



March 12, 2008

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Senators Baucus and Grassley:

California Health Advocates (CHA), the Center for Medicare Advocacy (CMA), and the Medicare Rights Center (MRC)—three consumer groups that represent and advocate for people with Medicare—write to express our on-going concerns over improper marketing practices by Medicare Advantage (MA) plans and Part D prescription drug plans (PDPs). All three organizations serve as consumer representatives to the National Association of Insurance Commissioners (NAIC) task force on marketing issues.

Last week, the Board of Directors of America's Health Insurance Plans (AHIP) released a set of proposals entitled "Strengthening Oversight of Medicare Advantage and Part D Marketing" aimed at addressing ongoing marketing abuses surrounding the sale of MA products. On March 6, 2008, CMS issued guidance to Medicare Advantage organizations entitled "Recommended Best Practices for Training Sales Agents and Brokers." We recognize that these two documents are a move in the right direction. However, we believe that these proposals fall well short of measures that are needed to truly stem the tide of marketing misconduct.

Many of the proposals offered by AHIP already exist in CMS Guidance. While we would like to see these and others codified in regulations that carry more legal weight, there is not too much that is "new" in the AHIP recommendations. Further, these proposals do not address some of the root problems fostering the current epidemic of marketing abuse, including overpayments to Medicare Advantage plans and corresponding commissions and other incentives paid to insurance agents, and the limited role of state insurance regulators under federal preemption rules.

Similarly, the new CMS guidance provides too little, too late in terms of protection for consumers. The March 6 directive sets forth only recommendations that plans may follow; it does not establish requirements with which plans must comply in order to contract with CMS. Again, these recommendations come as informal guidance and not as binding regulations that carry the full force and effect of the law. We believe that CMS can do more, using its regulatory, oversight, and enforcement authority, to protect people who rely on Medicare.

We ask the Senate Finance Committee to consider the following:

Federal vs. State Regulation

Instead of advocating for greater oversight by state regulatory agencies, AHIP supports “ongoing exchange of information and consultation” between CMS and state insurance regulators. AHIP wishes to “maintain [] the scope of federal preemption and avoid [] a dual federal/state regulatory system.”

We agree that CMS should require plans to appoint agents as well as the general notion that there should be increased coordination and cooperation between state and federal regulators. In addition, we believe that all MA and PDP enrollment applications should include the National Insurance Producer Registry (NIPR) license to enable better tracking of individual agent behavior. It is unacceptable that, at this late date, there is still not in place a system that enables CMS, the states, and the plans to identify problem agents and the plans they are selling. Instead of focusing on the demarcation between federal and state authority, CMS should adopt the systems that states have long used to enforce consumer protections.

However, AHIP’s proposals amount to endorsing the status quo regulatory scheme in which MA plans nationwide are regulated by one entity—CMS—that does not appear to have the capacity to provide adequate oversight. AHIP’s proposal would preserve an unworkable system that divorces oversight of agents from oversight of the plans they work for, complicating the task of enforcing consumer protections.

Unfortunately, the current federal regulatory framework is inadequate to protect consumers from marketing misconduct. Instead of having their hands tied by federal preemption, state regulators should have the authority to enforce compliance by plan sponsors of a common set of state laws on the marketing of Medicare insurance products. Further, we endorse NAIC’s position with respect to using the Medigap model for joint regulatory authority; this model has been successful in curbing many of the same types of abuses now occurring in the MA market.

Prohibition on Door-to-Door Marketing

CMS rules already prohibit unsolicited door-to-door marketing. Unfortunately, this practice continues and is exacerbated by insurance agents who misrepresent themselves and their intent to sell insurance when calling prospective enrollees in order to set up in-home visits.

In order to make inroads against this practice, CMS should implement reporting requirements that enable plans and CMS to identify and prevent unsolicited door-to-door sales, including flagging all in-home enrollments and requiring agents to document how an invitation for an in-home presentation was secured. Mass enrollments at sales presentations should also 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 agents.

Prohibiting Cross-Selling of Medicare and Non-Medicare Care-Related Products

We agree that agents should not be permitted to sell non-health care related products during a sale of Medicare products; however AHIP endorses a broad exception to this requirement that undermines the intent of such a prohibition. AHIP states that: “[m]arketing to current plan

members of health care related and non-health care-related products is governed by HIPAA and would not be addressed by this requirement.”

This broad exception is a disservice to Medicare beneficiaries in that it would seemingly allow companies that have already sold a particular beneficiary a product to market other products offered by the same company, and agents who have already sold a product to someone to market health and non-health related products to that same individual all at once.

As beneficiary representatives, we know first hand that evaluating, comparing, and deciding on an individual’s Medicare benefits is complicated enough. The process of analysis and choice of the best health care option should not be clouded by the sale of any other products (e.g., the sale of a Medicare Advantage plan along with a Medicare Advantage “plus” or “gap” plan should also be prohibited). An agent who has a pre-existing relationship with an individual client can come back later to sell other products; any hardship experienced by an insurance agent is far outweighed by the beneficiary protection against being sold multiple, complicated, and often unrelated products at one time.

Limitations on Cold Calling

We believe that current CMS rules concerning cold calling should be broadened into a stronger prohibition. AHIP’s proposal includes some positive improvements but does not go far enough in that 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 an agent. 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. We strongly disagree that such calls would not be defined as “cold.”

