>21</sup> Senkewicz testimony, p. 2-3. "We have consumers who have been bounced between CMS and our office, with each telling the consumer that the other has jurisdiction to handle their problem."

<sup>22</sup> Poolman testimony, p. 3-4; Senkewicz testimony, p. 5.

<sup>23</sup> Senkewicz testimony, p. 6.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)<sup>24</sup> was enacted. This legislation included prohibitions and limitations on certain sales and marketing activities under MA and PDPs.<sup>25</sup> A description of the new law is contained in Section 3.

## **B. The NAIC Medicare Private Plans Subgroup**

Pursuant to the direction of the NAIC's Health Insurance and Managed Care (B) Committee and Government Relations Leadership Council, the Senior Issues Task Force created the Medicare Private Plans Subgroup in July 2007. The goal of the Subgroup is to assess the Medicare private plans marketplace, define the concerns in the marketplace and provide possible solutions to those concerns to policymakers.

The Subgroup is modeled after the subgroup that originally developed standards for Medicare Supplement insurance after passage of OBRA 1990, and includes state regulators, CMS representatives, industry representatives, consumer representatives and other experts and interested parties. A complete list of Subgroup members and their affiliations is attached to this paper.

## **C. Marketplace Issues and Suggested Solutions**

In order to analyze the problems in the marketplace and provide suggested solutions, the paper is organized into the following broad categories. It should be noted that several sub-issues can fall into two or more of these categories, and many of the issues and sub-issues are inextricably intertwined.

- Marketing and Sales Practices (companies and producers)
- Oversight
- Financial Incentives (companies and producers)
- Program Design

During a hearing held by the NAIC on September 11, 2007, witnesses testified to a wide range of suggested improvements and solutions. The suggestions included improvements that could be accomplished through current law and current regulatory authority, as well as suggestions for changes in federal legislation. These and other suggestions made by Subgroup members have provided the basis of the suggestions discussed in later sections of this white paper.

**As stated in the introduction, it is important to note that the Subgroup did not attempt to reach consensus on all issues and suggestions. The paper attempts to gather all points of view and then attribute those to the appropriate interest groups. As the reader of this paper will see, there are some fundamental differences among the various interested parties that will likely not be bridged. At the same time, there are some areas where there is consensus among most Subgroup members.**

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<sup>24</sup> Public Law 110-275.

<sup>25</sup> These provisions are contained in Section 103 of P.L. 110-275.

## D. Current Efforts

In response to the problems documented in the marketplace, and the increased attention these problems received during 2007, many efforts have already begun and have been put in place to attempt to improve oversight of Medicare private plans. Since many of the issues are related to MA Private Fee-For-Service (MA-PFFS) plans, most of these efforts have been limited to PFFS plans. It should also be noted that various members of the Subgroup believe that some of these efforts do not go far enough in addressing the concerns already discussed in this paper.

### CMS Initiatives

CMS introduced a number of new requirements and procedures over 2007 and early 2008 for MA-PFFS plans. These new requirements were included in CMS' 2008 and 2009 Call Letters and in additional memoranda or letters to plan sponsors. The new procedures included creating a secret shopper program to monitor certain MA plan marketing events, requiring post-enrollment verification calls by plans of PFFS enrollees, requiring new disclaimer language on marketing materials, requiring new producer training requirements, and requiring mandatory reporting of marketing and sales events sponsored by the plans.<sup>26</sup> CMS has also established a special election period for marketing misrepresentations, for any beneficiary who was misled or deceived into enrolling into an MA plan or PDP.

On June 15, 2007, CMS announced that seven insurers that provide a majority of the MA coverage in the country agreed to suspend the marketing activities of their Private Fee-for-Service (PFFS) plans. CMS announced that the suspension would continue until the companies could certify to CMS that conditions outlined in CMS' 2008 Call Letter and its subsequent May 25, 2007, guidance memorandum had been met. On September 24, 2007, CMS announced that all seven plans had certified compliance with the above, and the moratorium was lifted. CMS and the plan sponsors believed that ensuring that plans meet the requirements in CMS' 2008 Call Letter and the May 25, 2007, guidance memorandum would address the problems in the MA marketplace.

In its 2009 Call Letter, CMS included a requirement that an MA or PDP marketing representative (producer) who meets with a beneficiary about Medicare coverage may not discuss other insurance products unless a separate appointment is scheduled at least 48 hours after the initial appointment.<sup>27</sup> CMS also indicated that it would update its Medicare Marketing Guidelines in 2009. In addition, CMS has made corrective action plan information publicly available on those plan sponsors on which a corrective action plan is ordered.

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<sup>26</sup> Memorandum from Abby Block (CMS) to Medicare Advantage Private Fee-for-Service (PFFS) Plans, "Ensuring Beneficiary Understanding of Private Fee-for-Service Plans, Actions and Best Practices" (May 25, 2007).

<sup>27</sup> CMS 2009 Call Letter to all Medicare Advantage Organizations (MAOs), Medicare Advantage Prescription Drug Organizations, Cost-Based Contractors, Prescription Drug Plan (PDP) sponsors, Employer / Union-Sponsored Group Health Plans, and Programs of All-Inclusive Care for the Elderly (PACE) Organizations, page 86 (March 17, 2008).

On May 15, 2008, CMS issued a Notice of Proposed Rulemaking (NPRM).<sup>28</sup> The proposed rule includes provisions affecting plan marketing standards and producer compensation; cost-sharing for dual-eligible MA enrollees; and the enrollment, appeals, marketing and sanctions processes. CMS hopes to issue a final rule by October 31, 2008, in order for new policy provisions to become effective for plan contract year 2009. In the NPRM, CMS proposes a number of new requirements on plan sponsors that add to and expand its authority over marketing practices. In addition, CMS proposes in the NPRM to codify a number of existing requirements that previously existed only in sub-regulatory guidance.

#### State Insurance Department Initiatives

The states have also been working, under their limited authority, to address the concerns in the market. Although states continue to have absolute authority over producer activity, states are preempted from regulatory authority over MA plans and PDPs, except for licensure and solvency. However, some states have made special efforts to limit abuses in their Medicare marketplace. The following are some examples of the efforts that states have made:

**Ohio.** The Ohio Department of Insurance has been holding outreach efforts with plans to explain what is and is not permissible under federal and state laws. Ohio has emphasized that companies need to take responsibility for producer training, compliance and oversight, and has encouraged plans to evaluate their regulatory compliance and producer training programs to ensure all necessary training components have been included. Ohio is further encouraging plans and producers to contact the Department of Insurance if they identify potential producer misconduct.

**Oklahoma.** The Oklahoma Insurance Department has issued several letters and bulletins setting out items that consumers, caregivers, producers and companies should be aware of as they reference marketing and sales plans of the carriers.

**Wisconsin.** The Wisconsin Office of the Commissioner of Insurance set up a work group of benefit specialists, insurance department personnel, advocates for older and disabled persons, and SHIP staff that developed consumer education material, informative press releases to help consumers navigate this market, a reporting mechanism to identify abusive tactics in the market, and a high-profile enforcement process in order to quickly handle producer abuse complaints. In addition, Wisconsin has met and continues to meet with MA plans to understand the products they are selling, their distribution systems and their service areas.

**Maine:** In 2006, the Maine legislature enacted legislation expressly prohibiting door-to-door sales, cross-selling and cold-lead advertising.

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<sup>28</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. 28556 (May 10, 2008) (to be codified at 42. C.F.R. pts 422 and 423). CMS states that the proposed changes in the NPRM draw upon the experience CMS has gained since 2006 and are intended to improve the administration of both the MA and Part D programs.

### Joint Federal-State Initiatives

Over the past several years, there has been an effort between state departments of insurance and CMS to work together to bridge the regulatory gap. In late 2005, the NAIC expressed concern to CMS about implementation of the MMA, particularly as it related to effective communication and information-sharing between the states and CMS. The NAIC and CMS realized that, in order to oversee these programs effectively, state departments and CMS would need to work cooperatively. To address these concerns, CMS and the NAIC Senior Issues (B) Task Force formed a work group to determine how to share necessary information about this market.

This work group developed a Memorandum of Understanding (MOU), signed by individual state departments of insurance and CMS, to permit the sharing of enforcement-related information as it relates to Medicare private plans. Nearly all states have now signed an MOU with CMS, and information-sharing has begun to a limited degree.<sup>29</sup> CMS has released guidance related to the implementation of the MOU to its regional offices that establishes an expected baseline of communication between CMS and state departments of insurance. In the spring of 2008, CMS began to grant state insurance regulators access to its Health Plan Management System (HPMS).<sup>30</sup> Through the HPMS, states can access beneficiary complaints in the Complaint Tracking Module (CTM) and can view scheduled marketing events for each plan by state. Additional modifications to the HPMS can be made as the need arises.

The CMS regional offices participate in the cooperative regulatory effort with the states and have met with many of the states in their regions. In many cases, CMS regional offices have long-standing relationships with state regulators, and in other cases, contacts have since been established. Some CMS regional offices meet regularly with all of the state departments of insurance in their region. CMS regional office liaisons hold quarterly calls (at a minimum) with each state in their region to keep the lines of communication open. Additionally, the liaison sends specific producer complaints received by CMS to the state department of insurance on a weekly basis, at a minimum.

In the past year, CMS and states have collaborated to discuss the MOU process, to provide updates on the MA environment, and to share enforcement activities. Attendees at the meetings have included the state insurance commissioner or a designee, CMS managers, and appropriate staff from the state and CMS. Topics at these meetings vary depending on issues important to the state. Most regions have been discussing specific producer complaints with state departments of insurance, including PFFS and/or MA marketing issues. Many have shared information regarding enforcement actions and reviewed the use of HPMS information. Other topics include complaint trends, CMS oversight initiatives, and outreach events.

### Outcomes of Information-Sharing between CMS and States

The following are a few examples of how states and CMS have shared information and taken action.

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<sup>29</sup> As of July 8, 2008, CMS had signed MOUs with 49 states, Puerto Rico, the District of Columbia, and the U.S. Virgin Islands. CMS anticipates a signed agreement with the remaining state soon.

<sup>30</sup> As of July 3, 2008, 46 regulators from 27 states had access to the Health Plan Management System.

- The Ohio Department of Insurance received a complaint from an apartment complex manager on behalf of three residents. The sales agent contended he was there because the residents requested appointments. The department shared the complaint with the Chicago Regional Office, which in turn shared the complaint with the plan. After the plan's investigation, the agent's contract was terminated.
- Collaboration between the Seattle Regional Office and the Idaho Department of Insurance led to the successful denial of a health plan's 2007 service area expansion application. The department had provided the Regional Office with weekly updates regarding the health plan's license status, ultimately sharing a letter denying the applicant a state license.
- The Philadelphia Regional Office identified a trend with a specific broker in Maryland. He was knocking on doors in senior communities in an attempt to enroll beneficiaries in PFFS plans. The Regional Office quickly began sharing information about this with the Maryland Department of Insurance, which is now actively investigating the allegations and examining enrollment applications the broker submitted.

### Medicare Private Plans Industry Initiatives

The insurance industry has taken steps to address recent issues that have arisen in the market and, individually and through its associations, has also made efforts to address these problems. In March 2008, the 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.<sup>31</sup> 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, recommendations to improve agent training and testing, and recommendations addressing agent compensation structures.<sup>32</sup> The statement recommends establishing an advisory panel and providing additional tools to states to monitor sales activities and address market conduct issues. These tools include appointment of producers by MA plans, requiring MA and Part D plans to comply with state information requests, and establishing a process for states to trigger CMS targeted audits.

Previously, in May 2007, AHIP's Board adopted a set of industry principles for protecting beneficiaries as they consider enrolling in MA and Part D plans and for ensuring that producers and plan marketing staff meet new qualifications and requirements.<sup>33</sup> Individual companies also have 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

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<sup>31</sup> It should be noted that America's Health Insurance Plans (AHIP) represents a large majority of, but not all, Medicare Advantage plans.

<sup>32</sup> 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.

<sup>33</sup> 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.

percent of questions answered correctly. This training is offered jointly by AHIP and the agent-broker industry.

### Producer Industry Initiatives

The producer community has made efforts to address the problems in the marketplace. Recognizing that the vast majority of licensed producers who sell Medicare-related products to Medicare beneficiaries have behaved properly, and that those who have behaved in an unethical manner do not represent the professional producer community, the National Association of Health Underwriters (NAHU) has increased its educational efforts among its members about rules concerning Medicare-related product sales.<sup>34</sup> In addition, NAHU has been a member of this Subgroup and is willing to work with and consider several options that directly affect its membership to address some of the problems and issues in the current MA market. NAHU has also jointly offered, in partnership with AHIP, a comprehensive five-part exam-based training program for Medicare product producers that has become the industry training standard.

In March of 2008, NAHU released comprehensive policy recommendations on this topic titled *Strategies for Improved Oversight and Accountability in Medicare Private Insurance Product Sales and Marketing*.<sup>35</sup>

### Consumer Advocate Initiatives

Various consumer advocacy organizations that work with Medicare beneficiaries who have been harmed by producer and plan marketing misconduct have made recommendations to address problems in the marketplace through various means, including congressional testimony, issue briefs, letters to legislators, correspondence with CMS, and discussion with state regulators.<sup>36</sup> These recommendations range from substantial changes to the MA and Part D programs, including standardization of benefit packages, to more specific recommendations, such as eliminating producer bonuses and leveling sales commissions paid between MA and Part D plan sales. Also, in response to the AHIP Board's March 2008 recommendations concerning the oversight of Medicare marketing activities, the Center for Medicare Advocacy, Medicare Rights Center and California Health Advocates wrote a letter to the Senate Finance Committee highlighting the inadequacies of the proposals.<sup>37</sup> Complaints filed by consumer advocacy organizations have also resulted in state actions taken against producers and in CMS-imposed Corrective Action Plans, including monetary fines taken against plans.

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<sup>34</sup> It should be noted that the National Association of Health Underwriters (NAHU) does not represent all agents and brokers who sell Medicare private plans.

<sup>35</sup> These policy recommendations address the ideas of mandatory appointments for MA producers, level commissions in the private Medicare product market, consistent and exam-based training for producers, and extending the Medicare open enrollment window to October 1-December 31 annually.

