



The Price Is Right: The Selling Of Medicare – New Marketing Rules Fail to Cure Problems in the Medicare Marketplace

DECEMBER 2008

Principal Authors:

David Lipschutz
Staff Attorney

Bonnie Burns
Training & Policy Specialist

Deepti Sethi
Legal Consultant

NOTE: This report was prepared with support from The California Endowment.

I. INTRODUCTION & BACKGROUND

Introduction

As the Medicare Part D prescription drug benefit nears the end of its third year, the annual selling season for Part D and Medicare Advantage plans is also coming to a close. Similar to the last three years, the 2008 Annual Coordinated Election Period (AEP) allows Medicare beneficiaries to choose from – and be marketed to by – a wide range of Medicare private plans across the country. Also similar to the last three selling seasons, Medicare beneficiaries are still subject to unscrupulous behavior on the part of a number of agents and brokers trying to maximize their compensation by steering people towards certain plans, regardless of whether such plans are in an individual's best interest. The sheer number and complexity of Medicare private plans makes informed decision making more difficult while simultaneously allowing plans and their agents to profit from the resulting fog of confusion which also hampers the ability of state regulators to protect beneficiaries.

This year, though, Congress and the Centers for Medicare and Medicaid Services (CMS) have made progress in their recognition of and efforts to address marketing misconduct in the Medicare marketplace. This year Congress passed the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and CMS has issued implementing regulations and clarifying guidance.¹ Many of the statutory and regulatory changes will improve beneficiary protections, but there are some

significant loopholes and/or exceptions to some of these rules, and it is yet unclear how other rules will be implemented. Some of these new rules are codifications of existing rules (e.g. a prohibition on unsolicited door-to-door marketing) that, in the view of those assisting Medicare beneficiaries, have been widely flaunted. Although the new rules will help, marketing misconduct continues. Above all, there remain ongoing systemic barriers to adequate oversight of the Medicare marketplace; federal preemption still plagues the regulation of Medicare Advantage and Part D plans by hindering or even preventing action at the state level, as does sporadic oversight and enforcement actions at the federal level.

This brief will explore these barriers, as well as review some of the changes in marketing rules implemented in 2008 by identifying strengths, weaknesses, and room for improvement. This brief is organized as follows:

- Part I provides a brief overview of changes to the regulation of the Medicare marketplace in the last couple of years;
- Part II explores unresolved systemic issues that prevent adequate oversight of marketing in the Medicare marketplace: federal law that preempts state authority; and the lack of adequate enforcement and oversight at the federal level;
- Part III analyzes selected new marketing rules, including their shortcomings;
- Part IV provides recommendations to better protect consumers from marketing abuses;

- Appendix 1: is an update on Medicare Advantage “Gap” Plans (following-up on an issue brief on the subject drafted by California Health Advocates in November 2007),² along with a couple of examples of ongoing marketing of these products to agents; and
- Appendices 2 and 3 are examples of marketing documents referenced in the text.

Background

The roll-out of the Part D prescription drug benefit in January 2006 coincided with an overall increase in the payment made to private insurance companies that offer Medicare Advantage (MA) plans through Medicare Part C (formerly known as Medicare+Choice). These new profit vehicles for plan sponsors and their contracted agents spawned an epidemic of misconduct surrounding the sale of Part D and MA plans not seen in Medicare since before Medigap plans were standardized.³ Medicare beneficiaries and consumer advocates have reported numerous cases of people being enrolled in plans without their knowledge and/or through deception, lies and misleading promises.⁴ Media reports about marketing misconduct grew and Congress began to hold hearings on the subject.⁵

Advocates and others argued that CMS was slow to both acknowledge and respond to the growing epidemic of misconduct in the marketing of Medicare private plans.⁶ Following pressure from Congress, consumer advocates, state regulators, and the media, CMS responded with new guidance for Medicare Private Fee-for-Service (PFFS) plans, and, in June 2007, seven PFFS plan sponsors announced a brief and voluntary suspension of marketing activities which was lifted prior to the 2007 Fall selling season.

To its credit, CMS subsequently developed a set of proposed rules issued in May 2008⁷ that made improvements to consumer protections, many of which were later adopted and codified in the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA). MIPPA, enacted in July 2008 following an override of President Bush’s veto, made additional changes to MA and Part D marketing rules (including some new rules as well as codification of existing rules).⁸ Pursuant to MIPPA, CMS issued a series of final and interim rules, along with additional guidance on marketing issues for the 2008 AEP.⁹

Some of the concepts in this brief are derived from comments to CMS’ May 2008 Notice of Proposed Rule Making drafted jointly by several consumer advocacy organizations, each of which submitted comments separately.¹⁰ Additional comments are drawn from the work of the National Association of Insurance Commissioners (NAIC) Senior Issues Task Force, Medicare Private Plans Subgroup, in which CHA participated,¹¹ resulting in a White Paper on The Regulation of Medicare Private Health Plans (adopted October 2008)¹²

II. UNRESOLVED SYSTEMIC PROBLEMS: LACK OF ADEQUATE FEDERAL ENFORCEMENT & FEDERAL PREEMPTION OF STATE AUTHORITY

Over the last year there have been some significant improvements to consumer protections in the Medicare marketplace, however we believe that serious problems will persist as long as the following barriers remain: the lack of adequate federal oversight and enforcement over Medicare plans by CMS; and federal preemption of state jurisdiction over Medicare private plans. We address each of these issues in turn.

Lack of Adequate Federal Enforcement

As referenced above, we believe CMS was slow to acknowledge and respond to marketing misconduct surrounding the sale of Medicare private plans. To its credit, it has changed both its rules and rhetoric surrounding consumer protections and the need to hold agents and plans accountable for their actions. In our view, though, these improvements are not enough to adequately police the Medicare marketplace.

2008 AEP SURVEILLANCE

Along with the roll-out of new marketing regulations and guidance, CMS has announced a program to enforce the new marketing regulations during the current Medicare Annual Coordinated Election Period (AEP).¹³

The 2008 AEP marketing surveillance strategy applies to private insurance companies, agents and brokers, and downstream entities. CMS has created a three-prong surveillance strategy to “detect, prevent, and respond” to marketing violations.¹⁴ The three prongs are:

- Communication
- Surveillance
- Compliance and Enforcement

The first prong of CMS’ new strategy is Communication – CMS communication with MA and PDP plans via marketing regulations, guidance documents, press releases and Health Plan Management System (HPMS) memoranda is the primary mechanism used to outline the rights of beneficiaries and the responsibilities of plans under the new MIPPA marketing provisions.

CMS is also turning to “state partners” for key communications (see discussion of federal preemption below), and is looking for opportunities to work with beneficiary advocates as well. We believe that this is an improvement over previous years when State Health Insurance Assistance Programs (SHIPs) and other advocates often found their attempts to report and resolve marketing violations thwarted due to a lack of enforcement processes at

the federal level. It is unclear, though, if SHIPs and other advocates can follow up and be told exactly what enforcement action by CMS was taken pursuant to a particular complaint. It would be helpful if advocates and those working directly with Medicare beneficiaries knew the result of their efforts to communicate events or possible violations to CMS. The responsibility for rectifying the mess that abusive marketing and enrollment creates often falls upon these entities as Medicare beneficiaries turn to SHIPs and others for assistance. SHIPs and other advocates deserve a clear set of expectations and transparent processes to ensure that they are using their already limited resources in the most judicious manner possible to assist beneficiaries, and to know the outcome of the abuses they report.

The second prong of CMS' new strategy is Surveillance – CMS will cast a “wide net” by hitting all contracted MA and PDP plans in all 50 states “at least once for the high risk plans.”¹⁵ Surveillance activities (referred to as “horizontal surveillance activities”) include secret shopping of marketing events; calling plan call centers to ensure that the information they’re providing is complete, understandable, and accurate; and using a clipping service (which monitors online, print and broadcast media for specific content). From this “horizontal surveillance” CMS will identify plan outliers to be targeted for a more intensive “vertical surveillance.”

The thought of each plan receiving some kind of scrutiny “at least once” unless results merit further attention is by almost any measurement woefully inadequate, and highlights the lack of adequate resources devoted to oversight at the federal level. This is akin to having one highway patrol officer cruise the 797 miles of Interstate 5 in California from Mexico to the Oregon border each day. More often than not, each plan selling a product in a given service area often has multiple events conducted by a number of different agents and entities, and each event is an opportunity for plans and agents to skirt marketing rules and/or provide bad information. For example, in the Fall of 2007, CMS sent secret shoppers to 240 marketing events and found inaccuracies or omissions in three-fourths of the sales presentations.¹⁶ Not only should the activities of each plan (and those that sell them) be reviewed more than once, there should be regular, ongoing monitoring at multiple levels. It is important to note that CMS has no method to obtain and verify licensing information on the agents or other entities soliciting consumers within a state for the sale of an insurance product at one of these sales events.

The use of clipping services may help CMS monitor marketing and sales events that are publicized in major publications. We have witnessed that CMS Region IX, for

example, has been quite responsive of late with respect to following up on non-compliant plan advertisements in California that have been brought to their attention. But, if history is an adequate predictor, the most egregious marketing violations will remain undetected because they are not advertised in major publications, but instead are very local and usually designed and produced by agents – e.g. flyers posted at senior centers or residence facilities, stuffed into local newspapers or newsletters, left on car windshields, left in the mail of residents living in mobile home parks, etc. – far out of reach of clipping services (see example in Appendix 3 below).

The third and final prong of CMS' new strategy is Compliance -- plans are expected to be proactive and fix the activities in violation of CMS' regulations as identified in CMS' compliance actions. All of the information collected through surveillance activities is used to build a case for Corrective Action Plans (CAPs) and enforcement measures, and immediate compliance action or additional surveillance can result.

While we applaud CMS' efforts to impose more oversight – and would like to see it successfully implemented – the organization's efforts to date have fallen short, given the level of unpunished misconduct witnessed by Medicare beneficiaries, consumer advocates, and state regulators. Although marketing violations began in earnest in 2006 with the roll-out of Part D and the increased reimbursements to MA plans, there was a significant lag in federal action, and CMS has ultimately done little to actually punish wrongdoing plans, create effective deterrents to marketing misconduct, or to assist states in actions against agents.