Similar to the exception noted above concerning the cross-selling of other products, AHIP proposes that unsolicited calls would be permitted “to offer information to beneficiaries with whom the company has an existing relationship, as permitted under HIPAA.” This carve-out from the cold-calling prohibition for persons that the company already has a “relationship” with would apparently mean that anyone enrolled in another insurance product offered by the same company (e.g., a Medigap policy, Part D plan, or even life insurance)—or who has a product sold by the same agent—could get unsolicited calls.

Further, many agents cold call individuals and set up in-home sales appointments by misrepresenting themselves (such as saying they are from Medicare, a SHIP program, Social Security, the “health department,” etc.). It is still unclear how this practice would be monitored and prevented by plans and regulators. In short, we are concerned that plans and agents can circumvent any limitations on cold calling by simply mailing someone a plan promotional document or calling prospective enrollees outside of the scripted, plan call center system.

Require Plan Type Designation

AHIP proposes to require plans to add a parenthetical plan type designation at the end of the plan name in pre-enrollment marketing materials. While certainly an improvement over current

requirements, we do not believe that this requirement goes far enough to reduce the confusion generated by scores of plan offerings that include names that have nothing to do with the delivery of health care (e.g., gold, golden, silver, green, secure, advantage, senior, complete, duet, etc.).

The sheer number of plan offerings coupled with plan names that have nothing to do with the delivery of health care exacerbate the already confusing Medicare marketplace. For example, in West Palm Beach County, Florida, there are four different Humana “Gold” plans; two that have drug coverage and two that don’t; leaving many enrollees confused about which plan they are actually in. Also, some plans use deceptive names, such as the “Any, Any, Any” Private Fee-for-Service (PFFS) plan, which promises enrollees that they can see “any” doctor, “anytime,” “anywhere” despite the challenges of finding providers willing to accept the plan.

In addition to a restriction of plan names, there should be a limit on the number of plans available in a given geographic area. For example, Alpine County in California has approximately 120 residents age 65 and older, who can choose from 40 MA plans and 57 PDPs—almost one plan for each Medicare beneficiary.

Broker/Agent Commission Structures

AHIP adds nothing to what CMS already requires beyond suggesting a process that may result in a commission structure designed to prevent “churning.” However, establishing a ratio between initial and replacement commissions will not reduce churning without a simultaneous prohibition on bonuses, volume rewards, and other financial incentives for new MA enrollments, a prohibition that is glaringly absent from AHIP’s proposal. Also absent from AHIP’s proposal is any discussion of reducing the exorbitant commissions that encourage high-pressure sales tactics, often for plans of dubious value. Plans should be prohibited from offering varying commissions based on plan types (MA vs. PDP) and should be restricted in their offerings of other incentives to maximize enrollments (such as bonuses, trips, etc.).

Conclusion

We recognize that both AHIP and CMS are acknowledging that changes must occur to the current regulatory oversight of MA plans in order to reduce marketing misconduct. However, we feel that the steps they have outlined are insufficient to produce meaningful improvements. Instead, these measures are likely aimed at warding off or steering Congressional attention toward more benign measures that do not significantly impact plan performance and profit. CMS’ continued reliance on guidance documents masks its reluctance to exercise its regulatory authority and monitor marketing sufficiently to eliminate or at least lessen marketing abuses.

In order to cure the ills of the current marketplace, we believe that the following steps are among those that must be taken in order to adequately protect consumers.

- Create standard benefit packages for MA plans and PDPs that would:
 - Establish no more than two annual limits for out-of-pocket costs;
 - Prohibit plans from carving out specific services from out-of-pocket limits;
 - Prohibit separate cost-sharing for individual Part B services;

- Require that MA plans charge no more cost-sharing for services than what is charged under traditional Medicare; and
- Limit the number of plans offered in a given geographic area.
- Apply the standardization and simplification requirements of the NAIC Medigap Model Act and Regulation to all MA and Part D plans.
 - These requirements should include loss ratio standards, guaranteed renewability requirements, suitability requirements, and other consumer protections.
- Rescind the statutory preemption that prevents states from enforcing state laws on consumer protections and the marketing of insurance products.
- Neutralize payment between traditional Medicare and the MA program (see, e.g., the recommendations from the Medicare Payment Advisory Commission) and use the current excess payments to strengthen access to benefits in other areas of Medicare, such as expanding eligibility for the Medicare Savings Programs and the Part D Low-Income Subsidy.
- Authorize NAIC to develop nationwide marketing guidelines, including:
 - Provisions that hold plans more accountable for the actions of agents selling their plan;
 - Prohibitions on plans from offering differential commissions based on the type of plan selected by the enrollee;
 - Prohibitions on agents from selling unrelated products; and
 - Development of more comprehensive disclosure documents with clear explanations about how certain choices can impact access to providers and other types of insurance coverage (e.g., retiree, Medigap, Medicaid, etc.).

We thank the Senate Finance Committee for the hearings it has held and its on-going interest in protecting Medicare beneficiaries. We look forward to working with you on these issues.

Sincerely,

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 Bonnie Burns, Training and Policy Specialist
 California Health Advocates

Judith A. Stein, Executive Director
 Vicki Gottlich, Senior Policy Attorney
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Identical letter sent to each member of the Senate Finance Committee