<sup>36</sup> For example, Issue Brief *After the Goldrush: The Marketing of Medicare Advantage and Part D Plans*, California Health Advocates and Medicare Rights Center (January 2007). This issue brief can be accessed at [www.cahealthadvocates.org/\\_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf](http://www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf).

<sup>37</sup> This letter can be accessed at [www.medicareadvocacy.org/MA\\_08.03.12MarketingLetter.pdf](http://www.medicareadvocacy.org/MA_08.03.12MarketingLetter.pdf).

## **SECTION 3. MARKETING AND SALES PRACTICES**

### **A. How Marketing and Sales Are Currently Regulated**

Pursuant to the MMA, states are preempted in the regulation of plan marketing and sales practices as they relate to MA plans and PDPs, while state licensure and solvency laws and state oversight of producers are preserved. State regulators and many consumer groups contend that this bifurcated regulatory system does not allow states to adequately protect their Medicare-eligible population.

This system bifurcates the regulation of producers from the regulation of plans so that states cannot hold plans responsible for the acts of their producers. Nor can states proactively require plans to comply with their unfair trade practices laws<sup>38</sup> and impose marketing and sales standards on their producers. States can therefore address abuses only on a case-by-case basis rather than on a systemic basis. This is not an efficient or adequate regulatory system.

#### Federal Marketing Guidelines

CMS has established a set of Medicare Marketing Guidelines for Medicare private plans.<sup>39</sup> The Marketing Guidelines, while focusing on plan level compliance, do not contain requirements for producers. As stated in the Guidelines, “These guidelines reflect CMS’ current, official position on marketing policy and operational instructions for Medicare Advantage plans, Medicare Advantage Prescription Drug plans, Prescription Drug plans (PDPs), and 1876 Cost plans.”<sup>40</sup>

Each plan is required to use these guidelines in conjunction with other CMS requirements and guidance. CMS has also issued marketing guidance to plans in the form of memoranda, letters, and Call Letters. However, the Marketing Guidelines, as well as these other materials, are sub-regulatory guidance that is not specifically contained in statute or regulation and may therefore, for enforcement purposes, lack the binding legal effect of regulations and statutes and be able to be changed regularly (e.g., annually).

The Marketing Guidelines provide for the submission, review and approval of marketing and sales material to CMS by the plans. The Guidelines set forth the types of filings that qualify for expedited review and also set forth deemer provisions on CMS.<sup>41</sup>

A review of the Marketing Guidelines notes that they delegate all responsibility for producer activity to the plans. State insurance regulators believe that this apparent failure in the Guidelines to reference the states’ regulatory roles in producer sales activity has resulted in some plan sponsors’ unwillingness to assist states in investigating alleged producer misconduct.

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<sup>38</sup> NAIC Model Unfair Trade Practices Act.

<sup>39</sup> Medicare Marketing Guidelines for Medicare Advantage Plans (MAs), Medicare Advantage Prescription Drug Plans (MA-PDs), Prescription Drug Plans (PDPs), and 1876 Cost Plans (published Aug. 15, 2005, updated July 25, 2006).

<sup>40</sup> Medicare Marketing Guidelines, page 1.

<sup>41</sup> Medicare Marketing Guidelines, page 1.

CMS has created certain “model documents” that plan sponsors may use and modify. The plan sponsor must certify that Medicare marketing materials use the CMS format and acceptable terminology, and must submit them to CMS. For “model” documents that the plan uses without modification, the plans must submit and certify that the marketing materials use the CMS format and acceptable terminology.

The model documents created by CMS and the use of model CMS documents modified by the plans have caused problems for consumers, particularly for dual-eligibles. Some CMS-approved materials contain incorrect descriptions and comparisons of benefits under Original Medicare and Medicaid. This has resulted in the inappropriate sale of certain products to these people. For example, marketing materials for Special Needs Plans (SNPs) may contain incorrect information about cost-sharing and other benefits available for dual-eligibles, since they are not required to include information explaining how Medicaid wraps around the SNP benefit.<sup>42</sup>

### Proposed Federal Rule

The NPRM issued by CMS on May 15, 2008, proposes a number of changes to marketing and sales requirements.<sup>43</sup> In addition, the NPRM proposes to codify a number of requirements that were previously announced by CMS but existed only in sub-regulatory guidance (i.e., in agency guidelines, memoranda, or letters).

The NPRM would codify CMS requirements regarding cold-calling, and would expand the current prohibition contained in the Medicare Marketing Guidelines on door-to-door solicitation to cover other unsolicited circumstances, such as waiting in the parking lot of senior centers and senior housing complexes to solicit enrollment as beneficiaries come and go. The NPRM would also prohibit sales activities at educational events or in areas such as waiting rooms, where patients’ primary goal is to receive health care-related services.<sup>44</sup>

The NPRM would also include new requirements on producer commissions, and would impose new limits on the value and type of promotional items plans may offer to potential enrollees. The restriction institutes a limit of a nominal amount (established by CMS in operational guidance), and prohibits plans from providing meals, regardless of value.

In addition, CMS proposes to codify a number of requirements that had previously existed in CMS guidance. The NPRM codifies requirements previously announced in its 2009 Call Letter. Appointments with beneficiaries to market Medicare plan products must be limited to the scope that the beneficiary agreed to in advance, and cross-selling of non-health care related products is prohibited. CMS proposes to codify the rule contained in the Medicare Marketing Guidelines that plan sponsors may use only state-licensed marketing representatives (producers), and

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<sup>42</sup> In one example raised by a consumer group, the Pennsylvania Department of Insurance asked a SNP to rewrite materials to incorporate accurate Medicaid cost-sharing information. While CMS provides plans with the opportunity to alter materials to reflect state-specific information, the SNP declined on the basis that the state is preempted from requiring a plan to change its marketing material.

<sup>43</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. 28556 (May 10, 2008).

<sup>44</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28582, 28595.

proposes a new requirement that plans report to states that they are using such agents in a manner consistent with state appointment laws.<sup>45</sup> The NPRM would codify previously announced requirements for producer training.

The NPRM would also clarify the calculation of fines or civil monetary penalties that may be imposed by CMS, such that CMS would have greater flexibility in determining penalty amounts and would have clearer authority to levy a penalty of up to \$25,000 for each enrollee affected, or likely to be affected, by the violation. The NPRM would not address all of the concerns expressed by consumer groups and state insurance regulators, nor does it contain all of the recommendations in this paper. Additionally, because the provisions of the NPRM are subject to public comment, it is unclear whether all of the protections and clarifications described above will be adopted in the final rule.

#### Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

This new law was enacted July 15, 2008, and contains provisions to address marketing and sales of MA plans and PDPs.<sup>46</sup> Some provisions of this new law are similar to provisions included in CMS' proposed federal regulation, some provisions codify or slightly modify current CMS guidance, and some provisions are new. The law includes prohibitions on certain types of activities such as: the use of inducements for enrollment; cross-selling of non-health related products; unsolicited means of direct contact (such as door-to-door sales or outbound telemarketing without the prospective enrollee initiating contact); the provision of meals at promotional and sales activities; and sales and marketing in health care settings or educational events. The law also requires plans to include plan types in plan names, limit the scope of marketing appointments, and train and test producers. The law codifies the requirement that producers must be licensed by states, and provides for the establishment of producer compensation guidelines. The law also adds new requirements that producers must be appointed as required by state law, and that plans must comply with state requests for information about producers as part of an investigation.

#### State Regulation of Plan Marketing and Sales Practices Preempted

Although states are preempted from regulating the marketing and sales practices of MA plans and PDPs, they are not preempted from regulating the activities of producers, and they can take action against producers who violate state laws. However, states have no reliable means of identifying the producers selling for the plans, nor is there a procedure for CMS or the states to receive the names of producers associated with enrollments that resulted from marketing misconduct.

Prior to the MMA, and as is the case with other state-regulated health plans, states often turned to Unfair Trade Practices laws as sources of regulatory authority. Most states have adopted the NAIC Model Unfair Trade Practices Act, or a similar statutory framework, that defines or provides for the determination of certain practices that constitute unfair methods of competition

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<sup>45</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28582.

<sup>46</sup> These provisions are contained in Section 103 of P.L. 110-275.

or unfair or deceptive acts or practices, and prohibits these unfair or deceptive practices in the “business of insurance.”

These prohibited practices include: misrepresentations and false statements of insurance policies; false information and false advertising; false statements and entries; rebates; failure to maintain marketing and performance records; failure to maintain complaint handling procedures; misrepresentation in insurance applications for the purpose of obtaining fees or commissions; and unfair financial planning practices. Because adherence to a state’s Unfair Trade Practices Act is generally a condition of licensure, there is a question as to whether these state provisions are preempted by federal law. Violations of state unfair trade practice laws can result in monetary penalties and suspension or revocation of an insurer’s “license” if the insurer knew or reasonably should have known that the practice was in violation of the law.

## **B. Improving Marketing and Sales Oversight**

Following is a list of suggestions to improve marketing and sales oversight activity. Note that not all members of the Subgroup support each recommendation. Responses and comments to each suggestion are provided, where applicable, with attribution.

### **Regulatory Framework:**

**Federal preemption of state insurance laws on MA and Part D plans should be as it was for Medicare+Choice plans prior to the MMA. The regulatory structure for marketing and sales activities could use the Medigap model as guidance.** (*State Regulators, Consumer Groups*)

State regulators and consumer groups maintain that general marketing and sales standards should be developed and then promulgated by CMS as a federal regulation, in a manner similar to Medigap. Further, states that adopt the CMS regulation as state law can then enforce those standards against the plans. However, states that do not adopt the CMS regulation would remain preempted in regulating the plans’ marketing and sales activity. It is important to note that these general marketing and sales standards are not the same as the standards contained in the NPRM discussed earlier in this paper. These standards would be similar to those contained in the Medigap model act and regulation promulgated into federal law under OBRA 1990 et. seq., and similar to the states’ unfair trade practices laws. States would need to enact or promulgate the model in order to enforce the general standards on the plan sponsors.

State regulators and consumer groups believe that the current federal regulatory framework does not adequately protect consumers from marketing and sales abuses. The current preemption of states’ regulatory authority of Medicare private plans, with the exception of licensing and solvency, separates the regulation of producers from the regulation of plans, resulting in an inefficient and inadequate regulatory framework. State regulators feel they should be able to share regulatory authority with CMS on Medicare private plans while at the same time operating in a regulatory environment that works for both the plans and the producers who sell the plans.

States should have the authority to enforce compliance by plan sponsors of a common set of state regulations developed by the NAIC and CMS on the marketing of Medicare insurance products. Under such a proposal, the burden on plans and confusion to beneficiaries would be minimized, as states would have no role in the bulk of CMS functions, including contract negotiation, pricing, enrollment and disenrollment, and approval of marketing materials. Under this proposal, state regulators would have greater authority over enforcement of marketing and sales violations and consumer protection.

*Comment from CMS:*

MA plans and PDPs are different from Medigap, and thus should be regulated differently. Payments for MA plans and PDPs come substantially or entirely from federal funding. Carriers contract directly with CMS to provide Medicare-covered services and often additional benefits to Medicare beneficiaries. All contract requirements, including those regarding marketing and sales, are established and enforced by CMS.

Medigap is a private health care plan sponsored by private health insurance companies and paid for with private health care dollars. No federal funds are involved in Medigap insurance. Therefore, unlike the case with MA and Medicare Part D, it is appropriate for Medigap insurers to be subject to state regulation, with limited direct federal oversight.

*Comment from Industry:*

Industry agrees with CMS' position on this recommendation. Since MA and Part D plans are not necessarily organized as a single-state product but rather on a regional or multi-state basis, dual federal-state regulation would create complex regulatory issues.<sup>47</sup> State regulation of MA, other than solvency and licensing, would result in conflicting and varied regulation of MA plans, which would be both costly and inefficient.

**Increase collaboration and information-sharing between CMS and state regulators, but do not change the fundamental federal oversight of Medicare private plans. (CMS)**

The increased collaboration, communication and information-sharing between states and federal regulators will help to address some problems in the marketplace. CMS suggests that the Memorandum of Understanding between states and CMS be used as the vehicle. If both states and CMS use these agreements fully as intended, states will be in a better position to exercise their authority over producers, and CMS will maintain federal oversight of this program.

*Comment from Industry:*

Industry agrees with and supports this recommendation.

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<sup>47</sup> For a discussion of regional and multi-state issues, see Testimony of Lois Wattman, BlueCross BlueShield of Minnesota: Public Hearing of the NAIC Medicare Private Plans Subgroup (September 11, 2007).

*Comment from State Regulators and Consumer Groups:*

State regulators and consumer groups note that all Subgroup members support the increased collaboration, coordination and information-sharing between CMS and state regulators. However, state regulators and consumer groups would not support this as the sole solution to the problems in the marketplace. This would be an endorsement of the status quo and the current bifurcated regulatory system, which does not allow states to adequately protect their citizens. Despite CMS' and states' best efforts, this approach of increasing collaboration and information-sharing has not worked up to this point to significantly alleviate fraud and abuse in the market.

**Require MA and Part D plans to comply with state requests for information about producers, as well as comply with state requests for information about the performance of a licensed producer as part of a state investigation into the individual's conduct. (Industry)**

Industry believes that this suggestion would allow state insurance regulators who are investigating the conduct of a producer marketing MA and Part D products to gain relevant information from the MA and Part D plan sponsor about the performance of the producer. State insurance regulators have indicated that investigation of the conduct of an insurance producer is sometimes difficult because of the lack of regulatory authority over MA and Part D plan sponsors; this suggestion would help provide states with additional tools to monitor sales activities and address market conduct issues within their borders. However, industry disagrees with suggestions that state regulators should be granted authority to require information directly from plans, and instead believes that the current federal oversight should be retained.

