



The Reluctant Regulator

Centers for Medicare and Medicaid Services' Response to Marketing Misconduct by Medicare Advantage Plans

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California Health Advocates (CHA) is a nonprofit organization dedicated to timely and responsive education and advocacy efforts on behalf of California Medicare beneficiaries and the pre-retirement population.

Medicare Rights Center (MRC) is the nation's largest independent source of Medicare information and assistance for people with Medicare. Founded in 1989, MRC helps older adults and people with disabilities get high-quality, affordable health care.

NOTE: *This Issue Brief is the fifth in a series on Medicare drug benefit issues for consumers drafted by California Health Advocates (CHA) and the Medicare Rights Center (MRC), with support from the California HealthCare Foundation.*

INTRODUCTION

Across the country, there is a growing chorus of advocates, state insurance departments, the media, members of Congress, and people with Medicare voicing complaints about aggressive and deceptive marketing of Medicare private plans to older adults and individuals with disabilities. Until very recently, the Centers for Medicare and Medicaid Services (CMS) and the insurance industry have largely blocked out these voices. CMS has, of late, taken steps designed to stem marketing misconduct, particularly with respect to the sale of one type of Medicare Advantage plan, Private Fee-for-Service (PFFS) plans.

While these actions are welcome, they do not demonstrate that CMS has the capacity or willingness to hold Medicare private plans to account for abusive marketing practices of their sales agents and brokers or to take the steps necessary to halt the ongoing aggressive, deceptive and fraudulent marketing of private Medicare plans. CMS's actions do not address the root cause of marketing misconduct – the overpayments to Medicare Advantage (MA) plans set by statute. These overpayments make every prospective MA enrollee a potential source of substantial profits, in turn encouraging aggressive marketing and funding the broker commissions and other financial incentives that fuel marketing abuse.

In January 2007, California Health Advocates and the Medicare Rights Center released a report entitled “After the Gold Rush: The Marketing of Medicare

Advantage and Part D Plans – Regulatory Oversight of Insurance Companies and Agents Inadequate to Protect Medicare Beneficiaries.”¹ In that report we: provided an overview of the Medicare landscape (including the types of plans offered); reviewed rules relating to marketing Medicare products; discussed consumer experiences with the marketing of a particular type of Medicare Advantage product – the Private Fee for Service (PFFS) plan – to highlight agent misconduct; discussed Medicare's oversight of Part D and Medicare Advantage plans; discussed state regulation of insurance agents; and provided recommendations for stricter oversight and accountability of plan sponsors and their agents.

Since the release of “After the Gold Rush,” reports of marketing misconduct have proliferated and three separate Congressional committees have held hearings on the issue. More information has come to light on CMS's response to marketing abuse, including the imposition of corrective action plans on a number of plan sponsors and the agency's recent agreement with seven PFFS plans to voluntarily suspend marketing until safeguards for consumers are put in place. The intervening months have also seen state insurance commissioners challenge the pre-emption of their authority over the marketing conduct of Medicare Advantage and Part D prescription drug plans by putting forward policy proposals that would reassert their authority over these plans. In this brief, we continue our analysis of problems

relating to the marketing of private Medicare plans by evaluating the effectiveness of CMS's response to reports of marketing misconduct, assessing the potential benefits of increased state oversight and enforcement and proposing additional policy recommendations that address the root causes of marketing misconduct.

1. CMS's Actions Concerning Marketing Misconduct

Slow to Respond to Growing Problems

As reports of misconduct surrounding the sale of private Medicare products grew across the country in late 2006 and early 2007, CMS assured the insurance industry "that problems are few, and to be expected."² As noted by CMS spokesperson Aaron Hase earlier this year, "[w]ith any program of this size, you will always be able to find a few people that are dissatisfied"³. Instead of keeping plan sponsors on a tight leash—or at the very least remaining publicly neutral and impartial about plans – CMS has often acted more as a cheerleader for the Medicare Advantage plans than a regulatory agency overseeing them.⁴

The insurance industry, of course, agreed with this toned-down assessment of marketing problems. For example, Mohit M. Ghose, vice president of public affairs for the America's Health Insurance Plan (AHIP) trade group, commented in January that marketing problems reported so far "could be considered part of the growing pains of implementing a new product line" or simply the "Act II jitters" according to industry consultant Jeff Fox of the Gorman Health Group.⁵ Insurance companies offering Medicare Advantage and Part D plans have denied that there have been problems with the way they conduct business. For example, on the eve of a Senate hearing discussing marketing misconduct, and following a Limited Market Conduct Exam of their company by the Oklahoma Insurance Department that found troubling instances of misconduct, a Humana senior vice president told the *New York Times* "people who chose its Medicare plans were overwhelmingly satisfied and that 'I would know if there were any problems.'⁶