CMS ENFORCEMENT ACTIONS

CMS posts information about Corrective Action Plans (CAPs) it imposes on plan sponsors which are a precursor to enforcement actions such as imposing civil monetary penalties and suspending marketing and enrollment activities.¹⁷ According to CMS' CAP Summary Report, of CAPs involving marketing requested by CMS in 2008, 20 are still open and 9 have closed (from 1/1/08 through 11/1/08).¹⁸

Although CMS seems to be increasing CAP activities, consumer advocates see the same actors, performing the same misdeeds, repeatedly without significant consequence. The following is an excerpt from a chart on CMS' website showing more serious Enforcement Actions (January 2006 – November 2008) starting from CMS' first marketing related action (in September 2007) through the present.¹⁹

| Organization Name | Contract Number (H=MA-PD; S=PDP) | Date Action Taken | Basis for Action | Action Taken | Status |
|-------------------|------------------------------------------|-------------------|-----------------------------|----------------------------------------|--------------------------------|
| Health Net | PDP (S5678) | 01/08/08 | Several Contract Violations | Suspension of enrollment and marketing | Sanction Lifted March 2008 |
| SDM HealthCare | MA-PD (H4009) | 12/07/07 | Several Contract Violations | Suspension of enrollment and marketing | Sanction lifted September 2008 |
| Chesapeake | PFFS (H7845) | 10/07/07 | Marketing Violations | Suspension of enrollment and marketing | Sanction Lifted Nov 2007 |
| Coventry | PFFS (H0846) | 09/07/07 | Marketing Violations | \$264,000 CMP | Resolved -Settlement \$190,000 |
| Humana | MA-PD (H1804), RPPO (R5826), PDP (S588)4 | 09/07/07 | Marketing Violations | \$75,000 CMP | Resolved Paid in full |

Following the imposition of a \$75,000 civil monetary penalty (CPM) levied against Humana in September 2007, CMS imposed a CPM against Coventry (reduced by \$74,000) also in September 2007, and suspended the enrollment and marketing of one plan for two months. Even assuming the subsequent enforcement actions against SDM HealthCare and Health Net were even partially related to marketing, CMS has not imposed any new enforcement actions against plans due to marketing misconduct since January 2008. This inaction flies in the face of the experience of consumer advocates and others, who see marketing abuses continue without meaningful punishment of the plans responsible for the sale of their products.

Even within the narrow scope of authority states retain as a result of federal preemption, state regulators have been far more aggressive in imposing meaningful punishment through monetary fines on plans engaging in misconduct in the Medicare marketplace.²⁰ For example, before CMS levied any sanctions against Medicare plan sponsors relating to marketing misconduct, one state regulator, Oklahoma Insurance Commissioner Kim Holland, was able to levy a \$500,000 fine against Humana in August 2007 for a violation of their state law by Humana's use of unlicensed agents, a fine that still totals more than all of CMS' marketing-related sanctions combined to date.²¹

In short, CMS' new enforcement strategies may provide a greater ability to report abusive marketing tactics and stronger communication, and hopefully better coop-

eration, between CMS and states. We hope that plan sponsors will be subject to improved and more rigorous targeted investigations which could lead to more meaningful enforcement actions including civil monetary penalties and suspension of enrollment and marketing activities. These well-intentioned efforts, though, will suffer as long as CMS continues to view plan sponsors as their "partners" first and foremost, instead of entities they are regulating in order to protect Medicare beneficiaries from misconduct. Enforcement of these new rules will be difficult to achieve, in part because of the loopholes in some of the rules, and in part because, as discussed next, state regulators – the best equipped to monitor and enforce rules against insurance companies – are still hamstrung by federal law.

Preemption of State Authority

Congress and CMS have made efforts over the last year to involve states more in Medicare regulation, including increased information sharing and requiring plan sponsors to adhere to state appointment laws. But, as discussed below, these efforts ultimately fall short of meaningful involvement by state regulators, whom are best equipped to monitor plan activity on the ground and punish misconduct.

FEDERAL PREEMPTION HINDERS ADEQUATE POLICING OF MEDICARE MARKETPLACE

The oversight and regulation of the Medicare marketplace continues to be hindered by a bifurcated regula-

tory system; plan sponsors and products are regulated under federal law, while sales of such products are regulated under state law. The separation of regulation and enforcement of the sales process from regulation and enforcement of the product and marketing activities creates a disjointed and often ineffective regulatory process. Federal preemption prohibits the application of state laws, including unfair trade practices, to the activities of plan sponsors thus denying states the ability to hold companies and sponsors responsible for the acts of their agents and other representatives.

The oversight of the Medicare Supplemental Insurance (Medigap) market is an example of an effective model of joint state and federal regulation. Companies, products, and selling agents are regulated by state law using minimum requirements established by federal law. The federal agency (CMS) defers to the experience and resources of state regulators for enforcement of these federal standards. This system also allows states to adopt additional consumer protections under state law that don't conflict with federal minimums and may be unique to a particular state's regulatory framework. This system has worked well over the last fifteen years, resulting in a dramatic reduction of abusive sales.

MA plan sponsors and their products, however, are generally exempt from all state laws, except licensing and solvency requirements, thus protecting these companies from state enforcement actions pertaining to their sales and marketing activities. State enforcement actions against agents selling the products of these companies may be compromised by a lack of cooperation by these plans, delaying or preventing states from taking appropriate steps to curtail marketing abuses. While sponsors may be required to report complaints they receive about an agent to the appropriate state insurance department, companies are left to decide the merits of each complaint and when, and if, punitive action will be taken. CMS may instruct companies to cooperate with states, but states have limited authority over those companies to require production of records or other data needed to investigate and take action against their paid producers (see discussion in next section).

An agent, unless he or she is an employee of a company, is likely to contract with several different companies, and be able to sell a wide range of insurance products in addition to MA and PDP products. A company receiving a complaint about an agent who is a high volume producer of its products may be reluctant to take action against such an agent but more than willing to correct any "mistakes" that have occurred as a result of that agent's actions. Even in the event that such an agent is fired by the company, or prohibited from selling the company's MA or Part D products, he or she can continue to sell MA and PDP products from other companies until such time as

the state insurance department can prove misconduct on the part of that agent, with or without the cooperation of the company whose products were sold. In fact, the action to fire an agent can be reversed at any time, or that agent may be able to continue selling that company's products through a Managing General Agent (MGA) contracting with that company, or through a third-party contracted with both the company and an MGA. (Also see discussion of the National Insurance Producer Registry (NIPR) below; without the use of this system, there is no way for CMS to effectively track agent movement between companies or in and out of these contracting arrangements.)

RECENT FEDERAL EFFORTS TO INCREASE ROLE OF STATES INSUFFICIENT

The role of states in the regulation of Medicare plans has increased somewhat due to recent changes in the law and CMS action. MIPPA requires each Medicare Advantage organization to only use agents and brokers who have been licensed under state law to sell MA plans offered by the MA organization. In the case where a state has such an appointment law, plan sponsors must abide by that law to allow a state to know who is authorized to sell a company's products. In addition, MIPPA requires each MA organization to "comply in a timely manner with any request by a state for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the state into the conduct of the agent, broker, or other third party."²² In an effort to involve states more in Medicare oversight, CMS now has a memorandum of understanding (MOU) with all 50 States (as well as D.C. and Puerto Rico) outlining "collaboration and information sharing."²³ These MOUs include communication strategies for CMS Regional Office/Department of Insurance (DOI) Liaisons as well as SHIP programs. CMS has also recently begun their first formal training with various departments of insurance to discuss CMS strategies for enforcement.

Despite these changes and CMS' insistence that states are "partners" in Medicare regulation, states still retain only minimal authority over plan activity and even some minor suggestions to improve overall regulatory efficiency have been summarily rejected by CMS. The NAIC White Paper notes that "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."²⁴ Agents moreover may sell the products of many different companies, making MA plans a minority of the products they sell for any particular company.

As discussed in the NAIC White Paper, states currently have regulatory systems in place to track agents (producers), including the National Insurance Producer Registry

(NIPR) Producer Database (PDB).²⁵ The PDB is “a central repository of producer licensing information” which is regularly updated and contains information such as producer demographics (including states in which the producer is licensed, authorized lines of business, license status, appointments terminations and regulatory actions).²⁶ Despite the value of this existing system with the potential to greatly improve the ability of both state and federal regulators to track and monitor agent activity, CMS does not require plans to use the NIPR number during sales of Medicare products, and has firmly rejected requests to do so stating “[W]e believe that States currently provide appropriate oversight, and have the necessary reporting mechanisms in place to track and monitor agent activity.”²⁷ This stance ignores the flaws created by federal preemption of plan activities, and leaves states hampered in their ability to proactively identify agents that could cause problems and/or allow CMS to closely monitor apparent “high risk” events based on any prior patterns or practices that constitute misconduct.

A market conduct examination of Humana by the Wisconsin insurance department found, among other things, that: “the company accepted 19 applications that did not identify the writing agent but only identified an agency name and internal agency number. The company was not able to provide the name of the writing agent [the agent that actually sold the plans] for the 19 applications.”²⁸ The mandatory use of the NIPR would have allowed Wisconsin to identify the agents involved in these sales.

In addition to the misconduct of individual agents, consumer advocates and state regulators have observed problems with marketing materials issued by plan sponsors, including plan materials that clearly violate state law with inaccurate and incomplete comparisons to individual state Medicaid programs. These are meant to entice individuals dually eligible for Medicare and Medicaid to enroll in plans and often result in access to care problems and new cost-sharing for this population. State insurance departments are nonetheless prohibited by CMS to apply state laws to plan marketing materials, even when materials that are distributed clearly violate their state laws.