*Note:*

The recently enacted MIPPA requires MA and PDP sponsors to comply with state requests for information regarding the performance of a licensed agent, broker or other third party representing the plan sponsor as part of an investigation by the state into the conduct of the agent, broker or other third party.<sup>48</sup>

*Comment from CMS:*

The NPRM specifies that plans must comply with state requests for information about the performance of a licensed agent or broker (producer) as part of a state's investigation into the individual's conduct. In addition, CMS will establish and maintain an MOU to share compliance and oversight information with states that agree to the MOU.<sup>49</sup> The proposed NPRM provisions help account for general compliance issues, since the MOUs with the states allow CMS to share compliance and oversight information.

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<sup>48</sup> Section 103(d)(1)-(2) of P.L. 110-275.

<sup>49</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28582, 28596.

*Comment from State Regulators and Consumer Groups:*

State regulators and consumer groups believe that it would be more effective to grant state regulators the authority to require this information from plans, rather than make this a federal requirement. Regardless of whether such authority is granted directly to states, this requirement should not be limited just to state requests for information about producers, but rather also include broader information requests to assist state regulators in their oversight responsibilities, including the ability to conduct market conduct reviews.

**Provide a process for a state to report information to CMS that could trigger a targeted audit by CMS. (Industry)**

Information reported by the states to CMS would be related to marketing violations by producers that the states find reflect systemic problems. CMS would be required to investigate to determine whether, and to what extent, the plan sponsor has already taken action to address the alleged misconduct and whether a focused CMS audit should be conducted or other action taken. CMS would also be required to provide an opportunity for the state insurance regulator to recommend specific issues that should be covered in the audit. CMS also would be required to acknowledge receipt of the state's information within two business days, provide weekly updates to the state about the progress of the inquiry, and provide the state a detailed report of its findings. Following a site visit, CMS would be required to provide the state with a preliminary report of the audit findings, including the plan's initial comments on the findings.

Industry believes that this would provide a process through which states could work in partnership with CMS to identify systemic marketplace abuses and address them through appropriate CMS regulatory action. This process, industry believes, provides state insurance regulators with an additional mechanism to address market conduct issues in their states.

The NPRM specifies that plans must comply with state requests for information about the performance of a licensed producer as part of a state's investigation into the individual's conduct.<sup>50</sup> In addition, CMS would share compliance and oversight information with states that sign an MOU.

*Comment from State Regulators and Consumer Groups:*

State regulators and consumer groups believe that this suggestion essentially leaves the status quo with respect to the fundamental issue of regulatory authority. Many of the actions states take on abusive sales and marketing practices are time-sensitive. This recommendation would simply establish another indirect and inefficient process that is unlikely to enable states to be responsive to time-sensitive issues they uncover.

**Clearer Names of Plans:**

**Discourage the use of product names such as “value,” “reward,” “gold,” “silver,” etc.**  
(State Regulators, Consumer Groups)

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<sup>50</sup> Ibid.

Some state regulators and consumer groups believe that vague plan names can be highly confusing, adding to the confusion that beneficiaries already face with this complex program. In some cases, a company may offer multiple plans of the same type, using a similar name.<sup>51</sup> In other cases, such plan names could mislead consumers as to the type of plan, or the availability of providers affiliated with a plan.<sup>52</sup>

While new requirements for plan names may be temporarily confusing for beneficiaries, the short-term risk of confusion is far outweighed by the long-term benefit of clarity to all Medicare beneficiaries subject to the marketplace of Medicare products. Many beneficiaries know only company, not plan, names. In addition, current members of MA plans must reassess their coverage each year, reducing any potential impact of a name change on existing members. After implementation of the standardized nomenclature for Medigap policies under OBRA 1990, many Medigap plan names needed to be changed. These requirements for Medigap policies have 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.

*Comment from Industry:*

While there was no direct opposition to this suggestion, it was noted that existing members of MA plans, particularly those who have been long-time members, may be confused by a requirement for plans to change names. At a minimum, there should be an exception for long-standing plan names that have been used for a long time and have therefore become well-known to beneficiaries.

**Require plans to add a parenthetical plan type designation at the end of the plan name in advertising and pre-enrollment marketing materials (e.g., ABC Plan [HMO]) unless the name already includes this information.** (*Industry, CMS, State Regulators, Consumer Groups*)<sup>53</sup>

Requiring clear descriptive terms such as “HMO” or “PDP” in parentheses may assist in minimizing beneficiary confusion associated with vague plan names.

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<sup>51</sup> Consumer groups note the following example: In West Palm Beach County, Fla., there are four different Humana “Gold” plans, including two with drug coverage and two without drug coverage, leaving many enrollees confused about which plans they are actually in. Comment Letter from California Health Advocates, Medicare Rights Center and Center for Medicare Advocacy, to NAIC Medicare Private Plans Subgroup (March 7, 2008).

<sup>52</sup> Also, PFFS plan names such as “Any, Any, Any” can be confusing and lead beneficiaries to minimize the difficulty they may have in finding providers willing to accept the plan. Comment Letter from California Health Advocates, Medicare Rights Center and Center for Medicare Advocacy, to NAIC Medicare Private Plans Subgroup (March 7, 2008).

<sup>53</sup> Comment Letter from America’s Health Insurance Plans to NAIC Medicare Private Plans Subgroup (December 21, 2007).

*Note:*

The recently enacted MIPPA requires MA organizations and PDP sponsors to ensure that the name of each plan offered by the organization or sponsor includes the plan type of the plan (using standard terminology developed by the Secretary of HHS).<sup>54</sup>

*Comment from Industry:*

Any requirement addressing the plan types should not interfere with corporate trademarks or product names in a way that could require amendment to trademarks or change in official corporate names or documents. Consideration should be given to whether other alternatives, like the Summary of Benefits or other documents, could better address the issue of clarifying types of plans without interfering with corporate issues such as trademark changes.

*Comment from Consumer Groups:*

This may be a helpful start, but it falls short of meaningfully reducing consumer confusion.

**Prohibition of Cross-selling:**

**Prohibit cross-selling of non-Medicare-related products (e.g., annuities, life insurance, limited health benefit, long-term care, dread disease) to a prospective enrollee during any Medicare private plan sales activity or presentation. (State Regulators, Consumer Groups)**

Cross-selling should be prohibited if the beneficiary did not request information about the unrelated product prior to an in-home sale. Evaluating, comparing and deciding on an individual's Medicare benefits is complicated enough, and it should not be clouded by the sale of any other products. A producer who has a pre-existing relationship with an individual client can come back later to sell other products; any hardship experienced by the producer is far outweighed by the beneficiary protection against being sold multiple, complicated and often unrelated products at one time. This would reduce the risk of beneficiaries being pressured to purchase products they did not intend to purchase and being subject to high-pressure sales tactics.

*Note:*

The recently enacted MIPPA prohibits the cross-selling of other non-health care products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to an MA plan or PDP.<sup>55</sup>

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<sup>54</sup> Section 103(c)(1)-(2) of P.L. 110-275.

<sup>55</sup> Section 103(a)(1)-(2) of P.L. 110-275.

*Comment from CMS:*

The NPRM would prohibit the marketing of non-health care related products to prospective enrollees during any MA or Part D sales activity or presentation.<sup>56</sup> In this prohibition of cross-selling, the NPRM notes that marketing of non-health care products to current plan members is subject to Health Insurance Portability and Accountability Act (HIPAA) rules.<sup>57</sup>

*Comment from Industry:*

Industry is also concerned about cross-selling of unrelated products, and believes that cross-selling should be prohibited. However, industry believes that this suggestion is too expansive, and should be limited to prohibit only the cross-selling of non-health-related products, rather than all non-Medicare-related products. A prospective enrollee should be able to receive information about other health-related products, such as a long-term care policy.

*Comment from the National Association of Health Underwriters and Industry:*

Cross-selling restrictions should include safe harbor for producers who are working with existing clients, as well as for clients who ask for specific information about other products during the course of a sales meeting.

**Up-selling:**

**Prohibit any Medicare private plan sales activity or presentation of Medicare private plans other than the one(s) for which the prospective enrollee originally agreed to consider. Any sales appointment should be limited in scope to products (e.g., MA, PDP, etc.) agreed upon in advance by the beneficiary. (State Regulators, Consumer Groups, Industry)**

*Note:*

The recently enacted MIPPA requires the Secretary to establish limitations on the scope of any marketing appointment with respect to the marketing of an MA plan or PDP to the scope agreed upon in advance with the prospective enrollee and documented by the plan sponsor. In the case where the marketing appointment is in person, such documentation shall be in writing.<sup>58</sup>

As proposed in the NPRM, CMS will require plans to abide by a new 48-hour cooling-off period.<sup>59</sup> Plan marketing representatives who meet with a beneficiary to discuss specific

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<sup>56</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28583; 28595.

<sup>57</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28583.

<sup>58</sup> Section 103(b)(1)-(2).

<sup>59</sup> CMS 2009 Call Letter, p. 86; Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28583, 28595.

lines of plan business (e.g., Medigap, MA or PDP) must inform the beneficiary of all products that will be discussed prior to an in-home appointment. Additional lines of plan business not identified prior to an in-home appointment would require a separate appointment that could not be scheduled until 48 hours after the initial appointment.

*Comment from State Regulators and Consumer Groups:*

This would reduce the risk of beneficiaries being pressured to purchase products they did not intend to purchase and being subject to high-pressure sales tactics. While in theory it would seem reasonable for beneficiaries to hear about all their Medicare-related choices during a single presentation, the reality of the current market may incentivize producers to push one product over another without regard to suitability. Therefore, limiting a presentation is desirable under the current circumstances. Beneficiaries are not limited in the information available to them, as they may make a later appointment to discuss other products. In order to learn about their range of choices, beneficiaries may seek information from SHIP counselors or other neutral parties to determine the most suitable type(s) of product before requesting sales appointments.

*Comment from Industry:*

This would allow a beneficiary to choose at the time of scheduling an appointment to receive information and compare the benefits of more than one Medicare-related product that might be appropriate for his or her health care needs while providing a consumer safeguard against high-pressure sales tactics.

*Comment from the National Association of Health Underwriters:*

Producers must be able to freely discuss with their clients all options that are included in CMS' *Medicare and You* handbook without worrying about restrictions. Producers often use this guide to review options and benefits with clients, and should be able to answer product-specific questions as they come up to best serve their individual clients. Sometimes senior clients who are unfamiliar with plan terminology request a meeting about one type of Medicare-related product when they really mean something else. By providing information about other insurance products that clients request, producers would only be providing clients with responsible service, and such actions should be allowed.

**Beneficiaries should be presented with other options to learn about their full range of Medicare-related plans, such as availability of a SHIP counselor.** (*Consumer Groups, State Regulators, Industry, CMS*)

MA and Part D sales should adhere to existing Medigap rules concerning statements about referrals to counseling assistance.<sup>60</sup> For example, all plan application forms should include the following language, as modified for MA plans and PDPs:

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<sup>60</sup> NAIC Model to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, Section 18A.

Counseling services may be available in your state to provide advice concerning your [enrollment in a Medicare Advantage plan or in a Medicare prescription drug plan] and concerning eligibility for the Medicare Low Income Subsidy (LIS) or medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

This would ensure that beneficiaries learned their full range of choices from a neutral and trained source. Information about SHIPs or other counseling options can be included in both CMS and plan sponsor information materials for beneficiaries. For example, the above sentence could be added to all plan application forms.

### **Other Unsolicited Contacts:**

*Note:* Current marketing guidelines permit plans to conduct outbound telemarketing with certain restrictions, including the use of CMS-reviewed and approved telemarketing scripts. Enrollment by outbound telemarketers is not permitted, but rather such calls are permitted solely to solicit requests for pre-enrollment information, describe benefits, and to alert existing beneficiaries to new benefits or health-related offers.

However, the recently enacted MIPPA prohibits “unsolicited means of direct contact” of prospective enrollees by MA plan and PDP sponsors, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating contact.<sup>61</sup>

**Implement a complete restriction on cold calls in the marketing of Medicare private plans. Current CMS definitions of prohibited calls should be expanded to cover other forms of unsolicited direct contacts with the potential enrollee by a plan.** *(State Regulators, Consumer Groups, CMS)*

Consumer groups and state regulators believe that this would protect Medicare beneficiaries from confusing and high-pressure sales tactics, and prevent beneficiaries from mistakenly enrolling in plans in which they did not intend to enroll.

The NPRM includes such prohibitions, and would expand the current prohibition on cold calls to also prohibit other unsolicited direct contacts of the potential enrollee by a plan, such as approaching potential enrollees in a parking lot, or selling a plan’s product door-to-door.<sup>62</sup>

### *Comment from Industry:*

Calls to existing customers should be exempt from the cold-calling restrictions. Plans should, for example, have the ability to initiate contact with current members that are under 65 in order to discuss their health care options upon becoming Medicare-eligible.

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<sup>61</sup> Section 103(a)(1)-(2) of P.L. 110-275.

<sup>62</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28582, 28595.

*Comment from the National Association of Health Underwriters:*

A broad brush approach would not be in the best interest of consumers. Producers should continue to be allowed to make cold calls, send information about plan benefits and enrollment forms, schedule appointments and alert existing beneficiaries about health-related offers. In addition, if changes are made to cold-calling requirements, calls to existing clients of a producer should be exempt from restrictions.

**Permit outbound calls when the call is made by plan employees or by a call center under contract to the plan to follow up on a plan mailing. The content of such calls should be limited to confirming receipt of the plan mailing, offering to mail additional information, or providing a telephone number for the beneficiary to call a plan marketing representative for additional information or request an appointment. Plans and their callers should be required to use CMS-approved scripts, record calls and abide by do-not-call requests. (Industry<sup>63</sup>)**

Industry believes that this would provide necessary safeguards against the specific problems that have been cited in the marketplace, while still leaving the beneficiary with an option to obtain information in a time, place and manner convenient to the individual.

*Comment from Consumer Groups:*

This proposal would not do much to limit cold calls, and a wide array of solicitations would still be permitted. For example, if a plan sends a mailing to prospective enrollees, the plan (or a call center under contract to the plan) would still be able to call a recipient of such a mailing and provide a phone number for a plan marketing representative for additional information or to request an appointment with a producer. Such calls would not be considered "cold calls," even though an individual did not request anything from the plan or might not have even read the plan's mailing.