According to *Medicare Advantage News*, a widely read industry newsletter, as of February of this year, federal and state regulators that are monitoring the marketplace said "that while they remain watchful, actual marketing problems – beyond anecdotes – don't appear to be rampant."⁷ The reality, though, was quite different. While CMS's public stance on marketing abuses remained passive, a growing number of state insurance regulators were reporting abusive sales tactics and warning their residents about marketing misconduct.⁸ For example, the Mississippi Insurance Department warned that "abusive sales practices relating to Medicare Insurance, first reported late last year, are spreading rapidly

throughout the state"⁹; similarly, the Kansas Insurance Commissioner noted that "aggressive marketing tactics to sell Medicare Advantage products, which in turn may mislead consumers to make decisions that could negatively affect their insurance coverage" is a "growing problem in Kansas, as well as other states."¹⁰

Corrective Action Plans, New Guidance and Voluntary Suspensions

CMS has been reticent to provide the public with information about their oversight and enforcement activities related to marketing misconduct by private Medicare plans. CMS testimony at a recent series of Congressional hearings reveals a largely hands-off agency approach, with little effort to hold private plans to account for fraudulent and deceptive actions by their independent agents and brokers.

No company has been fined by CMS for marketing misconduct, according to testimony on June 26th before the House Energy and Commerce Oversight Subcommittee by Abby Block, director of the CMS Center for Beneficiary Choices. Although over \$400,000 in fines have been levied against plans over the last year or so, these monetary penalties have all been prompted by plans' failure to provide enrollees with timely notices, according to Block.

Substantiated reports of marketing misconduct by independent brokers do not necessarily trigger CMS efforts to require plans to exercise better oversight of independent agents. Termination of an agent found to have engaged in misrepresentation can be sufficient corrective action by the plan, Block testified at the Energy and Commerce Subcommittee hearing. Block told the committee that Coventry Health Care had done the "right thing" when it fired an agent responsible for using deceptive tactics to conduct a mass enrollment at a Washington, DC, low-income housing complex, and no further action by CMS was necessary to hold the plan to account for the actions of its agent.

Patterns of abusive marketing that do result in CMS compliance audits and corrective action plans do not encompass safeguards necessary to prevent further marketing misconduct. CMS directed PacifiCare Life and Health Insurance Company, a United Healthcare company, to develop a corrective action plan in August 2006, but did not require full implementation of the plan, only "satisfactory progress" in time for the November 15th start of the Annual Election Period. CMS did not give provisional acceptance of the full corrective action plan until February 2007, three months after the marketing season had started. During that time, reports of abusive marketing of PacifiCare's Secure Horizons PFFS product continued and the company (along with six other plan sponsors) "voluntarily" suspended

marketing in June 2007 under an agreement with CMS.

WellCare Health Plan entered into a corrective action plan after a CMS audit in March 2007 following reports of a mass enrollment of low-income people with Medicare with limited English proficiency and other reports of marketing misconduct. The terms of that corrective action plan have not been made public, but WellCare officials have testified publicly that they follow every enrollment application with a call to gauge enrollee “satisfaction” with their sales experience. Despite those pre-enrollment calls and the additional compliance actions that are presumably part of WellCare’s corrective action plans, the company was included among those subject to the recent suspension agreement, which includes among its terms the performance of pre-enrollment verification calls.

In May 2007, CMS proposed broad regulatory changes that have a potential impact on the agency’s oversight and enforcement of marketing guidelines.¹¹ CMS proposed to reinstate “voluntary self-reporting” of instances of misconduct and fraud, explaining that the agency had first learned of some problems through the media, not directly from plans. The proposed rule also takes steps to streamline the process for imposition of civil and monetary penalties on plans.

Beyond proposing that plans “self-report” marketing misconduct and requiring plan-specific corrective actions, CMS has over the last few months taken a series of steps that purport to address the broader problem of deceptive marketing of Medicare Advantage Private Fee-for-Service (PFFS) plans. As pressure for vigorous action by advocates, states and Congress has mounted, CMS has accelerated the timeline for implementation of these steps. CMS’s actions started with the release of the Final 2008 Call Letter to Medicare Advantage and Part D Plans on April 20, 2007¹² – a routine, annual update in expectations set for plans for the next calendar year. This was followed by the release of PFFS Plan Guidance on May 25, 2007,¹³ which set out certain requirements and “best practices” for plans to meet prior to the next enrollment period. CMS action culminated with the announcement of the voluntary suspension of PFFS plan marketing by seven plan sponsors on June 15, 2007.¹⁴

CMS first broached the possibility of strengthening protections against abusive marketing of PFFS plans in its draft 2008 Call Letter to Medicare Advantage and Part D Plans issued in April. The draft Call Letter proposed, among other things, that PFFS plans would: use required disclaimer language in all marketing and enrollment as well as sales presentations starting with the annual enrollment period in November; provide documented training of marketing agents and brokers; and perform “outbound verification calls” to all new

applicants to verify that they understand the plan features and do in fact want to enroll, while CMS would employ a contractor to conduct “secret shopper” tests on sales and outreach activities.