In order to address the problem of plan materials that provide misleading state information, advocates have argued that states should have access to marketing materials created by plans. For example, in comments to the NPRM, advocates suggested that CMS should require plan sponsors to file marketing materials with state regulators, so that states will be able to differentiate between CMS-approved and unapproved material and take action accordingly. CMS, however, rejected this suggestion: “It is not necessary for plans to file marketing materials with

State regulators. All CMS approved marketing materials contain a unique material identification number. If anyone has a question about the legitimacy of plan marketing material, they can report it to CMS and it will be verified ...”²⁹ Although at first glance this argument may seem reasonable, a recent report by the Office of the Inspector General (OIG) highlights plan sponsors’ poor compliance with existing CMS rules concerning marketing materials. As reported by *Medicare Part D Compliance News*:

“Moreover, identification (ID) numbers from 45% of the reviewed materials failed to match the ID numbers in CMS’s system. Specifically, 42% of advertisements, 53% of comprehensive formularies, 40% of enrollment forms, 48% of pharmacy directories, and 51% of summary of benefits statements contained IDs that did not match the ID numbers in the agency’s Health Plan Management System (HPMS). OIG also found that 21% of the reviewed materials had IDs that did not follow the proper format.”³⁰

Finally, it should be noted that CMS has only provided implementing regulations and guidance concerning one of the two state-related MIPPA provisions meant to “Strengthen[...] the ability of states to act in collaboration with the Secretary to address fraudulent or inappropriate marketing practices.”³¹ While CMS has released regulations concerning the use of licensed agents and state appointment laws,³² the authors have found no similar discussion in CMS regulation, regulatory preamble, or guidance of the following MIPPA provision entitled “Compliance with state information requests”:

Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.³³

This provision requiring plans to cooperate with states is effective January 1, 2009, as are the new requirements concerning state appointment laws, but recent CMS publications do not discuss this provision, other than through possible indirect reference.³⁴ In addition, no instructions have been published to define “timely” nor has there been any clarification about what materials or information plans are required to make available to states concerning their relationship with an agent or other party.

State regulators have the relevant experience, willingness and ability to properly regulate Medicare plans sponsors; unfortunately, though, they currently lack the authority under federal law to do so.

CAN CMS KEEP UP WITH THE EVOLVING MEDICARE MARKETPLACE?

CMS, because of its relative lack of knowledge about and experience with the insurance marketplace, is still learning the business dynamics behind the actions of companies that contract with them to deliver Medicare benefits. Some companies easily anticipated the initial rush and momentum into private health insurance products in 2005, and the need to pay agents well to enroll people in those products and gain the necessary market share. Those companies contracted with CMS for two or more plans, usually a prescription drug plan (PDP) they used as their loss leader, allowing beneficiaries to remain in Original Medicare with a drug plan where they were comfortable, and a more profitable Medicare Advantage (MA) plan that could receive members from their PDP as premiums increased later and they were convinced to migrate out to a lower cost combination of coverage.

The growth in MA enrollments during the 2008 plan year may have come mostly from people moving from one plan to another within or between plan sponsors, not from Original Medicare into MA plans. This year sponsors of some of these plans may have far less need of an agent distribution channel and may instead concentrate on contacting their own members to migrate them between their various products, including (for some companies) into their Medigap products for those who choose, or are encouraged to return to Original Medicare. Since the current Medigap plans will be replaced with updated and reconfigured versions in June of 2010 due to changes in MIPPA, companies will have yet another reason in the 2009 AEP to contact their mem-

bers and explain the variety of choices available to them from their line-up of products in 2010.³⁵

Instead of using some of their current MA overpayments this year to reward agents enrolling people in their plans, companies can use those overpayments to set up call centers to discuss with their MA members the full range of their MA products, as well as Medigaps, for those members unhappy with the restrictions on their medical care, rising premiums and out-of-pocket expenses.

Commissions to agents this year have been cut back from previous years by new CMS requirements because companies found so many creative and unpalatable ways to reward agents who increased the company's market share in the first few critical years of the Part D program. The highest initial and renewal commission payments for the 2009 plan year may be from those companies needing to increase their market share to the critical tipping point where they can survive a cutback of the current overpayments, or to produce a member base they can contact about other coverage and products in future years.

These multi-year business strategies acknowledge a political fact that the new Congress will be forced to deal with physician reimbursements and may as a result also cut current overpayments to MA plans. Industry leaders will always be a few steps ahead of CMS and their ability to understand and react to current business situations. State regulators closer to the operation of the insurance marketplace are often quicker to notice and understand insurance changes and trends occurring in their state.

III. ANALYSIS OF SELECTED NEW MARKETING RULES

While MIPPA and conforming regulations and guidance have led to improvements in consumer protections, there are still some gaping exceptions, loopholes and questions of adequate monitoring that must be viewed in light of the ongoing systemic barriers of lack of federal enforcement and the federal preemption of state authority, discussed above.

The following section provides a critique of certain provisions contained in the new marketing rules (note that this is not an exhaustive analysis of all of the new rules). Some of these comments are culled from joint comments to CMS' NPRM submitted by several advocacy organizations.³⁶ For more analysis of CMS' NPRM, many provisions of which have subsequently been incorporated into MIPAA and implementing regulations, see CHA's comments to the NPRM.³⁷ In addition, there are new marketing provisions with which we agree that are not discussed

below, such as new rules regarding the provision of meals at sales events and the required inclusion of plan types in plan names as of 2010.

Prohibition on Unsolicited Contact

MIPPA prohibits any unsolicited means of direct contact with prospective enrollees, including soliciting door-to-door or outbound telemarketing, without the prospective enrollee initiating contact.

Elevating the current prohibition on unsolicited door-to-door marketing from guidance to regulation, as well as the expansion to other unsolicited means of direct contact, is a welcome improvement in consumer protection. If adequately enforced, this provision could help thwart agents who stake out hospitals, senior centers and accost people on the street. Violations of this rule, however, will be identified only when reported or otherwise discovered and tracked back to the product being sold and the sponsoring company. It will be difficult for consumers to identify an unsolicited contact, or know that they can or

should report it. Disputes will likely dissolve into “he said/ she said” arguments between offending agents and their prey. As a result, this provision will be nearly impossible to enforce, and places the responsibility of investigation and enforcement with the plan sponsor, thus weakening any deterrent effect the law may have. States applying state laws to a licensed company have much greater potential to take necessary investigative and enforcement action.

DOOR-TO-DOOR MARKETING

Although CMS guidelines already prohibited unsolicited door-to-door sales prior to codification in MIPPA and implementing regulations, this practice is still occurring with little visible consequence to agents or plans sponsors, in part because it is difficult to track and it is under-reported by victims (and is more than likely a “he said/ she said” situation – e.g., “She asked me to come see her,” “no I didn’t,” “yes you did you just forgot...”). In comments to the NPRM (as well as the NAIC White Paper), advocates stated that in order to effectively curb this practice, CMS must take affirmative steps in addition to placing this prohibition in regulation. We proposed that CMS implement reporting requirements that enable plans and CMS to identify and prevent unsolicited door-to-door sales; all in-home enrollments should be flagged, and agents should be required to document how an invitation for an in-home presentation was secured. Further, since in-home sales are more prone to abusive sales practices, plans must be required to document how agents arrange for each in-home sale, and that information should be audited by CMS and, if appropriate, state regulators. This would be easier to track if agents were required to use their NIPR number on everything the agent used, including business cards, plan applications, etc. (see discussion of NIPR numbers above).

In the NAIC White Paper, CMS responded to this argument by noting that: “CMS Marketing Guidelines already prohibit door-to-door sales. Implementation of this recommendation would be so burdensome as to be impractical and thus ineffective.”³⁸ In the preamble to final regulations, though, CMS indicates that it will consider additional guidance in the next Marketing Guidance update. CMS notes: “However, organizations should have internal reporting requirements established to maintain appropriate oversight of these and all marketing activities.”³⁹ This statement suggests that CMS will continue to allow plans to largely self-police their own activities. While an internal mechanism can be in place, and should be, it cannot replace oversight and enforcement action by CMS or state regulators. The ability to flag abusive marketing activities and rectify them after the fact differs significantly from systematic oversight and strict enforcement that can prevent the marketing activities from occurring in the first place.

While CMS now requires that the scope of a sales appointment to be agreed upon and documented in advance (see discussion below), this process appears prone to abuse, including forgery, or being filled out in advance and signed along with whatever else requires a signature (we note that as a general principle, disclosure notices cannot substitute for good laws or enforcement).

Abuses usually occur one at a time in a person’s home or in public spaces. There are seldom any witnesses, and often little physical evidence to prove an allegation of abusive sales practices. Seldom are beneficiaries even aware of an abusive practice until after the fact. Advocates and family members invest hours trying to unravel the resulting harm of enrollment into an inappropriate plan, and restoration or replacement of previous coverage. The flow of information about abusive practices when it is reported is often short-circuited by reporting to the wrong agency, or by an inability to accurately describe an action to the correct agency. The flow of information between state and federal agencies is often circuitous and unproductive for lack of appropriate documentation and/or inability to correctly and quickly link the offending parties (e.g, no NIPR number, no clear instructions for how to complain or what to include, too many “he said/she said” occurrences). All of the above illustrates the difficulty of a federal agency trying to enforce sales at the local level and the obvious ineffectiveness of these efforts on a nationwide basis.

APPROACHING IN COMMON AREAS

We applaud the intent of the new provision prohibiting agents/brokers from approaching beneficiaries in common areas such as parking lots, hallways, etc. It will be irresistible, though, for many brokers and agents to refrain from approaching people and this prohibition will be particularly hard to enforce. Agents can still set up a table prominently displaying free prizes in Wal-Mart near the pharmacy counter, or inside a Longs Drugs, CVS, or other place where medications are dispensed, and, as discussed below, even in the common areas of hospitals and medical groups.