**Plans should be responsible for screening the "Do Not Call" registry before providing leads to brokers. (Consumer Groups)**

*Comment from Industry:*

Industry believes that this recommendation would not provide additional protection for beneficiaries, since plans currently are required to abide by the Do Not Call registry and to honor "do not call again" requests.<sup>64</sup>

**Inducements to Enroll:**

**Prohibit the use of free gifts, prizes, cash or rebates as an inducement for enrollment. (State Regulators, Consumer Groups, Industry)**

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<sup>63</sup> America's Health Insurance Plans Board Statement (March 3, 2008).

<sup>64</sup> CMS Marketing Guidelines, p. 133.

*Note:*

Current law prohibits MA plan sponsors from providing “cash or other monetary rebates” as an inducement for enrollment.<sup>65</sup> The recently enacted MIPPA expands this prohibition to include gifts and prizes.<sup>66</sup>

*Comment from Industry:*

The use of inducements should be in accordance with CMS guidelines.

**In-Home Sales:**

**Sales of Medicare private plans in any kind of congregate living arrangement should be banned unless the individual resident requests an individual sales visit. (*Consumer Groups*)**

An invitation to a producer by one resident is not an invitation by other residents. When a producer engages in a sales or marketing presentation at such a living arrangement, the producer must arrange for a separate and independent visit, on a different day, with any other resident who requests a visit. A congregate living arrangement would include apartment and other housing complexes, whether or not they are designated as senior or disabled housing; assisted-living facilities; residential group homes; nursing homes; and other similar living arrangements. This prohibition would apply only to sales, not to marketing. Therefore this would not preclude group educational presentations.

*Comment from Industry:*

Industry recommends that sales activities in congregate living arrangements be limited consistent with existing CMS rules that permit such activities only in common areas of health care settings and prohibit sales activities at educational events such as health information fairs. When making appointments, industry supports requiring the marketing representative to provide the beneficiary with an opportunity to agree to the range of choices that would be discussed and document the agreement (for face-to-face appointments, documents should be in writing).

*Note from CMS:*

Educational events may be sponsored by plans or outside entities, and are events that are promoted to be educational in nature and have multiple vendors, such as health information fairs, conference expositions, or state- or community-sponsored events. Sales activities include the distribution or collection of plan applications.<sup>67</sup>

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<sup>65</sup> 42 U.S.C. 1395w-21(h)(4)(A).

<sup>66</sup> Section 103(a)(1)(A)(i) of P.L. 110-275.

<sup>67</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28583.

*Comment from the National Association of Health Underwriters:*

NAHU opposes any action to prohibit agents from selling products to seniors who live in senior citizen housing. While there is an understandable need to protect the minority of seniors who are not lucid or capable of making competent purchasing decisions, that description does not apply to the vast majority of seniors living in “senior housing,” which could be interpreted to mean older adult communities or assisted-living centers. Seniors living in these housing arrangements should not be restricted in their access to private insurance products and the services of licensed and trained health insurance producers. Even patients in nursing homes need access to affordable private insurance options, and many are capable of making such purchasing decisions and wish to use a licensed producer to do so.

**Implement reporting requirements that enable plans and CMS to identify and prevent unsolicited door-to-door sales. (Consumer Groups)**

Consumer groups believe that all in-home enrollments should be flagged, and producers should be required to document how an invitation for an in-home presentation was secured. Although CMS prohibits unsolicited door-to-door sales and industry has called for a ban on such sales, this practice is still occurring with little visible consequence to producers or plan sponsors, in part because it is difficult to track and is under-reported by victims. Since in-home sales are more prone to abusive sales practices, plans must be required to document how producers arrange for each in-home sale, and that information should be audited by CMS and, if appropriate, state regulators. Further, it is the understanding of consumer groups that some methods used to monitor producer behavior are employed by certain companies with regard to the sale of Medigap policies—these same measurements should also be employed with respect to MA plan sales.

*Comment from CMS:*

CMS Marketing Guidelines already prohibit door-to-door sales. Implementation of this recommendation would be so burdensome as to be impractical and thus ineffective.

*Comment from the National Association of Health Underwriters:*

NAHU supports door-to-door sales restrictions currently in place under federal guidelines. It is also important to note that many seniors prefer and request to meet with their health insurance producers in their home. Health reasons may limit their ability to drive or travel to a producer’s office, and many seniors also feel more comfortable in their home environment. Although unsolicited home meetings should not be condoned, it is a senior’s right to request a home meeting with their agent, and a producer’s ability to accommodate such requests should certainly be preserved.

**Implement reporting requirements that enable plans and CMS to identify and prevent mass enrollments (i.e., multiple enrollments at one location in a short period of time, such as after a sales presentation). (Consumer Groups)**

Mass enrollments at sales presentations should trigger increased plan efforts to verify suitability of the product for the new enrollee and should be discouraged or barred in the commission structure for producers. When multiple enrollments are made at one event over a short period of time, there is often insufficient time for producers to explain products to and answer questions from individual enrollees.

*Comment from Industry:*

Mass enrollments are sometimes appropriate, such as when an employer is dropping coverage and many retirees need to review and select a new option, so this should not be used as sole criteria to bar commissions. However, we support use of outbound information and verification calls to ensure that beneficiaries understand plan benefits and payment structures and to confirm their intent to enroll in the specific plan. In addition, plans are required to set commission structures to discourage inappropriate enrollments, for example, withdrawing or withholding commissions for rapid disenrollments.

*Comment from the National Association of Health Underwriters:*

Any additional regulations in the area of mass enrollments should allow attendees the option to request a personal interview, either at the end of the seminar or at a later date, for enrollment purposes, so the enrollee can obtain the complete guidance necessary to make an informed decision.

**Plans should monitor monthly enrollment figures for individual producers in order to ensure that high production does not indicate a failure to adequately explain suitable coverage options to consumers. (Consumer Groups)**

Because of the financial incentives, high monthly enrollment figures may signal unsuitable sales. Plan sponsors need to monitor high-volume producers and agencies to ensure that they are following the plan sponsor's suitability guidelines and the Medicare Marketing Guidelines.

*Comment from Industry:*

High production in itself is not necessarily an indicator of marketing abuse. Plans engage in systemic monitoring of a variety of factors, including beneficiary satisfaction, rapid disenrollment, and complaints. Also, plans should engage in verification calls to ensure that a beneficiary intended to enroll in the specific plan. Monitoring these factors and verifying intent to enroll provide more effective indicators of inappropriate marketing activities. In addition, the proposed requirements are not necessarily suitable to the MA or Part D market due to the limited annual enrollment period for MA and Part D, which may necessitate a high volume of enrollment for a particular producer during the permitted enrollment timeframe.

These requirements may result in overregulation of phone calls and visits by plan producers, as CMS would be required to hold plans accountable for this information.

*Comment from the National Association of Health Underwriters:*

If a producer is writing a high volume of business but no complaints are being generated and the producer is otherwise compliant, there is no reason for restrictions.

### **Suitability Standards**

**Develop suitability standards for the sale of all Medicare private plans.** (*State Regulators, Consumer Groups*)

Standards should be developed to ensure that beneficiaries are not placed into unsuitable plans. Standards may be in the form of guidelines of types of beneficiaries who are likely to be unsuitable for enrollment in certain types of plans, a checklist of questions that producers may ask prospective enrollees, or a list of information that producers should verify with prospective enrollees. These guidelines, checklists and lists should be designed to assist producers in enrolling beneficiaries into plans that best meet their needs, and to discourage unsuitable sales.

*Comment from CMS:*

This recommendation erroneously suggests that beneficiaries are placed in Medicare Advantage plans. The MA Program is a beneficiary *choice* program. In the same manner that beneficiaries were able to select their Medigap plans, beneficiaries are able to choose the MA plan that best meets their health needs. To ensure this, CMS provides information on the plans and their benefits through 1-800-MEDICARE, the Medicare & You Handbook and on the Medicare Options Compare Web tools. In addition, State Health Insurance and Assistance Programs (SHIP) and other community resources are available to beneficiaries to help them make informed choices. Furthermore, MA Organizations are required to educate beneficiaries about the benefits through mailings and customer service lines.

*Comment from Industry:*

Industry cautions that these standards/checklists may run afoul of the federal rules prohibiting discriminatory practices. MA plan sponsors are not able to deny Medicare beneficiaries access to plans, and plan sponsors must comply with the anti-discrimination laws that apply to these products. Creating a checklist of the “types of beneficiaries” who are likely to be unsuitable for enrollment in “certain types of plans” has the potential to result in complaints of discrimination and/or steering.

**Special consideration should be given to the marketing of PFFS plans, SNPs and other MA plans to dual-eligibles.** (*State Regulators, Consumer Groups*)

Plans should develop and enforce suitability standards and producer supervision on their producers who sell MA plans to dual-eligibles. In addition, any MA plan sold to a dual-eligible should be independently reviewed by the plan for suitability before the applicant is enrolled in the plan. Plans should be required to maintain auditable records on MA sales to dual-eligibles and should be required to periodically certify to CMS that they are in compliance with the above process.

*Comment from Consumer Groups:*

MA Private Fee-for-Service (PFFS) plans, in general, are ill-suited for individuals dually eligible for Medicare and Medicaid. Absent an outright ban on the sale of PFFS plans to dual-eligibles, all MA plan sponsors should be able to demonstrate the following before selling their plans to dual-eligibles: 1) prove they offer meaningfully better and more comprehensive benefits than those available through state Medicaid programs; 2) enrollees will not face diminished access to providers; 3) ensure that dual-eligibles have access to providers that accept both Medicare and Medicaid; and 4) protect dual-eligibles against balance billing or any other new out-of-pocket expenses (that they would not be responsible for if they remained in Original Medicare). Plans already are able to identify dual-eligible individuals who are eligible to enroll in an MA plan, so therefore are likely to be already reviewing income and asset information and/or Medicaid eligibility.

*Comment from CMS:*

CMS has proposed several requirements for Special Needs Plans (SNPs) in general and for Dual Eligible Special Needs Plans in particular.<sup>68</sup> CMS prohibits targeted marketing to dual-eligibles by PFFS plans, but by statute all MA products except SNPs are open to all eligible beneficiaries who live in the plan's service area.

*Comment from Industry:*

This suggestion lacks a clear definition of "suitability." If this recommendation is retained, suitability standards should 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.

While it is important to protect all beneficiaries, especially those who are most vulnerable (such as dual-eligibles), we would be concerned with a proposal that singles out and differentially treats dual-eligible beneficiaries. Any such proposal must ensure that it does not have unintended detrimental consequences to dual-eligible beneficiaries that could impose barriers in access to potentially valuable MA plan options for them. Moreover, we disagree with the statement that PFFS plans are generally ill-suited for dual-eligible beneficiaries. The significant cost savings and extra benefits offered by many PFFS plans could reduce the burden for many Medicare beneficiaries, including dual-eligible ones.

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<sup>68</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. 28559, 28560.

In addition, plans should not be responsible for making income and asset determinations prior to engaging a beneficiary. This would be resource-intensive for the plan and potentially intrusive to the beneficiary. Beneficiaries should also not have to divulge their income and asset levels prior to discussing their coverage options with plans, agents or brokers.

**Change enrollment applications to include provider acceptance and prescription drug coverage information.** (*National Association of Health Underwriters*)

This change in the application would assist in preventing unsuitable enrollments. On each enrollment form, ask whether the beneficiary had been able to determine if each of their key providers and/or prescriptions were covered by the plan of their choice. If this question was answered “no,” the carrier could then follow up with the enrollee prior to placing the plan into effect to verify the beneficiary’s comprehension of the plan’s restrictions.

*Comment from CMS:*

Changing the enrollment form as suggested above would require the establishment of some type of pre-enrollment verification process for all MA plans, similar to what is currently required prior to enrolling in PFFS plans, and could result in delays of valid, voluntary enrollments. In addition, beneficiaries who answer “no” to any of the numerous questions suggested could not be certain as to when or even if their enrollment was effective. Finally, many enrollments are completed online, with 1-800-Medicare, or through SHIPs, in the absence of any one-on-one producer contact.

In light of these concerns, CMS recommends a checklist with questions similar to those described above be provided as part of the plan’s marketing materials so that beneficiaries (along with their caregivers or counselors, if appropriate) can compare and evaluate their options before completing the enrollment form. Providing this checklist separate and apart from the enrollment form will encourage beneficiaries to consider their options more carefully in advance, rather than at the time they intend to enroll, which may or may not be close to the end of the particular enrollment period.

In addition, CMS is revising its model enrollment form for PFFS plans to include the statement: “Before seeing a provider, I should verify that the provider will accept <plans>.” CMS already requires that language be included on enrollment forms for group enrollments that advises beneficiaries to contact their employer or union to see how enrollment in the plan will affect their employer/union coverage.

*Comment from Consumer Groups:*

Beneficiaries need to be able to determine whether their providers participate in a plan and whether their prescriptions are covered in a plan before, not after, enrollment. Also, the questions of whether key providers and/or prescriptions are covered by the plan are not the only reasons that plans are unsuitable for dual-eligible beneficiaries. There are

also critical issues, such as the lack of coordination with Medicaid, the increase in cost-sharing to the beneficiary, and the fact that these plans sometimes charge premiums that Medicaid won't pay. In addition, many of the extra benefits MA plans offer (such as dental care) may already be available under Medicaid.

This checklist should be expanded to include the following: a question on whether key providers accept the plan; a question on whether prescription drugs are covered under the plan; a comparison of the premium between the old and new coverage; a comparison of out-of-pocket liability (limit, if any) between the current and new coverage; and an acknowledgement that enrollment could end retiree coverage (if any) and render supplemental coverage ineffective.

*Comment from Industry:*

This recommendation fails to take into account the many enrollments that are Internet-based or through State Health Insurance Assistance Programs (SHIPs) without any one-on-one producer contact.

Many dual-eligible individuals may benefit from enrolling in MA plans. Most MA plans provide coordinated care with a focus on prevention, disease and chronic care management—benefits not found in Original 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 Original Medicare in addition to Medicaid coverage.