Advocates seized on the proposal and argued CMS should begin immediate implementation of these requirements. In addition, advocates pushed to extend the requirements to all Medicare Advantage plans, since advocates have reported that while the majority of marketing misconduct appears to involve PFFS plans, marketing abuse also occurs during the sale of other types of MA plans. For its part, the insurance industry trade group, America’s Health Insurance Plans (AHIP), objected to the requirement that all PFFS plans conduct outbound verification calls to confirm potential enrollees’ understanding and intention.¹⁵ CMS deferred any decision on its proposals in the Final Call letter, which said the agency was “considering” imposing these requirements for PFFS plans.

After a May 15, 2007, hearing before the Senate Aging Committee CMS on May 25th issued guidance for PFFS plans implementing the requirements contained in the 2008 Call Letter, some effective immediately, others not until October.

Finally, with the June 15th suspension announcement, seven PFFS plans, representing 90 percent of beneficiary enrollment in this product, were voluntarily being held to these rules prior to any continuation of marketing of their PFFS products. CMS has stated that this suspension for a given plan will be lifted only when CMS certifies that the plan has systems and management controls in place to meet all of the conditions outlined in CMS’s 2008 Call Letter and the May 25th Guidance.

After a series of Congressional hearings and months of negative publicity finally spurred action, the administration touts the responsiveness of CMS and the plans, while continuing to deflect blame from the plans and onto agents. The press release announcing the suspension boasts that “CMS and the plans are stepping up to ensure that deceptive marketing practices end immediately” and assures the public that “CMS is proactive in protecting beneficiaries from rogue agents.”¹⁶

New PFFS Requirements

How effective will the new requirements be in curbing marketing abuse of Medicare Advantage plans? They have no impact on the marketing of any MA product other than PFFS plans, even though all MA plans (HMOs, PPOs, Special Needs Plans [SNPs]) have been the subject of abusive marketing. But even for the PFFS plans subject to these requirements there is little indication that the new protections will be effective

in curbing marketing abuse. In fact, a number of these safeguards, such as outbound verification calls, are already employed by the plans CMS singled out for “voluntary” marketing suspensions. While some of the new requirements imposed by CMS may be helpful in educating beneficiaries and providers about PFFS plans, the new requirements fall short in their specifics in providing effective consumer protection. Finally, these new requirements do nothing to strengthen enforcement of and compliance with these and other marketing protections. The following section provides a brief review of these new rules along with shortcomings we have identified (note that recommendations for improvement of these requirements are included at the end of this report).

Disclaimer Language – CMS is requiring disclaimer language in all marketing material that will more accurately describe how PFFS plans work, including the option of physicians to decline to accept the terms and conditions of a given plan. CMS has also created a model two-sided leaflet for consumers and providers, meant to be something enrollees can share with their providers, that must be included in all enrollment kits that are sent to prospective enrollees and must be available on the plan website. The May 25th guidance also requires plans to immediately discontinue use of any marketing material that inaccurately implies that PFFS plans function in the same manner as supplemental “Medigap” plans.

Together, these two mandates are meant to address the widespread marketing of PFFS plans as substitutes for Medigap plans. Disclaimer language and model leaflets by themselves, though, do not ensure an accurate description of the terms and conditions of the plan by individual agents in one-on-one marketing pitches. There is nothing in the new requirements that ensures that agents will highlight the disclaimer language or otherwise refrain from continuing to misrepresent PFFS plans as equivalent to Medigap plans, either in the way they function or the cost-sharing they charge. In addition, CMS has not indicated whether it will take disciplinary action against plans that used misleading materials, and nothing in the guidance alters CMS policies permitting plans to use marketing materials without prior CMS review.

The disclaimer language also does not provide adequate warnings to consumers of the potential changes to their coverage and the way they access covered benefits upon enrollment in a PFFS plan. For enrollees switching from Medigap plans, for example, it does not provide a clear explanation that their Medigap plan will no longer pay for their out-of-pocket costs and that they should cancel their Medigap policy. It does not explain that PFFS plans, unlike Medigap plans, will charge them cost-sharing or copayments for Medicare services. The disclaimer also fails to mention that Medicare Advantage

enrollees, with certain exceptions, will be locked-in to their MA plan for the calendar year or that they may not be able to buy their Medigap policy back again if they decide to drop the MA plan next year. In addition, despite the confusion over how PFFS plans work for people with both Medicare and Medicaid (which can vary by state), there is no disclaimer language specific to this population (e.g., regarding cost-sharing or access to Medicaid benefits).

Verification Calls – PFFS plan sponsors are required to conduct outbound education and verification calls to everyone requesting enrollment to ensure that the individual understands the plan rules. Educational letters must be sent following an unsuccessful attempt to contact the prospective enrollee. CMS provides both model scripts and letters for use by the plans.