OUTBOUND MARKETING CALLS

We appreciate the extension of this prohibition to include more scenarios, including calls to former members to market plans or products, and calls to confirm receipt of mailed information. We particularly applaud CMS for its clarifications in its recent guidance re: third party contacts, and the affirmative statement: “Any plan or its representative that accepts an appointment to sell an MA or PDP product that resulted from an unsolicited contact with a beneficiary regardless of who made the contact will be in violation of the prohibition against unsolicited contacts.”⁴⁰

With respect to third-party leads, though, there is no definition of “unsolicited.” Neither CMS nor state insurance

departments have any authority over third-party businesses that gather and sell leads. It will be nearly impossible for CMS to determine whether a lead being used by an agent is unsolicited, and it might not be defined as such if a consumer willingly returns something received in the mail and that returned information is subsequently sold and resold to agents.⁴¹

More importantly, CMS has created a gaping loophole for plan sponsors that greatly diminishes the scope of this prohibition, namely the allowance for plans to market other products they offer to their current enrollees. Note that MIPPA contains no articulated exceptions to the prohibition of unsolicited means of direct contact, although it does reference “prospective” enrollees.⁴² In regulations implementing MIPPA, CMS clarifies that this prohibition includes “outbound calling without the beneficiary initiating contact ... but does not include calling existing members.”⁴³ While it is clearly logical to allow plans to call their own members to conduct normal business related to the plan, we are greatly disappointed that CMS has

included in this exception efforts by the plan to market other products offered by the same organization (see, e.g., discussion re: Medigaps above).⁴⁴ Similarly, we are disappointed that CMS is allowing agents who enrolled a beneficiary into a plan to call that beneficiary while s/he is a member of that organization.⁴⁵

These loopholes foster the ability of plans to maximize enrollment in one type of product (for example, a Part D plan with a low premium) only to later try to convince their members to enroll in a more lucrative product (for example, an MA-PD) – a strategy known as “enroll and migrate.”⁴⁶ This carve-out apparently means that anyone enrolled in another insurance product offered by the same company (e.g. a Medigap policy, Part D plan or even life insurance, home owners, or auto policy by a subsidiary of the parent company, etc.) or returned a lead card in the past – or who has purchased a product sold by the same agent – could get unsolicited calls. Allowing such exceptions effectively guts this prohibition against unsolicited contacts, and should not be allowed.

COLD CALLING STILL A HOT TOPIC

A HICAP manager in California’s Central Valley reports the following (11/10/08): “I just got a call from a reputable health insurance broker. He wants to report a person in the area that is cold-calling, telling the beneficiary she WILL be at their door at a certain time and is there. She is selling PFFS either Health Net or Secure Horizons, or both, and threatens seniors that she will terminate their “Part Two” if they don’t sign up.”

A HICAP manager in rural Northern California reports the following (10/30/08): An agency representing [insurance company X] “has many agents under one district manager” and the “agents are “cold calling”, sometimes because a client may have contacted them a long time ago... or they are “following up”.... i.e. trying to get a new appointment. They were pushing short-term long-term care policies and Medigaps... but now they have an opportunity to promote MA and Part D.... [these agents have been] using heavy handed telemarketing for several weeks. ... Their lead statement is “I’m calling to let you know about the changes in Medicare benefits.”

A HICAP manager in California’s Central Valley reported that since the 2008 AEP started, she has heard of at least eight Medicare beneficiaries in her county that have received calls from people saying that they represent the Social Security Administration and want to come to their homes to discuss changes in Medicare. These calls appear to have been made by agents selling MA plans.

Prohibition on Cross-Selling

MIPPA prohibits the sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan. This, however, will not prevent agents from using Medicare as a means of getting through the door to sell other products. Using Medicare as the hook to sell other products is a long standing practice in the insurance industry. In those instances in which Medicare is used as means to sell other products, CMS regulations arguably may not have been violated since an agent might contend that there was no “intention” of selling an MA or PDP plan at all. The close connection between the federal Medicare program and commercial insurance companies often blurs the lines between the other types of insurance in the eyes of Medicare beneficiaries, particularly when one company or organization offers many different insurance products.

In addition, despite this prohibition, there remains the danger that other “medical” or “health” products that are unsuitable for individuals will still be sold during marketing sessions (see, e.g., discussion of limited benefit Medicare Advantage “gap” products in Appendix 1). In comments to the NRPM, advocates expressed agreement that agents should not be permitted to cross-sell non-health care related products during a sale of Medicare products, but pushed for the provision to be expanded to also bar cross-selling of all non-Medicare related health products, such as hospital indemnity, dread disease, catastrophic illness, nursing home benefits, accidental death, long-term care insurance, and other “health products.” We noted that consumers already face difficult decisions regarding their Medicare coverage options and should be allowed to focus on these diverse coverage options without the

UNSOLICITED MAILERS WITH “IMPORTANT MEDICARE INFORMATION”

Companies in the business of constructing and mailing lead generating solicitations commonly send out mailers that prompt recipients to respond in order to learn about Medicare, or changes to Medicare, as a hook to get in the door and sell something else. These mailers rarely mention Medicare Advantage or Part D plans. These companies are often neither insurance companies nor agents. Agents buy these leads, and at that point they are arguably unsolicited since the targeted consumer mailed them back.

While plan/agent mailings are allowed under current Medicare marketing rules, the type of mailing described here does not clearly articulate the attempt to generate leads and/or sell products. If a recipient responds to such a mailing by calling or writing to the mailing entity, and is then pitched a product (or at least an appointment to sell a product) is this an “unsolicited contact”? While recent CMS guidance states that “Third-parties may not make unsolicited calls to beneficiaries for non-MA and PDP products (for example, a ‘benefits compare’ meeting) and provide those contacts to plans for ultimate use as an MA or PDP sales appointment”, the guidance does not reference unsolicited mailings like this. Question: Are these types of unsolicited mailers prohibited under Medicare’s new marketing rules? We urge CMS to clarify that the scope of the current unsolicited contact rules include this type of beneficiary contact.

EXAMPLE – (See Appendix 2 for a reprint of the 2 page mailer discussed here.) A HICAP client in rural Northern California recently received an official looking mailer labeled “Medicare Information Update” -- “Important Document Enclosed – Open Immediately – Do Not Delay – Response Time is Limited.” The mailer had a detachable reply card with a check box: “Please see that I receive information on the 2009 changes to Medicare and the options available to me.” The text references MIPPA saying it has “changed the laws governing the Federal Medicare Program. These changes to Medicare have decreased the amount Medicare pays for your healthcare and increased the amount you are required to pay. However, you do have options that could save you money on your healthcare. For more information on these changes, how they personally affect you ... simply complete and return this post-paid card today...”

added complications of considering add-on health products, some of which may in fact duplicate some services covered by Medicare.

Scope of Appointments

In an effort to prevent Medicare beneficiaries from ending up in a product that they did not intend to enroll in, MIPAA requires advance agreement between the selling agent and the prospective enrollee regarding the scope of a sales appointment. Specifically, MIPPA states that “[s]uch limitation shall require advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement by the Medicare Advantage organization. In the case where the marketing appointment is in person, such documentation shall be in writing.”⁴⁷ While this provision aims to provide a new, minimal protection for beneficiaries, it would generally only protect individuals who are certain ahead of time what type of plan they wish to consider (e.g., “I want a Part D plan and I don’t want to talk about anything else”), and appears to be very easy for an agent to side-step by merely outlining the full range of Medicare products when setting up the appointment. Despite the limitations of this protection, though, CMS has rendered it all but meaningless through their subsequent guidance to plans and agents.

Although not required by MIPPA, CMS proposed, but later abandoned, a 48 hour cooling-off period during which additional lines of business not identified prior to an in-home appointment would require a separate appointment that could not be rescheduled until 48 hours after the initial appointment.⁴⁸ In its 11/10/08 guidance, CMS states that during a personal/individual appointment “when a beneficiary asks to discuss another product type, the agent must have the beneficiary sign a new Scope of Appointment form for the new product type and then may continue the marketing appointment. A new separate appointment is not required.” This deference to insurance agents effectively guts the 48 hour requirement, and can be easily manipulated by unscrupulous agents, circumventing the intent of the scope of appointment limitation altogether.

Similarly, CMS has effectively ignored MIPPA’s requirement of “advance agreement” and documentation “in writing” for in-person appointments. The language of the implementing regulation states that plans or their agents cannot “[m]arket any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary, and documented by the plan, prior to the appointment.”⁴⁹ In its 11/10/08 memo, CMS clarifies the requirements around written documentation by noting that the “documentation for personal/individual sales events must be in writing, in the form signed by the beneficiary, or a *recorded oral agreement* [emphasis added].”⁵⁰ In addition, the same memo notes that “[i]f it is not feasible for

the Scope of Appointment form to be executed prior to the appointment, an agent may have the beneficiary sign the form at the beginning of the marketing appointment.” In other words, if it is convenient for the agent, he can have the Medicare beneficiary sign the scope of appointment form in the presence of the agent in the high pressure in-home sales environment – precisely the scenario sought to be avoided.

Further, CMS’ revised Model Scope of Sales Appointment Confirmation Form (11/08) falls short of confirming beneficiary intent.⁵¹ The form only allows a choice between Part D products or Medicare Advantage plans collectively (including MA-PD, MA-only, HMO, PPO, PFFS, SNP, MSA and Cost plans). In addition, the form includes the following note in parentheses: “(Please note that an agent may also discuss a Medicare Supplemental policy with you.)” In other words, agents get a “freebie” or “gimmie” product to discuss, without prior beneficiary consent, making a mockery of distinctions between different “lines of business.” Additionally, while the form does require a beneficiary’s signature (or that of an authorized representative), and requires initials at the two boxes/choices instead of a check, unscrupulous agents will find it far easier to forge a person’s initials that already appear on the page than a signature (thus granting blanket permission to discuss the entire range of Medicare products). Unless a prospective enrollee retains a copy of such form, any subsequent disagreement about expressed beneficiary intent can easily devolve into a he said/she said morass (e.g., “I didn’t sign this – yes you did, you just don’t remember...”). Finally, we have heard – anecdotally – that CMS does not require agents to obtain more than one confirmation form if a prospective enrollee invites friends and neighbors over for a sales session.

Marketing in Health Care Settings

MIPPA and implementing regulations and guidance outline a prohibition on sales and marketing activities that are conducted in health care settings – areas where health care is delivered to individuals (such as physician offices and pharmacies), except in the case where such activities are conducted in common areas.

We agree that no marketing (sales activities, distribution/acceptance of enrollment forms) should occur in health care settings. The rules do allow, however, marketing in common areas. For example, during an NMTP call on September 25, 2008, CMS explained that an agent can set up a table in a hospital cafeteria, or a supermarket with a pharmacy, but people must approach the agent. As discussed above in the section on unsolicited contacts, we believe that this line will be easily blurred in practice and practically unenforceable. The temptation to initiate contact with prospective enrollees will be very hard to resist for many agents, and such conduct will very likely go unpunished. When is contact “unsolicited” – initial eye

contact, an informal “hello”? In addition, the presence of a small free gift is likely to bring people to a table and initiate discussion.