**Where appropriate, ensure that producers are aware of key state-specific programs and their interaction with Medicare private plans, including state Medicaid programs (for dual-eligibles), state pharmacy assistance programs and state Medicare savings programs.**

*(State Regulators, Consumer Groups)*

*Comment from CMS:*

CMS believes that states have the authority to require this recommendation, and CMS would applaud state enforcement of this type of provision. Anyone selling a plan's products must be trained on all relevant Medicare provisions as well as the provisions of the specific products they are selling. CMS requests that all agents must be trained and tested and that the test results must be documented.<sup>69</sup>

*Comment from Industry:*

It is neither CMS' nor the plan's responsibility to ensure that producers are trained on all state-specific programs. This authority regarding producer continuing education requirements currently resides in state insurance departments, and no new authority is needed. Also, in some states, producers are not used in marketing to dual-eligibles, so the

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<sup>69</sup> This requirement has been proposed to be codified into federal regulation, 73. Fed. Reg. 28583 (to be codified at 42. C.F.R. 422.2274(b)-(c)).

recommendation to require awareness of state Medicaid programs should be applied only as appropriate.

**Change enrollment applications to include verification of consumers' income and Medicare and Medicaid eligibility.** *(State Regulators)*

Requiring enrollment applications to include this type of information for prospective enrollees to complete will assist in preventing unsuitable enrollments. In including income information, the enrollment application should be limited to asking about ranges of income, rather than asking for specific amounts.

*Comment from CMS:*

CMS disagrees with this recommendation for a number of reasons. First, CMS' current model enrollment forms already request information from the applicant (e.g., name, date of birth, address, Medicare claim number) needed to confirm the individual's eligibility to enroll in an MA plan or stand-alone PDPs. MA organizations and PDP sponsors use this information to query CMS' systems and verify the individual's eligibility prior to submitting an enrollment to CMS. CMS established this query, in part, to help reduce the number of rejected enrollment submissions by plans.

Second, CMS' model enrollment forms are generally designed to capture the information needed to process the enrollment. Since an individual's income is not a factor in his/her eligibility to enroll in an MA plan or PDP, and asking for such information may appear unduly burdensome and as an unnecessary invasion of privacy, soliciting such information may, in fact, discourage the individual from enrolling in a plan, and may appear to be discriminatory. Furthermore, collecting income data could expose an opportunity for plans to "screen" applicants based on that information.

Thus far, CMS has refrained from sharing actual income data with plans prior to the beneficiary's enrollment, and CMS only recently modified systems to provide information to plans about individual eligibility for the low-income subsidy (LIS) when they query our system to confirm eligibility. CMS made this change because of the belief that the benefits of ensuring that the individual pays the correct premium and cost-sharing amounts outweighed any privacy concerns associated with sharing information about LIS status, which is merely derived from one's income and resources.

*Comment from Industry:*

This would put MA plans in the position of making income determinations. Health plans should not be making such determinations, but should be able to assist members and potential members with applying for special assistance from CMS, should the member request help in doing so.

**MA enrollment applications should incorporate Section 21A and Section 20A(3) of the Medigap Model Rules.** *(Consumer Groups)*

Section 21A requires that “in recommending the purchase or replacement of any Medicare supplement policy or certificate a [producer] shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.”

Section 20A(3) requires that “an issuer, directly or through its producers, shall ... [d]isplay prominently by type, stamp or other appropriate means, on the first page of the policy the following: [in bold] “Notice to buyer: This policy may not cover all of your medical expenses.”

*Comment from CMS:*

Under the NPRM, enrollees who are passively enrolled in a plan would be notified by the plan of their right to choose another plan. In addition, enrollees would receive a description of the costs and benefits of the new plan, how to access care, and any other conditions of enrollment established by CMS.<sup>70</sup> In addition, the provisions requiring (1) model of care, (2) arrangements with states, and (3) hold-harmless provisions all help ensure that a plan is suitable for dual-eligibles and other beneficiaries.

**Marketing Materials:**

**Limit advertisements from each plan sponsor to one particular product, e.g., their HMOs, PPOs, or PFFS plans. Prohibit generalized statements in advertisements that treat all products from the same sponsor as one product. Plan sponsors must make a distinction among the types of plans they are offering. For example, if a plan sponsor is advertising a PFFS and an HMO, the benefits for each must be listed separately. (Consumer Groups, State Regulators, Industry)**

If advertising benefits for more than one type of plan (for example, a PFFS and an HMO), the advertisement should clearly and separately list the benefits for each plan, rather than making generalized statements that may be misleading.

**Prohibit plan sponsors from using enrollee information to cold call and market other products. (Consumer Groups)**

Enrollment into one product offered by a plan sponsor is not an open invitation to be targeted for marketing of other products sold by the same plan sponsor. Plan enrollees should not be subject to industry efforts to maximize business lines that provide unsuitable coverage for their enrollees. Existing business relationships with PDP or Medigap enrollees do not provide plans with carte blanche to engage in aggressive marketing or intrusive and unsolicited marketing contacts. Enrollees in companies’ other lines of business, including PDP and Medigap supplements, should be protected under a comprehensive ban on cold calling.

*Comment from Industry:*

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<sup>70</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28577, 28592.

This suggestion severely interferes with the relationship that a plan sponsor has with its enrollee. A beneficiary voluntarily enters into a business relationship with his/her plan sponsor that generally includes the provision of information about relevant health care products. The suggested prohibition would arbitrarily label these communications as cold calls. There are instances where another product may be suitable for a beneficiary, and plan sponsors make beneficiaries aware of this. Additionally, use of enrollee information is subject to HIPAA protections. It is critical that plans be allowed to continue to be a trusted source of information to these members on the health care options available to them. It would be unfair to disadvantage beneficiaries by withholding information on other products that may be beneficial to them. For example, a company may have important information on new products that may meet beneficiaries' changing health care needs.

**Apply all relevant CMS marketing and sales guidelines on PFFS to all Medicare private plans (such as agent appointment rules, producer training requirements, and verification calls).** *(State Regulators, Consumer Groups, Industry)*

*Comment from Industry:*

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 were not an issue with HMO and PPO plan options.

Implementing this new requirement program-wide would be costly, both from 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 that need to be addressed. 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.

*Comment from CMS:*

Under the proposed rule, anyone selling a plan's Medicare products must be trained on the Medicare rules and regulations specific to the plan products they intend to sell, including passing a written test, and agent appointment rules apply as well.<sup>71</sup>

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<sup>71</sup>Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28584, 28596.

## **SECTION 4. PRODUCER OVERSIGHT**

### **A. Producer Training**

#### State Systems

Many states require pre-licensing education for producers. Almost all states require that producers receive ongoing continuing education training. In addition, some states also require ethics training.

#### CMS Requirements

As a result of the problems in the Medicare Advantage Private Fee-for-Service (MA-PFFS) market, CMS has implemented additional producer training requirements for all Medicare private plans. Companies are now responsible for ensuring that producers selling Medicare Advantage (MA) products have adequate training.

The content of the training program must cover the Medicare Marketing Guidelines, compliance requirements, federal and state regulations, and product-specific training. Further, CMS requires producers selling PFFS products to be trained and tested on the subject matter and to attain a minimum test score of 80 percent.<sup>72</sup>

The training platform being used was jointly offered by AHIP and NAHU, was reviewed by CMS, and is titled “Marketing Medicare Advantage and Part D Prescription Drug Plans: Understanding Medicare Basics, Plan Options, and Marketing and Enrollment Requirements.”<sup>73</sup> CMS requires MA plans and Medicare Prescription Drug Plans (PDPs) to document training, and to have internal monitoring and auditing procedures in place. CMS also requires plans to designate a compliance officer to ensure effective training upon hire of all personnel, including contractors and agents.

While some of these requirements were previously contained in sub-regulatory guidance, without the same legal effect as federal regulations (or the Medicare statute), CMS’ NPRM proposes to codify these training requirement.

#### Medicare Improvements for Patients and Providers Act of 2008:

This recently enacted law requires the Secretary of Health and Human Services to establish limitations with respect to required training, annual retraining and testing of producers.<sup>74</sup>

#### Industry Efforts

Companies have also elected to adopt voluntary requirements regarding producer training.

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<sup>72</sup> Memorandum from David A. Lewis (CMS) to All Medicare Advantage Organizations offering Private Fee for Service Plans, “Information on PFFS marketing oversight,” (November 28, 2007).

<sup>73</sup> This training program can be accessed at [www.MedicareOnlineTraining.com](http://www.MedicareOnlineTraining.com).

<sup>74</sup> Section 103(b)(1)-(2) of P.L. 110-275.

## **B. Producer Tracking and Oversight**

### State Systems

States have authority over producer behavior. Many states have similar procedures for acting on consumer complaints against producers and for pursuing necessary enforcement actions, including orders limiting producer activity, suspension or revocation of licenses, and monetary fines. As noted earlier, however, state unfair trade practices acts and other state laws have been interpreted by CMS as unenforceable against plan sponsors.<sup>75</sup>

States currently have regulatory systems in place to track producers and producer activity, including the National Insurance Producer Registry (NIPR) Producer Database (PDB). NIPR developed and implemented the PDB, which is a central repository of producer licensing information. It is updated on a regular and timely basis by participating state insurance departments.

The PDB contains producer information, including demographics such as name and address, license information (for example, states in which the producer is licensed, license numbers, authorized lines of business, and license status), appointments (including terminations), and regulatory actions. It permits users to create and download the information in a single report for all 50 states, the District of Columbia and Puerto Rico. The PDB also includes producer information from other enforcement-type data bases maintained by the NAIC.

In order to better track the producer who sells for the plan sponsors and clearly make plan sponsors responsible for the acts of their producers, many states require plans to appoint producers. State producer appointment laws are intended to tie producer activity to plans.

States also receive and act upon consumer complaints about producers.

### State Preemption and CMS Systems

CMS does not require nor facilitate the use of monitoring and reporting systems already in place at the state insurance regulatory level. For example, CMS does not require that Medicare private plans utilize National Insurance Producer Registry (NIPR) numbers. CMS has also interpreted state agent appointment laws as preempted, as part of the preemption provisions in the MMA restricting states from regulating the marketing of MA plans and PDPs, and therefore unenforceable by the states as they pertain to Medicare private plans. As such, MA plans and PDPs are not subject to the same state requirements as other private insurance companies in the market.

Current CMS Medicare marketing requirements make plan sponsors responsible for monitoring and acting on producer activity. CMS requires that plans verify state licensure of producers as required by state law, and that plans have a process in place to address producer problems. MA

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<sup>75</sup> See discussion of Unfair Trade Practices Act in Section 3A.

plan sponsors may report producer complaints to CMS, and in turn CMS communicates with states about producer complaints. The requirements do not require plan sponsors to collect nor report improper producer activity directly to state insurance regulators. CMS also requires that plans monitor their producers for marketing violations and signs that may indicate problems (such as rapid disenrollment, complaints, etc.) and requires plans to withhold or withdraw producer remuneration for rapid disenrollments.

CMS Medicare Marketing Guidelines require that plans use state-licensed producers. The NPRM proposes to codify that requirement. The NPRM also requires that MA plan sponsors report to states that they are using those agents in a manner consistent with state agent appointment laws. MA plan sponsors are supportive of this requirement, and some MA plan sponsors currently voluntarily appoint producers in states that have such requirements.<sup>76</sup> However, it should be noted that the NPRM states specifically that such laws are preempted. Since states are preempted from requiring plan sponsors to list/appoint their producers, this brings into question the states' authority to enforce such requirements, although there is no question that it will be fully enforceable by CMS.

CMS now requires that MA-PFFS plans track and report to CMS complaints concerning inappropriate producer marketing activity.<sup>77</sup> Further, pursuant to the terms of the MOU between state departments of insurance and CMS, CMS may then relay that information to state departments of insurance. Through the information-sharing MOU, CMS and states are able to share some information, at the discretion of each party. When CMS receives a consumer complaint about a producer in a state, CMS relays that information to the relevant state for action. State regulators now have access to CMS' Health Plan Management System (HPMS), where they can view specific complaints and generate reports for complaints nationwide. The NPRM would require that plans must comply with state requests for information about the performance of a licensed producer as part of a state's investigation into the individual's conduct.<sup>78</sup>

State regulators would prefer that plans be required to report inappropriate producer marketing activity directly to the appropriate state insurance departments. Some plans report that they have voluntarily decided to report producer complaints directly to states.

Additionally, with producer identification, tracking and regulatory systems already in place, state insurance regulators believe that they should be utilized in a manner that allows states to carry out their regulatory duties concerning MA and PDP producers. Further, NIPR producer identification numbers should be captured by Medicare private plans as they contract with agents in those states where appointments are required, plans should appoint the producers with whom they contract to sell their coverage, and the databases should be populated for Medicare private plan producer activity as they are for commercial insurance business.

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<sup>76</sup> America's Health Insurance Plans Board Statement (March 3, 2008).

<sup>77</sup> Memorandum from David A. Lewis (CMS).

<sup>78</sup> Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, Proposed Rule, 73 Fed. Reg. at 28584, 28596.

## Medicare Improvements for Patients and Providers Act of 2008

This recently enacted law codifies the existing requirement that plan sponsors use only producers who have been licensed under state law to sell MA plans and PDPs. In addition, the new law requires plan sponsors to abide by state appointment laws, where a state has such a law, and also report to the applicable state the termination of any such producer, including the reasons for such termination (as required under applicable state law). Also, this law requires plan sponsors to comply in a timely manner with any request for information regarding the performance of a licensed producer representing the sponsor as part of an investigation by the state into the conduct of the producer.<sup>79</sup>

### **C. Suggestions for Improving Producer Training and Producer Tracking and Oversight**

The following recommendations have been made to improve producer training and producer tracking and oversight.

**Require producers who sell Medicare-related products to meet state continuing education requirements specifically applicable to Medicare products and marketing and sales requirements. This continuing education should be consistent with CMS requirements.**

*(State regulators, CMS)*

States are responsible for establishing continuing education requirements for producers. Thus, this recommendation would not require federal action.

#### *Comment from CMS:*

CMS believes that states have the authority to require this recommendation, and CMS would applaud state enforcement of this type of provision. A state, under its authority, may include continuing education in its licensure requirements for agents. For example, an agent who sells a certain product could be required to have a certain number of hours of training.