To its credit, CMS rejected proposals to allow plans to use inbound calls made by potential enrollees to a plan in the presence of the agent selling the plan as a substitute for the required outbound verification call. The presence of the broker creates the potential for intimidation of the prospective enrollee, as Coventry Health Care Executive Vice-President Fran Soistman acknowledged before the House Energy and Commerce Oversight Subcommittee during a hearing on June 26th, 2007. Prior to the suspension agreement, WellCare had developed a plan to put in place such inbound verification calls, according to testimony before the Oversight Subcommittee.

Although they are a welcome requirement, outbound verification calls by the plans themselves have been unable to prevent marketing abuse. At least three of the plans covered by the suspension agreement—Humana, Secure Horizons and Universal American—had already been conducting such calls before the suspension and WellCare had been calling new enrollees to gauge “satisfaction” with their encounter with independent sales agents. But these calls have failed to prevent repeated instances of marketing misconduct that led, eventually, to the agreement to suspend marketing.

The Oklahoma Insurance Department’s examination of Humana’s market conduct found serious deficiencies in its verification call system, including instances when verification calls were not conducted and when they failed to prevent enrollment by individuals who lacked the mental capacity to make an informed decision. One notable complaint involving an individual who had “lifelong mental conditions” is illustrative, and worth reviewing here. While the Department investigators noted that “it was clear from this investigation that the member was confused as to what she had purchased and how it would work”, the plan Regulatory Compliance Director reviewed a tape of the verification call and concluded that “I’m not sure she really understood

the plan but she was not enrolled against her will or without her knowledge.” As a result, Humana took no action to prevent enrollment and only followed up on the marketing misconduct when notified by the state. Even then, the company downplayed the seriousness of the complaint.¹⁷

Plans are responsible not only for making sure the verification calls take place but also for making a determination as to whether the prospective enrollee understands how the plan works and whether the agent used deceptive tactics. These determinations are necessarily subjective. When plans conduct the verification calls themselves, there are no safeguards to ensure plans’ financial interest in maintaining enrollment will not influence these determinations.

Many instances of marketing misconduct in California involved the sale of plans to individuals who spoke Spanish or Chinese as their primary language, and as a result were not able to adequately communicate with agents who did not speak their language (but signed them up for plans anyway). CMS’s new requirements, however, do not reference whether (or require that) calls must be made in languages other than English.

Reporting of Scheduled Sales Presentations –

Under CMS’s new requirements, all PFFS plans must provide their CMS Regional Office Plan Manager with a schedule of all sales and marketing events it will conduct in the following month so that these presentations can be subject to CMS “secret shopper” monitoring.

There are many reports of agents scheduling presentations at senior/disabled subsidized housing residences or centers under the guise of discussing “Medicare changes” or “Medicare Part C” without disclosing that it is their intent to sell a product, leading many residents and managers duped into thinking that they are getting a substantive presentation instead of a sales pitch. It remains unclear if plans and agents will report these “educational” presentations as sales presentations.

Further, this reporting requirement includes neither in-home sales visits by agents nor unscheduled, drop-in visits to senior centers and subsidized housing facilities, all locations in which the most egregious marketing violations appear to occur. Secret shopper programs, while helpful, rely upon information that plans and agents provide regarding scheduled sales presentations. Such efforts will not effectively prevent prohibited door-to-door visits or monitor unscheduled, unsolicited sales at residences/facilities that often result in mass plan enrollments.

Agent Training – CMS has said that in order to resume marketing, the PFFS plans under the suspension agreement must require that all sales representatives,

both independent brokers and those directly employed, pass a written test demonstrating familiarity with Medicare and the particular PFFS product. This appears likely to be an online test, similar to annual certification exams already required by many plans. CMS is requiring PFFS plans to provide documented training of marketing agents and brokers on Medicare Advantage policy as well as unique aspects of the PFFS product. Although details are not yet available, requirements under consideration for the 2008 plan year may be more substantive.

Although it does nothing to enforce compliance with marketing guidelines or to reduce the financial incentives for brokers to skirt or violate those requirements, enhanced and comprehensive training will enable brokers and agents of good will to help people with Medicare make informed decisions about the most suitable coverage option.

The absence of substantive training for brokers was documented in the Oklahoma Insurance Department’s Market Conduct Exam of Humana Insurance Company. Among other things, the Market Conduct Exam reviewed the training of both in-house and delegated agents selling Humana products and found that while company agents/employees received a three-week training course, “delegated agents, i.e. independent agents” were required to complete a 16-hour training course including: three hours of self-study on Medicare and ethics; a one-day class for “Certification” (“product knowledge, Medicare requirements, ethics and compliance”) and two 2-hour Post-Certification telephone conference calls. The Oklahoma Department of Insurance concluded: “Although approved by CMS, this training program did not appear to be sufficiently comprehensive to fully cover a topic as complex as Medicare and the products which these agents would be selling. Most of the complaints submitted [to the Department], which alleged agent solicitation problems, occurred with agents who had received this ‘short course’ training.”