In comments to the NPRM, advocates argued that CMS should prohibit any sales, education and application collection at pharmacies in order to curtail marketing abuses occurring at pharmacies (or in close proximity to them). If pharmacies are located in larger retail stores, we noted, such activity should also be prohibited in any part of the retail store. CMS did not adopt this suggestion.

Cash or Other Monetary Rebates as Inducement for Enrollment

Previously an MA organization was not allowed to provide for cash or other monetary rebates as an inducement for enrollment. This prohibition has now been expanded to “cash, gifts, prizes, or other monetary rebates.”

Our experience shows that many agents pitch plan benefits in a manner that leads prospective enrollees to believe that they will receive cash or other monetary inducements if they enroll – for example, through pharmacy debit cards and/or Part B premium rebates. This practice appears to continue to be permitted under the new rules. While debit cards for over-the-counter pharmacy products may be benefits that are indeed available upon enrollment, consumer advocates note that many prospective enrollees interpret agents’ descriptions of such benefits as a cash benefit, and enroll in plans believing that they will receive, for example, \$20 cash every month (instead of a \$20 credit to apply towards over-the-counter items). We believe that agents and plan sponsors should be required to explain such benefits in a clear and comprehensive manner that explicitly informs prospective enrollees that such benefits are not monetary rebates being used as inducements to enroll.

Educational vs. Sales Events

We applaud CMS’ efforts to further clarify the distinction between sales and marketing events and the respective rules that apply. For the last few years, beneficiary advocates have reported numerous instances of agents and brokers offering to provide and/or advertising “educational events” about “Medicare changes” or “Medicare Part C” (or other similar general topics) at senior or disabled housing complexes or other facilities, only to end up distributing and collecting plan applications. Sales activities at these events have often led to mass enrollments of beneficiaries, which usually reflect insufficient time spent with each prospective enrollee to determine whether or not the particular plan is his/her best option. Advertisements for these events are often drafted and distributed by agents in their efforts to sell as many of these products as possible during a very short sales season. Plan sponsors may not have seen or even know of the existence of

LOCAL PHYSICIANS' GROUP PROMOTES EVENT BUT SCREENS ATTENDEES

Just prior to the current AEP, a HICAP manager in Southern California reported an advertisement for an event sponsored by a local independent physicians association (IPA) known to contract with Medicare Advantage plans. The event, called "Understanding Your 2009 Healthcare Options" and presented by a physician, advertised free flu shots and refreshments. The ad said: "Open to all Medicare eligible seniors" – clearly excluding those Medicare beneficiaries who are under 65 with disabilities. When the HICAP manager called to RSVP for the event, she was asked her date of birth, address, "current HMO", and whether she wanted a free flu shot; when she replied yes, she was told that they had to have her current HMO information as well as her doctor's name. Upon being alerted by the HICAP, CMS did follow up, and the IPA subsequently separated out its educational event from its sales event and advertised them, but the ads still violated CMS clarifications re: timing and location of sales and educational events together. We were informed that the IPA eventually cancelled the events altogether.

Agents sometimes approach facilities or community organizations and arrange for a lecture or other event in the common meeting area of a facility or community organization, or contact an individual in a facility who asks friends to attend a small group meeting. Each of these would escape notice by CMS unless reported. Note that we have encountered no events that have been scheduled exclusively for people with disabilities or that expressly include people with disabilities; conversely, events seem to be always focused on seniors even when the generic term "Medicare beneficiary" is used.

these advertisements (yet they benefit from any resulting enrollments). In spite of the fact that these advertisements are required to be approved by a plan, there are simply too many of them being generated by too many agents forced into a six week earnings period. Agents using these advertisements can not be disciplined under federal rules, and the advertisements they use are not subject to state regulation.

We appreciate CMS' clarification, and their efforts at policing this activity, but point out once again the regulatory difficulties of bifurcated enforcement and the inevitable gaps in that system. We would like to acknowledge that CMS Region IX has been particularly responsive to issues arising in California in the last few months concerning the advertising of plan/agent events and hope this vigilance and swiftness in response will continue.

As suggested in NPRM comments, we believe that plans and their agents should report both sales and educational events to CMS so that CMS and plan secret shoppers can be present and enforce the prohibition on marketing at educational events. This is likely to be an area where plans/agents will try to skirt the rules; further, it is easier to police notices and advertisements that are widely distributed, such as those published in a local paper (see, e.g., discussion re: federal enforcement above and CMS' use of a clipping service). Notices of events for smaller groups of people, such as those at a particular housing complex or senior center, are much more likely to escape regulatory notice (see example below).

Agent and Broker Training and Testing

MIPAA establishes a requirement for the training, annual retraining, and testing of agents, brokers and other third parties. Medicare Advantage organizations must use only individuals (as an agent, broker, or other third party representing the organization) that have completed an initial training and testing program, and annual retraining and testing program.

As expressed in comments to the NPRM, advocates are concerned that current training is not comprehensive enough and testing is not rigorous enough. Training should include how MA and Part D plans coordinate, if at all, with other kinds of insurance, such as Medigap, retiree and each state's Medicaid program where the plan's products are sold. Agents should also be trained about the dangers that beneficiaries might lose current coverage through other sources if they enroll in an MA or Part D plan. Further, agents should be trained with state-specific information, including, for example, eligibility for state-specific programs and Medicaid programs (including whether a state's Medicaid program pays coinsurance for MA plans to providers). Agents should also be trained in cultural competency, as well as how to address issues related to limited-English proficient beneficiaries, and beneficiaries with disabilities, including cognitive impairments.

In a similar vein, consumer advocates routinely find that plan call centers staffed by customer service representatives (CSRs) give out incorrect and incomplete information. Plans also should be required to ensure that their CSRs can perform at a minimum level.

Agent and Broker Commissions

MIPPA prohibits plans from using agent/broker compensation other than as provided under guidelines established by the Secretary. The Act directs that such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.⁵³ Implementing regulations include the requirement that plans submit to CMS their

AGENT FLYER ADVERTISING EVENT – SALES OR EDUCATIONAL?

Tenants in a mobile home park in California's Central Valley recently received flyers in their monthly rent statements advertising a "2009 Medicare Advantage Discussion" presented by a local insurance firm. The flyer, apparently not published anywhere, contains numerous violations of Medicare marketing rules, including:

- Has "Medicare & You" logo across the top, very similar to handbook of the same name
- The "2009 Medicare Advantage Discussion" is loosely billed as educational, but contains information about certain plans (without identifying them) by noting that MA coverage is "FREE", and has "\$0.00 premium"
- Includes note: "Who is Eligible for Medicare Advantage? If you are 65 years of age or older with Medicare Part A and B" – clearly excluding individuals under age 65 entitled to Medicare due to disability⁵²
- Notes: "Lunch will be served" despite prohibition on the provision of meals at sales events

This type of flyer – and the sales event itself – are not likely to be on CMS' radar. This highlights that CMS is not actually capturing or acting upon these activities in a manner that is dissuading plans or agents. Plans and agents continue to operate under a "fix it after (and only if) you are caught" approach. (Note that CHA contacted the insurance firm that issued this flyer, and they claimed that the event was cancelled, though we were unable to verify this. Nonetheless, we believe that this is an example likely duplicated across the county.) See Appendix 3 for a copy of the flyer referenced here.

compensation structures for the previous three years plus the compensation structure they are implementing for 2009. In addition, to discourage churning, CMS is requiring that plans pay renewal rate compensation in 2009 for all plan changes and that renewal commissions must be 50 percent of initial commissions, and be based on fair market value to avoid violating anti-kickback rules. Once CMS identifies that an initial compensation was warranted (in the instance of individuals newly eligible for Part D or Medicare Advantage), plans will retrospectively pay the agents and brokers an additional amount equal to the initial compensation rate filed with CMS.⁵⁴

We are pleased that Congress and CMS are seeking to regulate the compensation plan sponsors pay agents and brokers selling their products, since, as we have stated in earlier briefs, it is our belief that compensation paid to agents is a prime factor behind the epidemic of marketing

misconduct occurring since early 2006. CMS' efforts to address the issue of commissions, though, may be fighting the last war and not the current one. Companies may already have decided to focus on current members and migrate them to their most profitable plan. They may only need agents to pick up an increasingly smaller number of people willing to switch out of Original Medicare, or those who are newly eligible. Since companies can communicate without restriction with their current members they can lobby them to choose from among the company's own products, and they have the claims information to narrow or direct their choices. For instance, someone with high out-of-pocket costs who is currently in the company's MA-PD might be encouraged to move to their Medigap and Part D products at a higher monthly cost but with lower out-of-pocket costs and the flexibility to choose their providers. All current Medigap policies will be closed by June 30, 2010 when the new versions of the standardized policies will replace existing products allowing companies to increase premiums on existing policies and offer new ones at low introductory prices.

There are still wide swings between the commissions paid for Medicare Advantage enrollments, but the overall annual amounts are lower than the preceding years (in part due to new rules), and there seems to be little if any bonus activity. This reinforces the view that agents have become less important and migration between plans may be more important to the plan sponsors. Still, agents who have only six weeks to convince people to change their coverage, and another three months to convince them to switch into or out of an MA plan, will be working overtime to secure and maximize their annual income. The small if not insignificant commissions for PDPs clearly reveal where the profit lies for plan sponsors.

There are also some possible unintended consequences of the new compensation structure: agents with clients in higher compensation plans, in an effort to preserve their renewals may discourage review of the current year's plan benefits and encourage members to stay in what becomes an unsuitable plan. Conversely, agents seeking higher reimbursements may deliberately move existing clients in return for higher renewal commissions in subsequent years. This demonstrates the pitfalls of allowing companies to choose the amount of commission instead of establishing a standard or fixed commission for each type of plan. As long as plan benefits and costs continue to change on an annual basis, coverage stability will not be achieved, and sales will continue to be driven by the compensation agents can earn, and not by the best coverage for a Medicare beneficiary.

In order to truly minimize agent financial incentives to steer people to certain plans based upon their own financial gains, we believe that CMS should set a maximum dollar amount for all commissions for both MA and Part D plans. Absent establishment of a standard and level

commission for all such products, CMS should set a range of limited compensation and impose an overall limit. CMS actuaries have access to information necessary to enforce this through the plan bid process to create a level playing field.