#### *Comment from Industry:*

CMS already can require plans to ensure that producers meet certain criteria, and state regulators can also require their own continuing education requirements.

**Allow states to enforce agent appointment laws.** *(State Regulators, Industry, NAHU, Consumer Groups)*

Permitting enforcement of these state laws would provide state departments of insurance with more information to effectively address consumer complaints, as well as provide additional verification of the validity of Medicare producer licenses.

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<sup>79</sup> Section 103(d) of P.L. 110-275.

*Comment from CMS:*

CMS' recent proposed rule would require that MA organizations comply with the reporting requirements of state appointment laws.

*Comment from the National Association of Health Underwriters:*

Although many have urged CMS and states to create a national database to provide and share information about producers who have been sanctioned or terminated by plans, this database already exists (PDB, RIRS, SAD), and this idea could easily be implemented if appointments were required of producers selling Medicare private plans.

In the few states where formal appointments of producers are not required, participating carriers could provide the state department of insurance with a list of all producers with whom the carriers contract to sell their private Medicare offerings.

**Require plans to take responsibility for the acts of their agents and take corrective measures when a producer engages in misconduct while selling a plan's product.**

*(Consumer Groups, State Regulators, CMS)*

This would include the full range of sanctions including, but not limited to, the imposition of monetary sanctions against the plan sponsors and producers, and holding harmless individuals who have been harmed.

*Comment from CMS:*

Currently, the states have authority to take actions against producers that do not comply with their licensing rules. CMS does not preempt these actions. In the NPRM, CMS proposes to strengthen its authority to punish plans that are non-compliant by clarifying the calculation of fines or civil monetary penalties.<sup>80</sup>

*Comment from Industry and the National Association of Health Underwriters:*

CMS guidance already requires plans to take responsibility for the acts of their agents and take corrective measures when the producer engages in misconduct while selling a plan's product.<sup>81</sup>

**States should establish standards for subcontracting agents (producers) or agencies, including training requirements, monitoring processes, cold lead development, and do-not-call requirements. (State Regulators, Consumer Groups)**

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<sup>80</sup> The NPRM would give CMS greater flexibility in determining penalty amounts and would have clear authority to levy a penalty of up to \$25,000 for each enrollee, or likely to be affected, by the violation.

<sup>81</sup> Under CMS Medicare Marketing Guidelines, 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." Industry asserts that CMS takes into consideration the acts of agents when conducting oversight of compliance with the Guidelines.

This would ensure that infractions would be a violation of state laws, in addition to federal requirements.

*Comment from Industry and the National Association of Health Underwriters:*

Under current CMS guidance, MA and Part D plan sponsors are required to: implement producer training programs that address specified topics, including Medicare program rules and plan-specific product information; monitor producer compliance; and abide by federal do-not-call requirements. Therefore, industry does not believe that this recommendation provides any additional consumer protection and is likely to result in duplicative and conflicting state and federal requirements.

*Comment from CMS:*

CMS believes that states have the authority to require this recommendation, and CMS would applaud state enforcement of this type of provision.

**Require plans to include a producer's National Insurance Producer Registry (NIPR) number on all Medicare private plan applications.** *(Consumer Groups, State Regulators, Industry, National Association of Health Underwriters)*

## **SECTION 5. FINANCIAL INCENTIVES**

There is a difference of opinion among Subgroup members about whether financial payments to plans and producers have a direct connection with the types of marketing problems that have been witnessed in the Medicare private plan marketplace. State regulators and consumer groups believe that there is a strong connection, while CMS and industry generally dispute this assertion.

These types of issues can be divided into two categories: plan sponsor financial incentives (payments to plans) and producer financial incentives (compensation to producers). For each issue, the various viewpoints have been summarized. A list of recommendations by state regulators and consumer groups is provided; other interest groups did not submit recommendations.

### **A. Plan Sponsor Financial Incentives**

As stated earlier, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) included a number of significant changes to the Medicare Advantage (MA) bidding and payment structure. One of the main goals of the changes to the MA program was to expand private plan options for Medicare beneficiaries, as well as to expand the availability of these plans to all areas of the country. Prior to the MMA, the availability of, and participation in, Medicare+Choice plans had been low in many areas of the country, particularly rural areas.

One significant change was an increase in payment rates to MA plans, in order to encourage more participation in the program.<sup>82</sup> In 2006, Medicare paid \$7.1 billion more to MA plans than Medicare would have spent if MA plan beneficiaries had instead received care through Original Medicare.<sup>83</sup> Studies show that MA plans now receive payments that are on average 113% of the cost of Original Medicare.<sup>84</sup> The payment is even greater for MA-PFFS plans, which receive payments that are on average 117% of Original Medicare.<sup>85</sup> These increased payments have resulted in the rapid growth in MA, both in plan participation as well as beneficiary enrollment.

MA plans submit bids to CMS on an annual basis that reflect their anticipated costs of providing coverage to Medicare beneficiaries, including administrative costs and return on investment. These bids are compared to a benchmark, and plan sponsors are required to return 75% of the savings from bidding below the benchmark to beneficiaries in the form of additional benefits, reduced beneficiary cost-sharing, or reduced premium, while the government retains the remaining 25%. CMS, with its actuaries, has the authority to review these bids and often negotiates with plan sponsors before bids and benefit packages are finalized.

As a result of these changes, MA plan options are available for beneficiaries in all areas of the country.<sup>86</sup> These options typically include a range of plans available to beneficiaries, including low-cost, low-coverage options, as well as more costly higher-coverage plans, which may include additional benefits not otherwise available through Original Medicare.

#### State Regulators and Consumer Groups: Incentives for Harm

State regulators and consumer groups firmly believe that higher payment levels for MA plans are one of the primary drivers of marketing and sales abuses in the MA market, in particular with MA-PFFS plans. They believe that the additional funds have only provided marginal benefit to beneficiaries, in the form of additional benefits and reduced cost-sharing, while the high payment levels have provided a tremendous incentive for plan sponsors to sell as many of these plans as possible.<sup>87</sup>

State regulators and consumer groups are concerned that high profit potential has created incentives for companies to sell MA plans, particularly PFFS plans, over other, less profitable

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<sup>82</sup> For an overview of the Medicare Advantage Payment Policy, see Mark Merlis, *Medicare Advantage Payment Policy*, National Health Policy Forum (September 24, 2007).

<sup>83</sup> Government Accountability Office (GAO), *Medicare Advantage: Increased Spending Relative to Medicare Fee-For-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs* (February 2008).

<sup>84</sup> Medicare Payment Advisory Commission (MedPAC), *Report to Congress, to the House Ways & Means Subcommittee on Health* (March 11, 2008), p. 15.

<sup>85</sup> MedPAC Report to Congress, March 11, 2008, p. 15. However, industry notes that MedPAC's estimate of PFFS plans being paid at higher levels is an average that may not take into account greater enrollment in rural areas, where Congress enacted payment "floors" that are higher than traditional Medicare spending in rural areas.

<sup>86</sup> MedPAC Report to Congress, March 11, 2008, p. 237.

<sup>87</sup> GAO Testimony, *Medicare Advantage: Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries*, found that MA plans that received rebates from bidding above the benchmark allocated only 11% of their rebates to providing additional benefits, and even in cases where plans allocated rebates to reduced cost-sharing and premiums, some beneficiaries could pay more for services than they would in Original Medicare. In addition, 41% of beneficiaries in MA plans were also charged additional premium to pay for additional benefits and/or reduced cost-sharing.

plans (such as a Medigap plan or a stand-alone PDP), regardless of suitability.<sup>88</sup> They note further that reports of marketing abuses increased exponentially with the advent of the Part D program and implementation of the new MMA payment system. Many of the complaints originally centered on PFFS plans.<sup>89</sup> According to MedPAC, PFFS plans are one of the least efficient, with payments averaging 117% of Original Medicare expenditures.<sup>90</sup>

The incentives to enroll beneficiaries in MA plans rather than PDPs and/or Medigap policies can be seen in many reports of skewed commission structures or very large bonuses (or other compensation) that plans have offered producers, both of which are likely to incentivize a producer to steer beneficiaries towards the MA plan, rather than stay in Original Medicare.<sup>91</sup>

State regulators and consumer groups are also troubled by the impact that these incentives may have on producers to enroll certain beneficiaries, such as dual-eligibles or individuals eligible for the Low-Income Subsidy, into MA plans regardless of suitability or despite increased beneficiary cost-sharing. Indeed, plans with low premiums or seemingly low cost-sharing for certain services may be marketed as saving these individuals money, when in fact they may require greater out-of-pocket expenditures than Original Medicare.<sup>92</sup> Furthermore, plans do not report data necessary to determine whether they provide any managed care or whether their care coordination is effective.<sup>93</sup>

Therefore, state regulators and consumer groups believe that high levels of payments to plans have translated into financial incentives for producers, which have resulted in unsuitable sales, high pressure sales tactics designed to increase sales volume, and confusion to the Medicare-eligible population. State regulators and consumer groups also note that while the industry and CMS disagree with this analysis, there has not been offered an adequate alternative explanation for the exponential increase in marketing abuses surrounding the sale of MA products following changes in the payment structure.

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<sup>88</sup> “The overpayments now being made to the private insurance companies have clearly contributed to these marketing abuses. Because private plans receive 13-percent overpayment, on average, for each Medicare beneficiary they enroll (with overpayments to private fee-for-service plans averaging 17 percent), private plans have a significant incentive to maximize enrollment.” Edwin Park, *Informing the Debate About Curbing Medicare Advantage Overpayments* (Center on Budget and Policy Priorities, May 13, 2008).

<sup>89</sup> Robert A. Berenson, Melissa M. Goldstein, *Will Medicare Wither on the Vine? How Congress Has Advantaged Medicare Advantage – and What’s a Level Playing Field?* 1 St. Louis University Journal of Health Law and Policy 5, 28-33 (2007).

<sup>90</sup> MedPAC, Report to Congress (March 2008) at 246-248.

<sup>91</sup> For example, during a market conduct review, the Oklahoma Insurance Department found that one plan sponsor paid producers five times more for selling MA plans as for selling a PDP. In another example, one plan that offered normal bonuses of \$30 per enrollment offered \$150 bonuses for enrollments of 1,500 or more. Other examples were reported. For instance, one plan sponsor pays a \$500 commission per sale, but adds a \$500 bonus on the submission of the third application, an additional \$100 bonus on the fourth through tenth application, and a \$500 bonus on the submission of the tenth application. The total compensation for 10 MA applications is \$6,700.

<sup>92</sup> Ellen O’Brien, Jack Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice*, Commonwealth Foundation, April 2008, pg. 6.

<sup>93</sup> MedPAC, Report to Congress (March 2008) at 247.

### Industry: No Evidence of Relationship Between Payments and Abuses

Industry believes that plan payments and the payment structure for MA plans have little or no relationship to marketing and sales abuses. There have been no studies that show that the areas of the country that have the highest incidence of marketing abuses are those where MA plan payment levels are comparatively higher than Original Medicare. Without evidence of a correlation between marketplace abuses and MA plan payments, any proposed remedy to address marketing issues by changing the MA plan payment formula could have the unintended consequences of reducing health care options for beneficiaries in some areas of the country while not eliminating the marketing abuses at issue.<sup>94</sup> The insurance industry believes that the reported rise in marketplace abuses could be attributable to several differences in the marketplace post-MMA that are unrelated to payment rates to MA and Part D sponsors: for example, lack of familiarity among over 40 million consumers and caregivers with the new Medicare offerings in 2006; the introduction of a new sales force that lacked experience with these products and/or the needs of Medicare beneficiaries; and the unscrupulous actions of a limited group of individuals who are not representative of the broker and agent industry as a whole.

They note that higher commission levels for MA products often reflect the fact that MA plans are a comprehensive benefit package and thus require more training by the producer to understand the product and explain it to a beneficiary. The differences in producer commission structures between types of MA and PDP products is similar to the difference between comprehensive medical plans and limited benefit plans (e.g., pharmacy-only coverage) subject to state insurance regulation. In addition, insurers are permitted to use incentives and bonus programs, in addition to commissions, for the sale of state-regulated health insurance products. In fact, these types of compensation arrangements have been permitted for years in states and do not appear to have led to marketplace abuses.

As already noted, industry also stresses the importance of extra benefits, as well as disease management and care coordination activities, provided by MA plans. In addition, industry explains that almost all MA plans, including MA-PFFS plans, provide additional coverage to Medicare beneficiaries beyond what Original Medicare provides. Enrollment in an MA plan can help to significantly reduce cost-sharing for beneficiaries with the highest health care expenditures.<sup>95</sup> MA plan sponsors believe that the implications of the reimbursement reductions envisioned must be fully understood before proceeding down this path.<sup>96</sup>

The National Association of Health Underwriters also believes that it is important that all Americans, including Medicare beneficiaries, have a wide range of health plan choices available to them.

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<sup>94</sup> Adam Atherly and Kenneth E. Thorpe, *The Impact of Reductions in Medicare Advantage Funding on Beneficiaries*, Emory University (April 2007).

<sup>95</sup> Mark Merlis, "The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006," Henry J. Kaiser Family Foundation *Issue Brief*, January 2008. (See page 6, exhibit 4 – Expected Cost-Sharing for Basic Services under Original Medicare, Private Fee-for-Service and other Medicare Advantage Plans, by Beneficiary Spending Range, 2006, which shows a comparison of cost-sharing under Original Medicare and Medicare Advantage plans for beneficiaries with the top 25% of Medicare expenditures and the top 5% of Medicare expenditures.

<sup>96</sup> For a discussion of the implications of these reductions, see PricewaterhouseCoopers, "The Impact of Medicare Advantage Rate Reductions on Out-of-Pocket Expenses of Medicare Beneficiaries," July 2007.

### CMS: No Connection Between Payments and Problems

CMS agrees with industry that plan payments and the payment structure for MA plans have little or no relationship to marketing and sales abuses. They believe that it is flawed reasoning to directly equate payments to plans with the incidence of marketing and sales abuses. They point out that the compensation MA organizations pay to producers are considered administrative costs and are reflected in the bid, and that plan rebates may only be used to reduce beneficiary cost-sharing or provide additional benefits, and are therefore not available for sales commissions.