In May, AHIP also voiced support for training requirements in a set of principles entitled “Protecting Beneficiaries: Improving and Monitoring Medicare Marketing Practices.”¹⁸ AHIP urged CMS “to establish standards for training that requires that specific topics must be addressed in detail.” Some industry experts agree that plans should provide for more in-depth training of agents. Jeff Fox of Gorman Health Group states “we advise plans to train brokers as if they were employees. Go through state regulations with them, Medicare compliance, product definitions, marketing guidelines, and tips for educating beneficiaries on the concept of the product.”¹⁹

In promoting its “Medicare Sales Training and

Certification Program,” which is a training course/ certification program for plan sponsors and their agents that is offered for sale by Gorman, a promotional brochure states that “...most agents simply don’t understand Medicare’s complicated benefit structure – or what they can and cannot say legally to beneficiaries – placing organizations at risk. Meanwhile, MA-PDs and PDPs hampered in their marketing efforts by Medicare lock-in enrollment rules often rely on outside, independent agents to sell their products, making training and oversight of these individuals particularly challenging.”²⁰

Agent Termination as Enforcement

Medicare Advantage plans have typically addressed high-profile marketing abuse cases—those identified by advocates, Congressional staff or the media—by terminating the agent responsible. CMS has deflected much of the criticism about the plans themselves solely to a “few bad apples” – a seemingly handful of agents engaging in fraudulent activity while selling plans—and has emphasized the tracking and termination of “rogue agents” as the core of their enforcement efforts. Some plans have publicly touted the number of individual agents terminated for marketing abuse, although no data has been made public that correlates the agents

AGENTS UNDER-TRAINED & UNDER-EQUIPPED

Co-Author Attends Meeting Between Agents & PFFS Plan Representative

In early March 2007, co-author Bonnie Burns was invited to attend an informational meeting held in Northern California between an insurance company representative and agents who were selling the company’s Medicare Advantage Private Fee for Service (PFFS) plan. One of the agents extended the invitation to Ms. Burns after his contact with a local Medicare counseling program.

The agents attending the meeting lived and worked in several Northern California counties and appeared to be owners or employees of small town insurance businesses. Some of these individuals had close ties with specific ethnic or minority communities, having spent years establishing a trust relationship, while others had a broader clientele or service area. Throughout the meeting many of the agents expressed deep concern for the welfare of their clients and frustration with the company’s systems they had been instructed to use.

During a heated discussion with the company representative the agents complained that they had been unable to get the marketing materials they needed in January and well into February, during the height of the Medicare Advantage Open Enrollment Period (OEP), a sales period that would last only a few months for most people with Medicare. They complained about not being able to obtain sales brochures that described the company’s PFFS plan and other materials they needed to conduct public seminars and sales sessions.

There was a discussion primarily related to PFFS plans that included questions about Medicare Advantage and Part D plans that revealed enormous gaps in knowledge about Medicare plans in general, and PFFS plans in particular. It was clear from the discussion that these agents had a lack of fundamental knowledge and understanding about how these plans worked, and in particular how Medicaid benefits interacted with a PFFS plan. This group of agents had been encouraged to concentrate their PFFS sales efforts on people with both Medicare and Medicaid coverage and had been selling the plan’s extra benefits for vision, hearing and dental as being better than those provided by Medicaid (Medi-Cal in California), which was not true of most Medicaid benefits in California.

One agent complained that after selling the company’s PFFS plan to several clients who have both Medicare and Medicaid coverage, she discovered that the county medical center, where most low-income residents get all their medical care, including the only two county hospitals, would not accept the company’s PFFS plan she had sold them. In addition, the doctors in that county who did accept the PFFS plan would not also accept Medi-Cal and charged co-payments these patients had not previously been obligated to pay.

At the end of the meeting the company representative noted that the company was under intense scrutiny by CMS because of reports of bad sales practices. She then announced that agents who wanted to continue selling the company’s products would have to complete a retraining course within the next two months. When asked about the course material and how much time would be involved to complete it, she responded that it was a review of everything they had already had in their initial training and should take them only about an hour and five minutes to complete the course using the Internet.

The agent who had organized this meeting and was a vocal critic of the company’s poor support for the agents selling its products was fired without cause two days after this meeting.

terminated with specific instances of marketing abuse. However, the one comprehensive investigation to date — the Oklahoma Insurance Department’s market conduct investigation of Humana—details numerous instances of marketing abuse that did not trigger disciplinary action against the agent.

While agent terminations may have a disciplinary effect on “rogue agents,” they do not entail any penalty to the company itself. Plan sponsors remain free to provide poor training and support for agents, high commissions and other incentives that encourage aggressive marketing, and are not compelled to enact compliance procedures that would systematically address marketing misconduct by the agents. Companies can cut loose individual agents who have been caught by investigative reporters or advocates, while keeping in place a system that rewards such misconduct through commissions and turns a blind eye to internal signals, such as mass enrollments, that should trigger greater oversight.