INSURANCE AGENTS WEIGH IN ...

WELCOME to MEDICARE – Now Duck and Cover

Due to the restructuring of commissions, agents will clearly be focused on trying to obtain initial or first-year commissions. As noted by an agent posting on an agent online forum, “I learned today that MIPPA rules don’t apply to turning 65 leads because they don’t have Medicare yet. ... I almost feel sorry for these prospects - they are going to get hammered with calls and mail from agents.”⁵⁵

OLD DOGS & NEW TRICKS

We fear that too many agents/brokers will still operate with their pecuniary interests first, clients’ needs a distant second. Although clearly anecdotal – and certainly not applicable to the entire agent community – here is the thread of a recent post on an agent online forum (note that errors are in the original text):

“I just got Aetna’s new commissions and they’re par for the course, 450-225. But they are not retro-ing renewals so Im left with no choice but to move as many of these cases to AARP or Americhoice to get them on the new renewal scale. I just wish these company’s understood how an Agent works ...ughh and I thought I wouldn’t write a fresh piece of business this year. Is anyone else angling this way by keeping old business that adjusts to te new scale retroactively in that carrier and placing existing business that doesnt retroactive into new carriers to get to the new scale ?”

In response to another agent suggesting that this might constitute churning, the poster replies: “Nah, Im not doing anyone a disservice if they fit into AARP or Americhoice Im gonna move them. AARP has lower co-pays, dental, and a more extensive formulary. Americhoice is much more rich in benefits, life alert, OTC benefit, etc. I placed most people in Aetna for the bonuses they ofered anyway. And besides there’s no rules against churning, CMS is trying to lessen it.”

When the second agent continues to protest that this approach is based upon chasing bonuses, the poster states: “I got over 400 active cases in the last 2 years Ive had 1 single solitary complaint.”⁵⁶

IV. RECOMMENDATIONS & CONCLUSION

California Health Advocates, along with other advocacy organizations, has opined about the various causes of the epidemic of marketing misconduct surrounding the sale of Medicare Advantage and Part D products over the last three years. Among the root causes, we believe, are financial incentives that drive marketing abuses – payment to Medicare Advantage plans and, correspondingly, compensation paid to agents. As discussed above, CMS and Congress are attempting to address the issue of agent compensation, although it remains to be seen if current efforts will adequately curtail abuses. The issue of payment to MA plans may be taken up by the next Congress and the incoming Obama Administration.⁵⁷ Leveling MA payment to that of fee-for-service providers, we believe, is certainly a step in the right direction to reduce unscrupulous plan behavior and secure Medicare’s financial footing.

Even with such actions, though, we believe that several significant structural changes must be made to the Medicare program and the manner in which it is regulated in order to both effectively combat marketing abuse and put the Medicare program on the right course for those it is designed to serve. As raised elsewhere, we recommend the following major changes to the program:

- Standardize Medicare Advantage and Part D plan benefits – as we argued in a joint issue brief with the Medicare Rights Center titled “Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans” (September 2007).⁵⁸ MA and Part D plans should be standardized in order to provide true, meaningful distinctions between plans that would enable beneficiaries to make informed decisions about how they wish to access their health coverage. The sheer number of plans, plan designs, and details are overwhelming and preclude Medicare beneficiaries from making the right choice of coverage for their own unique financial and medical situation forcing reliance on more knowledgeable sources including agents.
- Allow the Original Medicare program to administer the Part D prescription drug benefit, instead of forcing Medicare beneficiaries to purchase coverage through the private market. As it stands now, the private sector is delivering social insurance benefits at an increased cost to taxpayers, and creating beneficiary confusion combined with increased administrative costs of plan sponsors and all down stream participants.
- Congress should allow states greater authority over plan marketing activities so that they can, among other things, more closely tie agent/broker oversight to CMS marketing and plan oversight.⁵⁹

In addition to these broad structural changes, as well as comments made throughout this brief, we offer the following general recommendations concerning the regulation of the Medicare marketplace.⁶⁰

- 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, e.g. after a sales presentation). Mass enrollments at sale 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 agents. When multiple enrollments are made at one event over a short period of time, there is often insufficient time for agents to explain products to and answer questions from individual enrollees.
 - Plans should monitor monthly enrollment figures for individual agents in order to ensure that high production does not indicate a failure to adequately explain suitable coverage options to consumers. Commissions, production bonuses and other compensation offered by
- plan sponsors create incentives for agents to maximize sales volumes, but high monthly enrollment figures may signal unsuitable sales. Plan sponsors need to monitor high volume agents and agencies to ensure that they are following the plan sponsor's suitability guidelines and Medicare marketing rules.
 - Prospective enrollees should be presented with other options to learn about their full range of Medicare-related plans, such as SHIP counselors. MA and Part D sales should follow existing Medigap rules concerning disclosure requirements and referrals for counseling assistance (see, e.g., NAIC Model to Implement the NAIC Medicare Supplemental Insurance Minimum Standards Model Act, Section 18A). SHIP information should be included on all marketing materials, and agents should know and provide information on the name, location, and phone number of the local SHIP.⁶¹
 - Develop suitability standards for the sale of all Medicare private plans with special consideration to the marketing of PFFS plans, SNPs and other MA plans to dual eligibles.⁶²

APPENDIX 1: MEDICARE ADVANTAGE “GAP” PRODUCTS – A REGULATORY NOD VS. SHOVE

In November 2007, California Health Advocates (CHA) released an issue brief exploring the rise of Medicare Advantage “gap” products, which are individual cash benefit or fixed payment insurance products marketed to insurance agents as a “wrap-around plan” designed to fill in the gaps in Medicare Advantage plans for their clients.⁶³ These products are designed to pay cash benefits directly to enrollees of MA plans to mitigate the out-of-pocket costs imposed by their MA plan. Among other things, we argued that the presence of these plans is a symptom of a larger disease in the Medicare Advantage program – that many MA plans appear to be shifting greater costs onto enrollees, some even in excess of what they would pay in Original Medicare.

Medicare beneficiaries are often led to believe that Medicare doesn't cover illness such as cancer and other dread diseases in the same way other health services are covered, or that they will have enormous out-of-pocket expenses if they are hospitalized. As a result they can be convinced to buy additional benefits to cover a wide variety of potentially expensive medical costs. Insurance companies have long been able to exploit consumer ignorance about Medicare coverage, and individuals' fears about the high cost of medical care in general, and, more recently, the high cost sharing imposed by some MA plans. Over the years insurance companies have developed specific insurance products to pay cash benefits for bits and pieces of health care costs, such as ambulance

trips, hospital days, or accidental injury. These products can be sold separately at small premium cost, or more recently bundled together into an attractive package of benefits—such as the “gap” products referenced here—to provide coverage for expenses imposed by an MA plan. In some cases these benefits may actually duplicate other benefits to which a beneficiary is entitled to because of other primary coverage.

These cash or fixed benefit policies pay benefits regardless of whether Medicare also pays. The anti-duplication rules contained in 42 USC §1395ss(d)(3)(A)(i)(IV), actually exempt health insurance “...that pays benefits regardless of other health benefits...”⁶⁴ As a result the NAIC Model Regulation for Medigap policies contains 14 different disclosure notices that are required to be used in the sale of any of these products to someone with Medicare. While CMS regulations at 42 CFR §403.205(a)(2) describe Medigap as a policy that “is primarily designed, or is otherwise purported to provide payment for expenses incurred for services and items that are not reimbursed under the Medicare program because of deductibles, coinsurance, or other limitations under Medicare” these “gap” products pay in addition to Medicare and are marketed to people with and without Medicare benefits, avoiding the “primarily designed” requirement.

Section 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) attempted to clarify that “[a]ny health insurance policy that provides reimbursement for expenses incurred for items and services for which payment may be made [by Medicare] but which are not reimbursable by reason of the applicability of

deductibles, coinsurance, copayments or other limitations imposed by a Medicare Advantage plan (including a Medicare Advantage private fee-for-service plan) under Part C [of the Medicare statute] shall comply with the requirements of section 1882 (o) of such Act (42 U.S.C. 1395ss(o)).” (Section 1882(o) refers to rules that apply to the sale and structure of Medicare Supplemental Insurance policies (aka Medigaps).)

Federal law under MIPPA appears to require any insurance product sold expressly to supplement MA plans to be regulated as a Medigap policy. Insurance products so marketed and sold must comply with state rules for Medigap policies, or cease being marketed and sold. Unfortunately, the law misses the target. Insurance companies can find many ways to design their products to escape these rules by simply unbundling these small pieces of insurance coverage, and ceasing to market them as a supplement to a Medicare Advantage plan. The private market for insurance products remains malleable, and in the absence of legislative changes to the anti-duplication rules MIPPA alone will not prohibit the sale of these cash benefit policies to people in MA plans or in Original Medicare. However, states now have the ammunition to regulate any product that a company continues to bundle and market to pay the out-of-pocket costs imposed by Medicare or MA plans.

We believe that CMS should ask the National Association of Insurance Commissioners (NAIC) to survey their member states and find out which states allow the sale of these products, determine how these products are being regulated, determine if these are being sold to supplement Medicare benefits, and make the results available to CMS.

CMS should study the MIPPA rule and the anti-duplication rules and issue a bulletin to state insurance departments advising them of how these products should be regulated and the standard for determining which products meet the standards described in MIPPA and should therefore be regulated as a Medigap policy.

Without clear direction from the federal government it is unlikely that the sale of these products to Medicare beneficiaries will cease anytime soon.

EXAMPLE: ONE “GAP” SPONSOR STILL GOING STRONG ...

Guarantee Trust and Life Insurance Co. (GTL) was one of the plan sponsors offering these “gap” products identified in CHA’s brief. It appears that GTL is not slowing down. In a recent email alert to agents/brokers, GTL announced its “ADVANTAGE PLUS Bonus Program” that declares, in order to thank agents for all of their business, “we are pleased to announce an Advantage Plus Bonus Program where you can earn a bonus of up to \$15 per application!” (See Appendix 1A.) The announcement then explains how agents can take advantage of this program, by submitting Advantage Plus applications between October 20, 2008 and March 31, 2009 to get a bonus (5 to 20 applications yield a \$5 application bonus, 21-50 a \$10 bonus and 51+ a \$15 bonus per application; in addition, agents can earn points to help them qualify for the 2009 “Soaring to New Heights” Sales Convention at the Resort at Pelican Hill in Newport Beach, CA).