CMS also agrees with industry in stressing the importance of extra benefits and services provided by MA plans. CMS has reported that MA enrollees are saving an average of almost \$90 per month because of the improved benefits and lower out-of-pocket costs provided by MA plans.<sup>97</sup>

CMS understands that, in order to demonstrate the value of the MA program and determine to what extent beneficiaries use the benefits available, it will be necessary to collect the appropriate data from health plans. For Plan Year 2009, CMS will begin to gather this data from plans and has already identified a preliminary set of 12 measures for collection. These measures were published in the Federal Register on June 27, 2008, and CMS will accept public comment on the data collection.

In responding to the concern that plans are being incentivized to sell MA plans over stand-alone PDPs, CMS also points out that the difference in profit margins between MA plans and stand-alone PDPs is rooted in part in the difference in risk associated with the two types of plans. MA plans assume greater risk than PDPs. When a health insurance company enrolls a member, it receives a monthly capitation in exchange for assuming the risk associated with covering the enrollee's health care costs. In contrast, a stand-alone PDP assumes only the risk associated with the enrollee's prescription drug costs. In addition, the Part D program builds in additional risk protection for plans through the risk corridors and reinsurance provisions. Should an MA plan's enrollees' health care costs exceed the capitation rate, those costs must be absorbed by the plan, even if the result is negative with no risk-sharing by the government.

### **Recommendation by State Regulators and Consumer Groups**

#### **Bring plan sponsor financial compensation for MA plans in line with Original Medicare.**

There does not seem to be sufficient justification for the high payment levels, particularly for PFFS plans, which appear to incentivize and contribute to problems in the marketplace.<sup>98</sup>

#### *Comment from Industry:*

Industry does not believe that MA plan payment level is a driver of marketplace abuses, so the implementation of this recommendation will not serve to protect seniors, and in fact may adversely impact beneficiaries in certain areas of the country by resulting in

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<sup>97</sup> Presentation by Abby Block before the National Medicare Education Panel (October 24, 2007).

<sup>98</sup> MedPAC, Report to Congress (March 2008).

increased premiums, increased out-of-pocket costs and reduction in plan options. According to a 2007 study, proposed MA funding cuts similar to the ones suggested here would cause roughly one-third of MA enrollees (more than 3 million people) to lose their MA coverage. Beneficiaries who lose their MA coverage may face an increase in costs of \$825 per year.<sup>99</sup>

## **B. Producer Financial Incentives**

As pointed out above, producer compensation for MA plans, especially for MA-PFFS plans, may be substantially greater than for other Medicare-related health insurance products sold to the Medicare-eligible population.

### State Regulators and Consumer Groups: Incentives Have Resulted in Abuses

State insurance regulators and consumer groups feel very strongly that these financial incentives have resulted in significant producer misconduct ranging from unsuitable sales to outright fraudulent activity. Although many producers are conducting themselves in a forthright and honest manner, state regulators have reported significant producer misconduct in the area of MA sales in recent NAIC surveys, as discussed earlier in this paper.<sup>100</sup> Unfortunately, state regulators and consumer groups continue to receive complaints about marketing abuses.

State regulators and consumers believe that these abuses in the marketplace are directly linked to the higher compensation for producers, including bonuses. CMS actuaries have the ability to review the amounts projected for commissions in the MA plan bid process. Marketing and sales expenses are included as part of the bid.<sup>101</sup> Congressional hearings exploring marketing abuse in the MA marketplace highlighted, among other things, one plan sponsor that offered a \$10,000 bonus to agents who enrolled 150 people into their MA plan by the end of the Open Enrollment Period (OEP), and other plan sponsors that offered similar cash bonuses as well as trips to Las Vegas and flat-screen TVs for high-producing agents.<sup>102</sup>

In addition, after March 31, when open enrollment has ended, there is even more incentive for producers to enroll dual-eligibles into MA plans (even though they are likely to be ill-suited for these plans), as they are the only Medicare beneficiaries permitted to enroll during this timeframe, except for those who first become eligible for Medicare.

### Industry: Consumer Protections Are Needed

Industry representatives maintain that marketing abuses that have occurred in the marketplace,

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<sup>99</sup> Atherly and Thorpe study.

<sup>100</sup> Summary of NAIC First State Survey; Summary of NAIC Second State Survey.

<sup>101</sup> The CMS “Instructions for Completing the Medicare Advantage Bid Pricing Tool” includes at Worksheet 4, “Line w”, that an MA plan provide in the bid specified “Non-medical expenses” that include “marketing and sales, direct administration, indirect administration” as part of the bid.

<sup>102</sup> See, for example, Senate Finance Committee hearings “Selling to Seniors: The Need for Accountability and Oversight of Sales by Medicare Private Plans (Part 1 – 2/7/08; Part 2 – 2/13/08); House Energy & Commerce Committee, Oversight & Investigations Subcommittee hearing “Predatory Sales Practices in Medicare Advantage” (6/26/07).

while troubling, are not reflective of overall industry practices. Additionally, the reported incidences of producer misconduct are not the result of the financial incentives to write business provided to the producers. However, they do agree that standards should be developed for agent commissions in order to protect seniors against any potential harm, as improved training and oversight is the proper way to address marketing problems. These standards should be developed in concert with various other consumer protections, such as limitations on certain marketing and sales practices.

#### CMS: Action Taken to Reduce Abuse

CMS has been very concerned with the problems in the marketplace and has taken steps to improve oversight. In the NPRM, CMS requires that MA organizations establish commission structures for sales producers that are level across all years and across all MA plan product types—HMOs, PPOs and PFFS plans. Commission structures for PDPs would have to be level across the sponsors' plans and plan years as well. These requirements are designed to discourage annual "churning" of beneficiaries from plan to plan as a result of the incentive for producers to encourage beneficiaries to enroll in products that may not meet the beneficiaries' health needs, but pay the producer the highest commission.

#### Medicare Improvements for Patients and Providers Act of 2008:

This recently enacted law requires that the Secretary of Health and Human Services establish limitations with respect to compensation for producers.<sup>103</sup> These guidelines are required to ensure that the use of compensation creates incentives for producers to enroll individuals in the MA and prescription drug program that is intended to best meet their health care needs.

#### **Recommendations by State Regulators and Consumer Groups**

- 1. Consider requiring MA plans to be guaranteed renewable. Such a requirement could justify a greater compensation level because the plan sponsors would not be able to quit the program in any given year as they can today.** (It should be noted, however, that the utility of guaranteed renewability may be diminished without a corresponding requirement preventing plans from substantially changing benefits from year to year.)

#### *Comment from Industry:*

The application of guaranteed renewability standards on MA plans is inconsistent with the manner in which the program is funded. Guaranteed renewability of MA plans would require the plan sponsor to continue to offer a plan to a beneficiary indefinitely, and the plan benefit structure must remain the same. This restriction would not work with a program that is dependent on being awarded a contract with the federal government and funding levels that are subject to annual change by Congress. Plan sponsors cannot guarantee products when they are unsure of the reimbursement level from year to year. Additionally, if a plan sponsor is not awarded a contract with CMS or leaves the MA program, it can not continue to administer Medicare benefits.

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<sup>103</sup> Section 103(b)(1)-(2) of P.L. 110-275.

*Comment from the National Association of Health Underwriters:*

A requirement of guaranteed renewability is not practical for either insurance carriers or for Medicare beneficiaries, given the nature of the program's funding and the fact that plan benefits can substantially change from year to year.

- 2. As an alternative to guaranteed renewability, consider removing the MA "lock-in." This would allow beneficiaries to switch to better-suited plans throughout the year.**

*Comment from the National Association of Health Underwriters:*

Lifting the MA "lock-in" provisions to allow beneficiaries to switch from plan to plan during the year is not practical. Health insurance contracts generally last for one year, in order to provide for a stable pool of risk across time. Allowing beneficiaries to change plans on a whim would promote adverse selection and could prove costly for the entire insured population. Instead, it is the role of the ethical insurance producer to place his or her client with the most suitable insurance product, and annually review his or her client's benefits to ensure adequate coverage over time.

- 3. Review producer compensation, especially with respect to bonus levels based only on volume rather than suitability and persistency. The financial incentives illustrated above are a clear example of incentives for unsuitable sales, high-pressure sales tactics and outright fraud. Limit bonuses and other compensation for high-volume sales.**

*Comment from the National Association of Health Underwriters:*

While Medicare private plan commissions should be stabilized, there should be no limits on commissions and/or bonuses received, and there should be no restriction on how carriers determine bonuses to be awarded. Such restrictions would limit the competitive marketplace and would penalize some very responsible agents for their efficiency. There should be no requirement to monitor a producer's production. If a producer is writing a high volume of business but no complaints are being generated and the producer is otherwise compliant, there is no need for restrictions.

- 4. Limit producer compensation as it is for Medicare supplement insurance (Medigap plans). Under the Medigap model, first-year compensation may not be greater than twice renewal compensation, and renewal compensation must be paid for at least five years. In addition, limit replacement commissions to not greater than the renewal commissions for the product. Require plan sponsors to recoup commissions from producers if the policy is cancelled for any reason within the first six months of issuance.**

*Comment from the National Association of Health Underwriters:*

There should be a different commission structure between MA plans and stand-alone PDPs. A single commission payment for the PDPs may be appropriate, as the

commissions are very low to begin with, since the service needs on a simple stand-alone drug benefit are much less than the service required on a comprehensive MA plan. When enrolling a client in a PDP, the producer generally spends a great deal of time on the initial enrollment to ensure that the PDP is appropriate for the client's specific needs. Following enrollment, due to the limited nature of the benefit, there are generally few service issues. Producers should not be discouraged from marketing PDPs because their compensation is deferred to only a few dollars a month.

Commissions for MA plans should be level, but the commission amount should be higher in the initial year than in renewal years, reflecting the extra efforts to initiate a policy. While being cautious that higher initial commissions do not result in churning, the vast majority of producers will only suggest changing to a new plan if it is more appropriate in the client's situation. Since MA plans can substantially change benefits from year to year, an annual change of plan does not always represent greed on the part of the producer, but instead is oftentimes warranted to best meet the needs of the consumer.

**5. Consider requiring MA plans to meet a certain loss ratio over the life of the plan, similar to the requirements for Medigap plans.**

*Comment from Industry and the National Association of Health Underwriters:*

Minimum loss ratios are not a good measure of quality of care or value provided to beneficiaries under MA plans because these ratios focus primarily on the amount of money paid out in claims at the point of illness or incident, but do not take into account investment in programs that focus on maintaining wellness and improving health outcomes. Minimum loss ratios fail to account for the fact that many "administrative" functions such as care coordination, quality improvement, utilization review, and health information technology (e.g., e-prescribing and electronic health records) help to improve health outcomes for beneficiaries and reduce costs. The application of loss ratios to MA plans could shift the focus of the program away from integrated care delivery to claims processing and payment at the point of service.

**6. Utilize the NAIC to develop model regulations that restrain the absolute level of MA commissions and ensure there is a direct relationship between the actuarial value of coverage and the level of commission. For the sale of Medigap plans, commissions that are based on a percentage of premium incentivize producers to sell richer, more comprehensive coverage, while consumer preference generates market competition for lower-premium plans.**

Under MA, there is often an inverse relationship between the value of the plan and the level of commission, as plans use higher commissions to push sales of low-premium, low-value plans that may provide inadequate financial protection to beneficiaries. A regulatory structure for commissions, together with minimum standards for MA benefit packages, could align incentives so that producers are compensated more for selling high-value plans and less for selling low-value plans.

*Comment from the National Association of Health Underwriters:*

Although there are “bad apples” in the producer industry, it is important to note that the vast majority of health insurance producers work very hard to find quality and appropriate Medicare coverage options at the best possible price for millions of beneficiaries. There should be stable commissions in the private Medicare private plan marketplace, and incentives for making quick sales and/or making recommendations to change policies on an annual basis without regard to a consumer’s health care needs should be removed. Currently, many MA plans pay a one-time fee as compensation to agents upon the sale of a policy. A more stable commission structure would allow producers to focus on their true professional calling of servicing health insurance clients after the sale. However, in crafting a level commission policy, it is important not to financially penalize the thousands of producers who responsibly serve their clients. It is also critical that policymakers allow market forces to dictate the terms and amounts of commissions, and do not create an unlevel playing field by making the commission requirements different for Medicare private plans than what is allowed in other private insurance markets.

**7. Require plan producers to disclose to the consumer the commissions they pay for the sale of Medicare Private Plans.**

*Comment from Industry:*

The information that is being recommended for disclosure is proprietary. Additionally, current 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, and the concern may be better addressed by making changes to producer commission structure.

*Comment from the National Association of Health Underwriters:*

This information may be proprietary. In addition, current Medicare Marketing Guidelines require sales representatives to disclose to potential enrollees that they may be compensated by the plan sponsor for the sale of the product.

**SECTION 6. PROGRAM DESIGN**

State insurance regulators and consumer groups have raised a number of issues concerning the design of Medicare Advantage (MA) and Medicare prescription drug plans (PDP) that both groups strongly feel have contributed to some of the problems identified in the MA and PDP marketplace.

## A. Number of Plans Available

One of the results of the changes made by the MMA to encourage participation in the MA program is that there are now many plan choices available to beneficiaries in most areas. In addition to MA plan options, this also includes the option to stay in Original Medicare and enroll into a Medicare supplement plan and/or a Medicare prescription drug plan.

According to information on the Medicare.gov Web site, a county in one state had 44 MA Private Fee-for-Service (PFFS) plans available. Some plan sponsors had multiple MA-PFFS plans available along with other MA-Managed Care plans such as regional and local PPOs and HMOs. Each plan's coverages were different, along with different cost shares. In some instances, these same plan sponsors offered multiple PDPs and Medicare Advantage Prescription Drug plans with varying prescription drug formularies.

State Regulators and Consumer Groups: Too many plans = No meaningful choice

State insurance regulators and consumer groups believe that, under the premise of consumer choice, far too many plans are being marketed and sold to the Medicare-eligible in a geographic region, making an informed choice virtually impossible.