Effect of Voluntary Suspension and New Requirements

Despite media attention paid to the voluntary suspension of PFFS plan marketing by the seven plan sponsors, it is questionable whether the suspension will actually curb marketing abuses or have any meaningful impact on the companies involved. As discussed above, some of the plans were already required to implement these new measures as conditions of corrective action plans following reports of abuse surrounding the sale of their products.²¹ CMS has also been quick to downplay assumptions that it is exercising regulatory authority over the plans as a result of widespread misconduct; as noted by a top CMS official, “This isn’t really enforcement. This is a voluntary agreement. In terms of the conditions we’ve put forward, they are just what we would consider to be good business management.”²²

According to health care business information company HealthLeaders-InterStudy, the voluntary suspension agreement between CMS and seven insurance companies “likely will salvage the reputation of the [PFFS] product and its major sellers without significantly jeopardizing potential sales.”²³ Further, “the agreement will have little impact on the PFFS market, and will allow CMS to look responsive after receiving criticism by some in Congress for letting marketing abuses go unchecked. Insurers can clean up the acts of a few rogue agents without damaging their long-term enrollment prospects.”²⁴

CMS has stated that it will review plan compliance as soon as plans indicate they are ready. Some plans have said that they already meet the new requirements and will be marketing again soon.²⁵

State officials who have seen their insurance departments flooded with marketing complaints about Medicare Advantage plans have also expressed skepticism that the suspension agreement and new safeguards will solve the problem. In testimony before the House Energy and Commerce Oversight Subcommittee, North Dakota Insurance Commissioner Jim Poolman described the marketing suspension agreement as “not good enough” and expressed skepticism of CMS’s enforcement capacity. At the same hearing, Mississippi Deputy Insurance Commissioner Lee Harrell downplayed the prospect that enrollment verification calls would stem abusive marketing, particularly such calls involving Medicare beneficiaries with cognitive impairments. Harrell told the committee that the current “piecemeal approach to enforcement is not working, nor is it realistic to expect that it will.”

2. Financial Incentives Drive Marketing Abuse

Financial Incentives for Plans

Medicare Advantage plans are a lucrative product line for health insurance companies. Medicare currently pays companies for each MA enrollee an average of \$1,000 per year more than the cost of caring for someone in the same locality under Original Medicare.²⁶ Overpayments for PFFS plans are even greater, averaging 19 percent over average costs under Original Medicare.²⁷ These payment rates result in windfall profits for Medicare Advantage plan sponsors and drive aggressive marketing strategies that put a bounty on the head of every person with Medicare, regardless of whether the plan is suitable for the individual.

The most prevalent cases of deceptive and fraudulent marketing practices have their origin in marketing strategies designed to maximize enrollment. In the experience of many advocates, a typical case involves an individual seeking enrollment in a stand-alone prescription drug plan but who is instead enrolled in a Medicare Advantage plan, often through an in-home marketing pitch scheduled at the insistence of plan call center operators or independent agents. These types of cases stem from strategies designed to use enrollment in a private Part D prescription drug plan—a necessity for many since drug coverage is not available under Original Medicare—as the entry way for enrollment in a Medicare Advantage plan.

Another common scenario reported by advocates involves an individual who is switched from coverage that suits their needs—a Medigap policy that covers all cost-sharing for an individual with high monthly expenses, or a Medicare Advantage plan with a formulary that covers an individual’s drug regimen and a network that includes local hospitals and the individual’s

longtime physician(s). Through active misrepresentation (about the extent of drug coverage or provider participation, for example) or through selective omissions (emphasizing low premiums while neglecting to explain high cost-sharing for medical services) individuals are induced to change their current coverage and enroll in a less suitable plan. These marketing strategies are drawn from strategies designed to “poach” members from competing Medicare Advantage or Medigap plans.

People with both Medicare and Medicaid coverage (often referred to as “dual eligibles” or “duals”) have been particular targets of aggressive and deceptive marketing by MA plans, including HMOs, Special Needs Plans and PFFS plans, in part, because their exemption from “lock-in” allows them to change drug plans on a monthly basis. Some plan sponsors have cautioned their marketing representatives that PFFS plans may actually increase out-of-pocket spending of dual eligibles, who

already have most (if not all) Medicare cost-sharing paid for by the state Medicaid program, and therefore may not be suitable products for this population.²⁸ Other plan sponsors, though, such as WellCare, continue to specifically target dual eligibles with their PFFS products.

The strategies that drive these marketing abuses are evident in insurance industry literature. A presentation by Veridign Health Solutions, a company offering Medicare Advantage administrative services, outlines a marketing strategy for insurance companies that includes “poaching” members from other plans and “preserving” current plan membership.²⁹ Veridign notes that: “Part D is a market share fight, not necessarily a growth market – How we get them (poaching) and how we keep them (preservation) becomes marketing strategy post lock-in.” Dual eligibles, “low-income, and [the] institutionalized” are characterized as being “priceless” targets (invoking a well-known MasterCard advertising

PIGSKIN & VEGAS WINS!