These are the same sales incentives promoted by MA and Part D plans during the last few years that led to recent improvements to marketing rules. However, this GTL promotion flaunts these new guidelines applicable to agents selling Medicare Advantage and Part D plans, even though MA enrollees are clearly the target of such efforts.

APPENDIX 1A: MEDICARE ADVANTAGE "GAP" PRODUCTS: EXAMPLES

Announcing GTL's ADVANTAGE PLUS Bonus Program!

A few years ago when the Medicare Advantage market was in its infancy, GTL worked closely with its **valued field partners** to be the first to introduce an innovative, cutting-edge product designed to fill a variety of co-pays, deductibles and coverage gaps from your clients health plans.

Today, because of your hard work, GTL's Advantage Plus product has become *the* leader in the market. Based on your feedback, Advantage Plus has helped many of you solidify **relationships** with your clients, generate Medicare Advantage sales you would have otherwise lost, and improve client loyalty.

Over the past year, there have been many attempts to copy our **innovative** plan, but with your help, Advantage Plus continues to stay ahead of the competition!

**TO THANK YOU FOR ALL OF YOUR BUSINESS,
WE ARE PLEASED TO ANNOUNCE AN ADVANTAGE
PLUS BONUS PROGRAM WHERE YOU CAN EARN
A BONUS OF UP TO \$15 PER APPLICATION!***

Here's How:

Submit Advantage Plus Applications between Monday, October 20, 2008 and Tuesday, March 31, 2009, and you'll get a bonus!

- * Submit 5 to 20 applications during the period and receive a \$5 per application bonus
- * Submit 21 to 50 applications during the period and receive a \$10 per application bonus
- * Submit 51+ applications during the period and receive a \$15 per application*

REMEMBER, you will also earn 1.5 points for every dollar of Advantage Plus annualized premium issued, which will help you qualify for the 2009 "Soaring to New Heights" Sales Convention!

To learn more, contact your FMO or GTL directly at 800.323.6907 or agency@gtlic.com.

Applications must be submitted during the contest period and issued, paid for and in force as of April 30, 2009 to qualify. Bonus will be paid on May 1, 2009.

gtlagentportal.com

• GTL's NEW Website for Agent Use Only •

Soaring to New Heights

GTL's 2009 Sales Convention • The Resort at Pelican Hill
www.gtlcshill.com

[GTL Home](#) [About Us](#) [Products & Services](#) [Customer Service](#) [Agent Connection](#) [Contact](#)

THIS AGENT-SPECIFIC E-MAIL HAS BEEN SENT TO YOU COURTESY OF

GTL

1275 N. Milwaukee Ave. Glenview IL 60025-9954
Life & Health Sales 800.323.6907

G.T.L. INSIDER

The News... The Products... The Possibilities... YOUR SUCCESS IS OUR FOCUS!

Check out our portfolio of simplified, yet issue products!



[Get! View Links? Go Here](#)

**Did your MA carrier increase its copays this year?
Then Look to GTL's Advantage Plus Product!**

With the recent changes in Medicare Advantage copays and deductibles, why not increase your commissions?

During Open Enrollment, it's a great time to look at GTL's Advantage Plus product! Advantage Plus can help to fill some of the copayments, deductibles and gaps in coverage. Adding an Advantage Plus plan can solidify your MA sales and enhance your relationship with clients. You can also generate substantial additional income with a product known for its outstanding renewal rate!

Also, you may have recently received our **brand new Advantage Plus "Biz" Disc** in the mail! This disc provides a comprehensive product package including a training presentation, Advantage Plus software, appropriate state-specific forms, and more. If you have not yet received a training disc, please contact us at (800) 323-6907 or email us at agency@gtlic.com.

Our **Advantage Plus bonus program** continues! When you write Advantage Plus applications now through March 31, 2009, you can earn a bonus of up to \$15 per application.* Plus, you earn 1.5 points for every dollar of Advantage Plus annualized premium issued, which helps you qualify for the 2009 "Soaring to New Heights" Sales Convention.

Qualifications:

- Submit 5 to 20 applications during the period and receive \$5 per application bonus
- Submit 21 to 50 applications during the period and receive \$10 per application bonus
- Submit 51+ applications during the period and receive \$15 per application bonus

Applications must be submitted during the contest period and issued, paid for and in force as of April 30, 2009 to qualify. Bonus will be paid in May 2009.

Soaring to New Heights

GTL's 2009 Sales Convention • The Resort at Pelican Hill
www.gtlcshill.com

gtlagentportal.com

• GTL's NEW Web Site for Agent Use Only •

APPENDIX 2: "MEDICARE CHANGES" MAILER

IMPORTANT
2009 CHANGES IN MEDICARE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law No. 108-173) and the Medicare Improvements for Patients and Providers Act of 2008 (Public Law No. 110-275) have changed the laws governing the Federal Medicare Program.

These changes to Medicare have decreased the amount Medicare pays for your healthcare and increased the amount you are required to pay. However, you do have options that could save you money on your healthcare.

For more information on these changes, how they personally affect you, and the options you have on your healthcare, simply complete and return this postage-paid card today. There is absolutely no cost or obligation for this information.

MASP_G_V2

IMPORTANT - PLEASE VERIFY ADDRESS ON OTHER SIDE OF REPLY CARD. NOT CONNECTED WITH OR ENDORSED BY THE US GOVERNMENT OR ANY STATE AGENCY.



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 1 MCCORDSVILLE IN
POSTAGE WILL BE PAID BY ADDRESSEE

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



**Detach here
And
mail today!**

Important Information For Medicare Beneficiaries
Open Immediately - Do Not Delay
Response Time is Limited

Please see that I receive information on the 2009 changes to Medicare and the options available to me.

Name _____ Age _____
Spouse _____ Age _____
Phone (____) _____

FOR DEPARTMENT USE ONLY

MASP_G_V2

APPENDIX 3: AGENT FLYER ADVERTISING SALES EVENT



Medicare & you

**Residents are invited
To
The 2009 Medicare Advantage
Discussion presented by
3 PM Friday Nov 14, 2008
At The Clubhouse**

What is Medicare Advantage?
Medicare beneficiaries have the option of enrolling in Medicare Advantage—the program through which private plans participate in Medicare—rather than receiving their care through the FFS program. They may choose to do so because such plans provide additional benefits beyond those available within traditional Medicare, including coverage for services not covered by FFS Medicare (for instance, dental services) and cash rebates of premiums or reduced cost-sharing.

This coverage includes your prescription drug coverage, doctor visits, and dental. The best part about it; **ITS FREE!!!!**

- \$0.00 premium
- Doctor visits / Emergency
- Dental

Who is Eligible for Medicare Advantage ? If you are 65 years of age or older with Medicare part A and B.