As reviewed in Section 2, federal law allows for a number of different types of MA plans, each of which has its own unique characteristics under the law. Federal law also requires that MA plans have coverage that is at least actuarially equivalent to Original Medicare. Coverage levels are not specified. Further comment on coverages is contained in a later portion of this discussion.

State insurance regulators and consumer groups do not agree with the industry's and CMS' assessment of the market. State regulators argue that all of the available resources have proved ineffective at protecting consumers and assuring that beneficiaries are enrolled in suitable plans. While they agree that consumer choice is a good thing, too much choice involving very complicated and technical products can result in no choice at all. The number of plans—plus the number of variables in terms of cost-sharing for different services, provider networks and coverage criteria—create “too many moving parts” for most beneficiaries to be able to make an informed analysis.<sup>104</sup> MedPAC also determined that beneficiaries could not get information they needed about certain benefits.<sup>105</sup>

Industry: The Importance of Consumer Choice

Most plan sponsors believe that the large number of plans provides more consumer choice by enabling consumers to select the plan that suits them best. Some beneficiaries may choose a plan with a low or no premium and higher out-of-pocket costs on a pay-as-you-go basis, while others may choose higher premiums and lower cost-sharing. The ability to design benefit packages that offer beneficiaries those choices is fundamental to the structure of the MA program.

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<sup>104</sup> Ellen O'Brien, Jack Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice*, Commonwealth Foundation, April 2008, pg. 4.

<sup>105</sup> MedPAC, Report to Congress (March 2008) at 247.

In addition, CMS and plan sponsors believe that having more plans and plan sponsors creates a competitive market, which in turn offers more benefits and lower prices to consumers.

The National Association of Health Underwriters (NAHU) also strongly disagrees with limiting the number of health plan choices available to Medicare beneficiaries and believes that the private competitive marketplace should be allowed to accommodate as many choices as the plan sponsors feel the market can bear. NAHU believes that limiting competition and choice never has a positive impact on price, and Medicare beneficiaries deserve as many health plan options as possible so that they can select the products that best suit their personal needs and budgets.

#### CMS: Emphasis on Beneficiary Choice

CMS argues that the MA program was specifically designed in statute to provide beneficiaries with choices and trade-offs among plan offerings. With the proviso that Medicare Part C (MA) benefits must be at least actuarially equivalent to Original Medicare, the statute specifically allows plan flexibility in how they distribute cost-sharing among the various covered services. Plans also have the option of providing an out-of-pocket maximum or catastrophic limit on out-of-pocket costs.

Further, CMS and plan sponsors argue that there are resources available to consumers to help them make enrollment decisions, including: the Medicare.gov Web site, which includes the Medicare Options Compare feature; the Medicare & You handbook, which is mailed to every Medicare beneficiary; 1-800-MEDICARE; producers of the plan sponsors; family members; neighbors; and SHIP counselors.

### **B. Comparability of Benefits and Plan Designs**

As pointed out above, federal law requires that MA plans provide coverage that is at least actuarially equivalent to the coverage provided under Original Medicare. Requiring actuarial equivalence is not, however, requiring that coverage be the same as under Original Medicare. Hence, virtually every plan's coverage is different than every other plan's coverage. In addition to the benefits covered, cost-shares, deductibles, co-payments and co-insurance, out-of-pocket spending limits, and aggregate coverage limits are different in each plan, even for those plans that are offered by a plan sponsor and are of the same plan type. As long as they meet the actuarial equivalency test described above, they are qualified plans. Benefits and benefit plan designs are not standardized in the MA program.

Thus, for consumers to make an informed buying decision, they will need to understand the myriad benefits provided, the cost-shares contained and, if the MA plan includes prescription drug coverage, the drug formulary for each MA plan available in their geographic area. Consumers will then need to match these variables with their current health care needs.

### State Regulators, Consumer Groups, and Some Industry: Impossible Comparisons

State regulators, consumer groups and some industry believe that it is an almost impossible task for consumers to adequately compare plans, and therefore it is very difficult for beneficiaries to make informed decisions.

Not only do beneficiaries have to consider an overwhelming number of plans, they have to attempt to compare the differences in coverage,<sup>106</sup> and plans are also able to alter premiums, coverage levels, benefits and cost-sharing every year. These changes mean that consumers must go through the same analytical process for choosing a plan every year to ensure that they have an appropriate plan.

State regulators, consumer groups and some industry also point out the vulnerable and unique nature of the Medicare-eligible population, as opposed to the general population.

### Industry: The Importance of Choice

Most of the industry believes that choice is a fundamental tenet of the MA program. They also report that these types of comparisons, as well as the need to reevaluate coverage annually, is similar to all other types of commercial insurance, and therefore not atypical. Most of the industry also believes that promoting broad changes in program design will lead to significant beneficiary confusion.

### CMS: The Importance of Choice

CMS agrees with industry in emphasizing the importance of consumer choice, and in arguing that these types of decisions are similar to the types of decisions consumers face in all other types of commercial insurance. While protections should be considered as appropriate for the Medicare-eligible population, this population should not be given less ability to pick and choose their health care coverage than any other population.

## **C. Annual Changes in Plans**

One of the characteristics of MA plans and PDPs is the fact that the contract between CMS and plans is only for one calendar year, and plans are able to make changes to benefits, cost-sharing and formularies every year. In addition, plan sponsors may decide to non-renew plans on an annual basis.

### State Regulators and Consumer Groups: Lack of Guaranteed Renewability Results in Instability

State insurance regulators and consumer groups believe that this ability to pull plans each year has resulted in significant instability in the MA market. In fact, plan sponsors are allowed to withdraw plans annually from certain geographic areas, yet the plan sponsors may keep those

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<sup>106</sup> Ellen O'Brien, Jack Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice*, Commonwealth Foundation, April 2008.

same plans active in other geographic areas. The ability to withdraw the plans annually means that there is no true commitment to the MA program required beyond one calendar year.

When plan sponsors withdraw products from the market, affected beneficiaries enrolled in those products must find other coverage. With either decision, the cost and coverages could be substantially different for the beneficiaries than under the MA plan that had left the market. State insurance regulators and consumer groups feel strongly that Medicare-eligible consumers deserve stability in their government-sponsored health insurance coverage from year to year. The ability of plan sponsors to not only change coverages and cost-shares each year, but to withdraw plans from the market, results in a disservice to the Medicare-eligible population and has resulted in unneeded stress to many of these individuals.

Industry: Guaranteed Renewability  
Would Not Work for These Products

The plan sponsors report that, in order to participate in this market, they need to be able to make the business decision to pull out of the market if market forces warrant such a decision. For example, forcing plan sponsors to continue offering plans at a loss or when few or no beneficiaries enroll is not economically feasible and would not be responsive to consumer preferences. This could result in many plan sponsors being unable to continue their participation in the program. Not allowing plan sponsors to withdraw their plans from a market or a geographic location makes it very difficult for them to price their products with the best value for the beneficiary, especially in a competitive market environment.

Industry also believes that promoting broad changes in program design will lead to significant beneficiary confusion and would fail 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, plan sponsors recommend undertaking an additional examination of the consequences of MA program restructuring before making broad recommendations. An example is the recommendation of multiple-year contracts for MA plans 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.

The National Association of Health Underwriters believes that a guaranteed renewability requirement for MA plans is not practical, given the current annual financing structure of these plans. They are also concerned that such a requirement would increase beneficiary costs, as plans would not be able to accurately price products on a multi-year basis due to potential annual financing changes.

CMS: No Evidence of Instability

CMS argues that there is no evidence of program instability that would warrant a major contracting change such as guaranteeing plan renewability from year to year. In the Medicare Prescription Drug program, only six organizations, covering only 3,325 out of a total 17.3 million beneficiaries, had contract terminations, non-renewals or service-area reductions between 2007 and 2008. In the MA program, 36 organizations had service-area reductions and 16 had

non-renewals between 2007 and 2008, affecting 54,000 beneficiaries (which is well under 1% of MA enrollees).

### **Recommendations by State Regulators and Consumer Groups**

#### **1. The number of plans available by plan sponsor should be limited to no more than two plans by plan type.**

Prescription drug coverage would be a subset of plan type. For example, a plan sponsor that offers the four different MA plan types could offer two plans by type, with or without prescription drug coverage, limited to the two options available under the following PDP limitation. For PDP coverage, plan sponsors would be limited to two PDP options, one with coverage in the “donut hole” and one with no coverage in the “donut hole.”

##### *Comment from Industry:*

Industry strongly disagrees with the suggestion to limit the number of plan types available by plan sponsor to no more than two per plan type. Industry believes that this recommendation is not based on a study of the existing market, impact on beneficiary benefit options, or beneficiary preference. Industry believes that plan differences are designed to provide choice and convenience to meet the varying health care needs and preferences of the diverse beneficiary population. This limitation would also discriminate against companies exclusively providing prescription drug benefits, and CMS already has rules in place to address this issue.

##### *Comment from CMS:*

To place an arbitrary numerical limit on the number of plan offerings would be to ignore the substance of what differentiates one plan from another. Consistent with CMS’ 2009 Call Letter, CMS negotiates with PDP sponsors to ensure sufficient differentiation among PDP sponsors’ approved bids. This negotiation will be based on analysis that considers key benefit characteristics such as differences in deductibles, formularies and expected out-of-pocket costs. CMS intends to build on “lessons learned” as they continue to accumulate program experience in order to further refine their analyses and identify additional methods for determining whether there are substantial differences in benefit packages.

Additionally, consistent with the policy CMS adopted in the 2008 Call Letter, PDP sponsors or parent organizations with new acquisitions will be afforded a period of three years to transition their plan offerings to meet the goal of ensuring that the Part D sponsors’ offerings are substantially different from one another.

#### **2. There should be standard definitions in the marketing and sales activities of these products.**

**3. Benefit and benefit plan designs for MA plans should be standardized, as benefits and benefit plan designs are for Medigap coverage using the Medigap model used under OBRA 1990.**

The NAIC should be called upon to establish a working group consisting of the interested parties as outlined under the OBRA 1990 Medigap standardization requirements to develop the benefits and benefit plan designs. The authority and thereby the compliance with these standards would still rest with CMS and not the states. Plans would not be required to file their plan designs with the states for approval. There should be some flexibility given to plans for innovative benefit designs that are non-discriminatory and do not disadvantage the sickest, most vulnerable beneficiaries.

*Comment from Industry:*

Industry disagrees with the recommendation of standardization of benefits for MA plans, as it 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. Standardizing plans similar to Medigap would lock benefits into an inflexible structure that would be slow and difficult to change. Under the MA program, government payments change every year, and plans must increase or decrease the value of benefits and premiums in accordance with these funding changes. Standardizing benefits is simply inconsistent with the MA bidding and payment methodology and would likely lock seniors into plans that are frozen in time with the potential for premiums that spiral out of control.

*Comment from CMS:*

This recommendation is not appropriate because MA plans are not like Medigap plans. The design of MA plans is intended to mirror the types and styles of plans in the commercial market. Medigap coverage, as the name indicates, is limited to supplementing Original Medicare, which is very different from MA coverage, which includes coverage for Part A and Part B services as well as supplementary benefits as determined by the plan. Therefore, beneficiary choice is much more significant in MA than in Medigap.

*Comment from the National Association of Health Underwriters:*

MA plans should not be standardized. The nature of the program and funding mechanism is very different from Medigap, and plan standardization may not be practical for MA plans. Plan standardization limits innovation and competition, which can negatively impact both price and consumer choice.

**4. MA plans and PDPs should be required to stay in a market for more than just one year unless there are extraordinary circumstances. While we are not recommending traditional guaranteed renewability as with Medigap, we feel strongly that the ability**

**for plans to exit a market after only one year results in too much instability and disruption for the Medicare-eligible.**

We recommend that a study group be appointed consisting of experts and interested parties, including plan sponsors, CMS, state insurance regulators and independent actuaries to provide Congress a recommendation on how to address this issue.

*Comment by CMS:*

CMS disagrees that there is evidence of program instability that would warrant a requirement of guaranteed renewability. There have been minimal contract terminations, non-renewals, or service-area reductions between 2007 and 2008. In addition, there are several reasons why multi-year contracts would neither benefit Medicare beneficiaries nor the program in general. Specifically:

- The overall cost of the benefit might increase due to the increased risk from the longer contracting period. MA and Part D sponsors would need to account for this risk with higher bids. In particular, sponsors would not know how to cost-out the price for new drugs or benefits that are not yet on the market or Medicare-covered services.
- If bids are locked in for multiple years, legislative changes, new benefits, new drugs and/or new clinical guidelines could have an impact on bids. Significant impacts could result in the necessity for mid-cycle bid adjustments. This process could be very complicated for CMS and contractors.
- CMS would lose leverage to negotiate with organizations to reduce the number of plan offerings within a sponsor organization when the offerings were not significantly different, as organizations would lose their current flexibility to modify or withdraw plan offerings annually. It might also inhibit CMS' ability to non-renew contracts with plans that may not be adequately serving their members.
- Even multi-year contracts would terminate at some point.

**NAIC Subgroup on Medicare Private Plans:**

State Regulators:

Wisconsin (Chair)  
Alabama  
Arkansas  
California  
Florida  
Idaho  
Illinois  
Kansas  
Louisiana  
Maryland  
Minnesota  
Mississippi

Nebraska  
New Mexico  
New York  
North Carolina  
North Dakota  
Ohio  
Oklahoma  
Oregon  
Pennsylvania  
Tennessee  
Utah

Federal Regulator:

Centers for Medicare and Medicaid Service

Consumer Groups:

AARP  
California Health Advocates  
Center for Medicare Advocacy

Kaiser Family Foundation  
Medicare Rights Center  
National Council On Aging

Industry Representatives:

America's Health Insurance Plans  
Anthem/Wellpoint  
Blue Cross Blue Shield Association  
Blue Cross Blue Shield of Florida  
Humana

Kaiser Permanente  
Sterling Insurance Company  
Universal American Financial Corporation  
United Healthcare  
Wellcare

Other Interested Party Representatives:

National Association of Health Underwriters  
Schiffbauer Law Office  
Old Surety Life Insurance