Plans Prompt Agents to Maximize Enrollment Through Contests

During the Medicare Annual Election Period (AEP) at the end of 2006, WellCare, a Medicare private health plan sponsor, offered football-themed contests for agents selling their PFFS products. The “First and Goal/Extra Points” contest promised agents “There’s no limit to how much you can earn!” Under the “First and Goal” portion of the contest, agents could “Earn an additional \$75 for every PFFS application you get over the goal line on or before December 31, 2006 for January 1, 2007 effective dates.” In the “Extra Points” phase of the contest, agents who “tasted victory” with the “First and Goal bonus program” could “score again” if they “Kick 100 or more PFFS applications through the uprights on or before December 31, 2006 for January 1, 2007 effective dates [to] earn an additional \$25 on every application.” On a chart designed to look like a football coach’s blackboard, the flyer provided some examples of how much agents can earn, including: “250 PFFS Sales x \$250 (base), plus \$75 per sale = \$84,250 PLUS \$25 Extra Point per sale [over the first 100] = \$90,500 total.”

But wait – there’s more – the companion “Half-Time Giveaway” contest benefited “Four lucky WellCare producers” who won a Panasonic 42” Plasma HDTV (retail value of \$1,439.99) in December 2006. Every new WellCare PFFS application submitted between November 15th and December 29th, 2006 counted as one entry in the Giveaway. Agents were told “The more PFFS applications you submit to WellCare each week, the greater your chances of winning – it’s even possible to win more than once!” Both fliers for these contests note: “For Agent Use Only. Not Intended for Consumers.”

Coventry Health and Life Insurance Company, which offers Advantra Freedom PFFS plans, offered a different “Broker Contest and Awards Program” during the 2006 Annual Enrollment Period (AEP). This Contest had three parts: 1) a one-time Agent Contract Drawing or lottery to determine the winner of \$5,000 (to be eligible, participants had to submit his/her agent contract to Coventry no later than November 1, 2006); 2) Weekly Application Production Awards (“WAPAs”) whereby each valid application for a PFFS plan was counted (between 10-24 valid applications in a week = \$25 debit card, all the way up to 100+ valid applications = \$1,000 cash); and, finally, 3) a Trip to Las Vegas, Nevada (roundtrip airfare and three nights’ accommodation) for the 25 participants that generated the most valid applications between November 15th, 2006 and March 31, 2007.

[See WellCare’s “First and Goal/Extra Points” contest flyer at: http://www.brokersassistance.com/pdf/wellcare/wellcare%20flyer_Extra%20Points.pdf and the “Half-Time Giveaway” contest flyer at: http://www.brokersassistance.com/pdf/wellcare/Half-time_flyer_Wellcare1.pdf

See a description of the Coventry/Advantra contest at: <http://www.advantrafreedom.com/content/plan/91/BrokerContestandAwardsProgramRules1106.pdf>]

campaign) since they are exempt from lock-in rules that restrict most individuals' ability to join, switch or disenroll from Medicare plans. Veridign's presentation highlights how this particularly vulnerable population should be a primary target for marketers. Similarly, prior to the roll-out of Part D, a noted industry consultant advised plans to "Prepare for Poaching and Preservation: Many low-income beneficiaries are going to have a tough time in the PDPs they're auto-assigned to, presenting an opportunity to 'poach' them mid-year, given their lock-in exemption."³⁰

Financial Incentives for Agents

As discussed in "After the Gold Rush," plan sponsors typically pay much larger commissions to agents per Medicare Advantage plan enrollment than for stand-alone PDP enrollment. We argued that this commission structure encourages agents to steer people with Medicare towards Medicare Advantage products, regardless of whether such products are actually the best option for the individual. We believe that higher commissions paid for enrolling people in PFFS plans in particular (and Medicare Advantage plans in general) have rewarded overly aggressive and unscrupulous behavior by agents, resulting in real harm to individuals.

In addition to this unbalanced commission structure, sponsoring insurance companies offer added incentives such as contests or awards to agents and brokers selling their products, providing further inducement to steer people towards Medicare Advantage, and particularly PFFS, products. In a sidebar accompanying this text are examples of contests specifically for agents selling PFFS plans offered by WellCare and Coventry/Advantra. While the conduct of many agents has clearly been reprehensible, they are acting with the advice and consent of – and heavy prodding by – the plan sponsors themselves.

3. Conclusion and Recommendations

Two deficiencies stand out in our assessment of CMS's regulatory response to widespread marketing misconduct by the sales agents of Medicare Advantage plans:

- No effort has been made to address the financial incentives for Medicare Advantage plans and their agents that drive abusive marketing.
- No plan has been punished through civil and monetary penalties for fraudulent, deceptive or abusive marketing by their agents.