Lunch Will Be Served

Insurance Services
Fresno, CA

- 1 Public Law 110-275; also see “Background” section of this brief.
- 2 See CHA issue brief “There’s a Hole in the Bucket: New “Gap” Product Being Sold to Fill-in Medicare Advantage Deficiencies” (November 2007) at : <http://www.cahealthadvocates.org/advocacy/2007/theres-a-hole.html>.
- 3 Medigap plans were standardized pursuant to the Omnibus Budget and Reconciliation Act of 1990 (OBRA), Pub. Law 101-508.
- 4 See, e.g., California Health Advocates (CHA) and the Medicare Rights Center (MRC) joint issue brief entitled “After the Gold Rush: The Marketing of Medicare Advantage and Part D Plans” (January 2007) at: http://www.cahealthadvocates.org/_pdf/advocacy/2007/AfterTheGoldrush.pdf.
- 5 See, e.g., Senate Finance Committee (2/7/08: <http://finance.senate.gov/sitepages/hearing020708.htm> , 2/13/08: <http://finance.senate.gov/sitepages/hearing021308.htm>), House Energy & Commerce Oversight Subcommittee (6/26/07: http://energycommerce.house.gov/index.php?option=com_content&task=view&id=644&Itemid=95), and House Ways & Means Health Subcommittee (5/22/07: <http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=561>).
- 6 See, e.g., follow-up issue brief drafted jointly by CHA and MRC entitled “The Reluctant Regulator: Centers for Medicare and Medicaid Services’ Response to Marketing Misconduct by Medicare Advantage Plans” (July 2007) at: <http://www.cahealthadvocates.org/advocacy/2007/reluctant.html>.
- 7 CMS’ Notice of Proposed Rule Making (NPRM) -- (CMS 4131-P), 73 Fed Reg 28556 (May 16, 2008).
- 8 See MIPPA section 103.
- 9 CMS issued: Final Rules (CMS 4131-F) – 9/15/08, Interim Final Rules (CMS 4138-IFC) – 9/15/08, Interim Final Rule (re: commissions) (CMS 4138-IFC2) – 11/14/08, and additional guidance, including Guidance for regulations in CMS 4131-F and CMS 4138-IFC (9/15/08), Clarification of guidance for regulations in CMS 4131-F and CMS 4138-IFC (10/8/08) – (rescinded on 10/24/08), 2nd Group of Marketing Questions for regulations in CMS 4131-F and CMS 4138-IFC (10/17/08), Special Notice on Compensation Structure Requirements (10/24/08), and Guidance for marketing requirements re: unsolicited contacts, employer/union group plans, scope of appointments, and other marketing provisions (11/10/08).
- 10 (NPRM - CMS 4131-P). See July 15, 2008 comments to the NPRM posted on CHA’s website at: http://www.cahealthadvocates.org/_pdf/advocacy/2008/CHA-comments-regs-0708.pdf); organizations that contributed to these comments include CHA, Center for Medicare Advocacy, Inc., Health Assistance Partnership, Medicare Rights Center, and the National Senior Citizens Law Center.
- 11 CHA participated in the Senior Issues Task Force, Medicare Private Plans Subgroup with state regulators, CMS, insurance industry representatives, other advocates and interested parties (CHA primarily submitted joint comments during this process with the Center for Medicare Advocacy, Inc., and the Medicare Rights Center).
- 12 See NAIC website at: http://www.naic.org/documents/committees_b_senior_issues_medpp_white_paper_final.pdf.
- 13 See, e.g., National Medicare Training Program (NMTP) Teleconference October 28, 2008 – materials available at: http://www.cms.hhs.gov/NationalMedicareTrainingProgram/10_Audio_Conference_Training.asp ; also see discussion on 2008 Annual Election Period Marketing Surveillance slides and discussion with Michael Kavouras, Acting Director Division of Medicare Advantage Operations, CMS. Specifically slides 45-63 and pages 28-45 of the call transcript.
- 14 CMS NMTP Call – 10/28/08, transcript, pp. 29-30.
- 15 CMS NMTP Call – 10/28/08, transcript page 33.
- 16 “States Look to Rein in Private Medicare Plans” by Robert Pear, *New York Times*, 5/5/08.
- 17 See regulations addressing “intermediate sanctions” including civil monetary penalties and suspension of enrollment, payment and marketing at 42 CFR §422.750, et. seq. and 42 CFR §423.750, et. seq.
- 18 See CMS website at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/Downloads/CAP_Summary_Report.pdf (updated 11/1/08; viewed 11/23/08).
- 19 See CMS website at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/Downloads/Enforcement_Actions_Web.pdf (viewed 11/23/08).
- 20 See, e.g., “Humana pays \$750,000 to Resolve Complaints” by Ryan Foley, AP, *HTRNews.com*, 9/11/08, describing Wisconsin’s Office of Insurance Commissioner’s forfeiture assessed due to “numerous problems with the company’s marketing of Medicare products, its handling of claims and underwriting” as well as the use of unlicensed agents; also see Press Release issued by the Illinois Department of Financial and Professional Regulation, Division of Insurance, entitled entitled “Unauthorized Medicare Prescription Coverage Sold By Humana Insurance Company” 1/16/08, discussing a \$500,000 fine.
- 21 See, e.g., “Humana Pays \$500,000 Fine in Okla. for Unlicensed Sales” *Insurance Journal*, Wells Publishing, Inc., 8/24/07
- 22 MIPPA (P.L. 110-275), section 103(d).
- 23 See, e.g. CMS NMTP Call 10/28/08 – slides and transcript (slide 52, transcript pp 31-32).
- 24 NAIC White Paper, p. 18
- 25 NAIC White Paper, p. 40
- 26 NAIC White Paper, p. 40
- 27 Preamble to CMS 4131-F, p. 54213; also see NAIC White Paper, p. 40.
- 28 See: State of Wisconsin, Office of the Commissioner of Insurance, Market Conduct Examination of Humana Insurance Company, Green Bay, Wisconsin, September 10-26, 2007 (pg. 40)
- 29 Preamble to CMS 4131-F, p. 54211 Fed Reg. Vol. 73, No. 182.
- 30 *Medicare Part D Compliance News*, October 2008; also see OIG report at: www.oig.hhs.gov/oei/reports/oei-01-06-00050.pdf.
- 31 This is the title of section 103(d) of MIPPA.
- 32 See 42 C.F.R §422.2272(c) and CMS 4138-IFC, preamble at p. 54237.
- 33 MIPPA sec 103(d)(1), amending Section 1851(h) of the Social Security Act, specifically new section (7)(B).
- 34 See, e.g., preamble to CMS 4131-F, section “E. Licensing of Marketing Representatives and Confirmation of Marketing Resources” beginning at p. 54212; see, specifically, p. 54213: “A number of commenters requested that CMS develop guidance specifying the information that Plans must provide to States and establish a streamlined process for data submission. Response: We believe States currently provide appropriate oversight and have the necessary reporting mechanisms in place to track and monitor agent activity. The intent of this requirement is to provide support to States as they exercise their oversight authority and we note that the requirement we are finalizing is generally in accordance with

- the Medicare Improvements for Patients and Providers Act (MIPPA). We will consider this comment when updating marketing guidance in the future.”
- 35 For an example of insurance industry positioning, see, e.g., an 11/17/08 letter from Blue Cross Blue Shield Association VP of legislative and regulatory affairs to CMS Acting Administrator Kerry Weems that states: “We support CMS’s ban on door-to-door solicitation....We recommend, however, that CMS clarify the difference between marketing to prospective enrollees and plan communications with current members, so as to preserve and protect a plan’s ability to call, contact, write to, and otherwise interact with current members about the benefits and services available to them”, quoted in *Medicare Advantage News* (11/20/08) at <http://www.aishhealth.com/Products/NewsMAN.html>.
 - 36 See footnotes in “Background” section above.
 - 37 See, e.g., comments to NPRM submitted by CHA, drafted jointly by several advocacy organizations; includes discussion of issues such as: disclosure of plan information, language access, discriminatory activity, plan names, co-branding, nominal gifts, employer plans, confirming enrollment and understanding at: http://www.cahealthadvocates.org/_pdf/advocacy/2008/CHA-comments-regs-0708.pdf (July 15, 2008).
 - 38 NAIC White Paper, p. 30.
 - 39 Preamble to CMS 4131-F, p. 54214.
 - 40 CMS Memo entitled “Guidance for marketing requirements re: unsolicited contacts, employer/union group plans, scope of appointments, and other marketing provisions” dated 11/10/08 (language also appears in 10/8/08 rescinded memo).
 - 41 In addition, unanswered questions about how this prohibition will be enforced include: Can agents still buy leads from third parties in the business of generating leads? (See example of “Medicare Changes” flyer below.) What does “unsolicited” mean in the context of someone signing a lead card for a lead generating company? They are often asked if they want more information on recent changes to Medicare, etc. Is CMS finally going to take action against those lead card companies that use Medicare as a hook for getting a card returned with contact information?
 - 42 See MIPPA, section 103(a), amending section 1851 of the Social Security Act, specifically new subsection (j)(1)(A): “Unsolicited means of direct contact – Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating the contact.”
 - 43 CMS 4131-F, preamble, p. 54213.
 - 44 Note that CMS’ 11/10/08 Memorandum entitled “Guidance for marketing requirements re: unsolicited contacts, employer/ union group plans, scope of appointments, and other marketing provisions” clarifies previous guidance issued on 9/15/08 that “broadly stated that the prohibition against outbound calls included calls by plans to existing members. We would like to clarify that plans continue to be allowed to call their current members for any reason.”
 - 45 Id.; the 11/10/08 memo clarifies that “agents/brokers can make calls only to the beneficiaries they enrolled into the plan.”
 - 46 Further, this exception actually facilitates a company’s business plan to migrate existing customers back and forth between its available products; e.g., “Unhappy with the restrictions of your MA plan? We will gladly guarantee issue you our Medigap policy at rock bottom premium cost.” Such premium breaks can’t be duplicated by any other company because this company is willingly subsidizing the premium.
 - 47 MIPPA sec. 103(b), amending section 1851 of the Social Security Act, specifically adding (2)(A) to subsection (j).
 - 48 CMS originally proposed the 48 hour cooling off period in its May 2008 NPRM; also see CMS 4138-IFC pp. 54236-7, which also clarifies the meaning of “lines of business” (including PDPs, MA-PDs, MA-only, Medigap).
 - 49 42 CFR §422.2268(g).
 - 50 CMS guidance memo, 11/10/08; also see, e.g., CMS NMTP Call on 9/25/08: slide 13 “agreement to scope of appointment must be documented by plan in writing or recorded by phone”; also note that during the call, a CMS representative verbally clarified that an “agent can’t get permission at in-home appointment.”
 - 51 See CMS’ Model Scope of Sales Appointment Confirmation Form attached to its 11/10/08 guidance memo.
 - 52 See Kaiser Family Foundation report “Pitching Private Medicare Plans: An Analysis of Medicare Advantage and Prescription Drug Plan Advertising” (September 2008) that found, among other things, that “consistent with prior research, insurers tend to devote relatively little advertising attention to certain segments of the Medicare population, such as the under-65 disabled and seniors with serious medical needs, groups for whom health insurance choices are especially important.”
 - 53 MIPPA, section 103(b), amending Social Security Act section 1851, specifically adding (2)(D) to subsection (j).
 - 54 See, generally, CMS-4138-IFC2, 73 Fed Reg 67406 (11/14/08).
 - 55 See www.insurance-forums.net, visited 11/20/08.
 - 56 See www.insurance-forms.net, visited 11/19/08
 - 57 See, e.g., “Congressional Democrats Signal Intention to Enact Deep Medicare Managed Care Cuts” by Steve Tesky, BNA 11/17/08
 - 58 See CHA’s website at: <http://www.cahealthadvocates.org/advocacy/2007/informed.html><http://www.cahealthadvocates.org/advocacy/2007/informed.html>.
 - 59 We believe that there are certain areas within the Medicare program that should remain under CMS’ jurisdiction; see, generally, comments of state regulators and consumer groups in the NAIC White Paper (10/08) at: http://www.naic.org/documents/committees_b_senior_issues_medpp_white_paper_final.pdf.
 - 60 Note that many of these recommendations appear in CHA’s comments to CMS’ NPRM, drafted jointly with several consumer advocacy organizations; see: http://www.cahealthadvocates.org/_pdf/advocacy/2008/CHA-comments-regs-0708.pdf.
 - 61 Note that in the NAIC White Paper, Consumer Groups, State Regulators, Industry and CMS all agreed with this concept, but, to our knowledge, it is still not required.
 - 62 See NAIC White Paper and recent CHA issue briefs on dual eligibles in Medicare Advantage plans, including Special Needs Plans (SNPs).
 - 63 See “There’s a Hole in the Bucket: New “Gap” Product Being Sold to Fill-in Medicare Advantage Deficiencies” (November 2007) at: <http://www.cahealthadvocates.org/advocacy/2007/theres-a-hole.html>.
 - 64 See 42 USC §1395ss(d)(3)(A)(i)(iv): “For purposes of this subparagraph, a health insurance policy (other than a Medicare supplemental policy) providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to “duplicate” any health benefits under this subchapter, under subchapter XIX of this chapter, or under a health insurance policy, and subclauses (I) and (III) of clause (i) do not apply to such a policy.”