In our view, both deficiencies must be viewed within the context of a broader, ongoing debate concerning how Medicare beneficiaries (and the broader public) should access health coverage and services – through primarily

market-based entities vs. government administration and programs. CMS's goal of promoting and increasing enrollment in the Medicare Advantage program, the Medicare Modernization Act's built-in overpayments to Medicare Advantage plans despite the resulting fiscal jeopardy this poses for the Medicare program, and CMS's hesitant, belated and largely ineffective response to the explosion in marketing complaints are all rooted in this debate. At the same time, CMS has rejected recommendations for enactment of modest consumer protections, such as those outlined in the report "After the Gold Rush," and in joint comments on the Draft 2008 Call letter submitted by several advocacy organizations.³¹

The time has come for people with Medicare to look beyond CMS to Congress and state departments of insurance to obtain the consumer protections they need. In that spirit, we make the following principal recommendations:

- **Congress should eliminate the overpayments to Medicare Advantage plans and put payments on par with local costs under Original Medicare.** Pegging Medicare Advantage payment benchmarks to Original Medicare costs—the costs of the most efficient provider – will encourage plans to devote their resources to improving efficiency and adding value to their products and eliminate the windfall profits that are driving aggressive marketing strategies and paying for commissions and bonuses for unscrupulous agents. Legislation that stemmed abusive marketing of Medigap supplemental plans in the early 1990s was successful in part because it limited the profitability of Medigap plans—and thus the financial incentives for aggressive marketing – by establishing minimum medical loss ratios—minimum percentages of premium income that must be spent on medical benefits. Putting Medicare Advantage payments on par with Original Medicare costs should likewise dampen incentives for aggressive marketing.
- **Congress should rescind the statutory pre-emption that prevents states from enforcing state laws on consumer protections and the marketing of insurance products.** Despite having their hands tied by federal pre-emption of their authority, a number of states have shown they have the necessary independence to effectively regulate Medicare Advantage plans. States should have the authority, when a pattern of marketing misconduct by a Medicare Advantage plan is demonstrated, to order plans to "cease and desist" from enrollment, to levy financial penalties and to revoke the licensure of state plans. States should have the authority to require plans to appoint their independent agents and brokers and hold the plans accountable for the actions of these plan representatives.

- **Congress should authorize the establishment of a commission comprised of representatives from CMS, the National Association of Insurance Commissioners, consumer advocates and Medicare Advantage plans to develop nationwide marketing guidelines in time for the 2008 annual election period.** These guidelines for marketing conduct should be enforceable by CMS and state departments of insurance.

In addition to these broad recommendations, we urge that Congress direct CMS to enact the following protections concerning the marketing of Medicare Advantage and Part D plans. CMS has recently offered some proposals to address marketing abuses, but we believe that these measures do not go far enough to fix the entire range of marketing misconduct surrounding the sale of MA plans. More fundamental changes are required in order to adequately protect people with Medicare from fraud and misrepresentation.

- **Ban the sale of PFFS plans to dual eligibles unless plans can prove they offer more comprehensive benefits than those available through the state.** We urge Congress to carefully review the sale of PFFS plans to individuals dually eligible for Medicare and Medicaid. PFFS plans should prove that they both provide meaningfully better and more comprehensive benefits than those currently available through state Medicaid programs and are accepted by a broad range of providers in a given service area (including physicians, hospitals, clinics, etc.) before they can continue to market to duals.
- **Disclose corrective actions.** When advocates file complaints with Medicare about plan conduct, the results of these complaints, if any, are rarely made available. In an effort to encourage people with Medicare to report bad plan conduct, to deter plans from engaging in such conduct and to provide consumers with the information they need to make an informed choice when selecting a plan, CMS should make sanctions and other corrective plans/efforts it imposes on plans publicly available and easily accessible, including through their website.
- **Standardize broker commissions.** The current commission structure employed by plan sponsors creates an incentive to sell certain MA plans over PDP plans, regardless of whether it is the best option for an individual. Medicare should require plans to adopt the concept of limiting replacement commissions to discourage inappropriate replacements (in other words, an agent should not get the same commission for selling a person a second PDP or MA plan when they have coverage under an existing MA or Medigap plan). Broker commissions should also be structured to discourage mass enrollments and to encourage,

through renewal commissions, the sale of suitable insurance products.

- **Eliminate the lock-in provision.** Instead of restricting most people to making plan choices at certain times of the year, we believe that all people with Medicare should be allowed to change plans on a monthly basis. Coupled with the recommendations we make above re: suitability standards and replacement commissions, this would allow enrollees to undo bad choices more easily.

- **Recommendations specific to CMS's new PFFS requirements – In the text above, we highlighted some of the shortcomings of CMS's new marketing requirements applicable to PFFS plans.** In addition to applying these new requirements to **all** Medicare Advantage and Part D plan sales, we offer the following specific recommendations to improve CMS's new rules:

- *Disclaimer Language* – Disclaimer language should provide adequate warnings to consumers of the changes to their coverage that may occur upon enrollment in a PFFS plan; for enrollees switching from Medigap plans, it should provide a clear explanation that their Medigap plan will no longer pay for their out-of-pocket costs and that they should cancel their Medigap policy; it should explain that PFFS plans, unlike Medigap plans, will charge them cost-sharing or copayments for Medicare services. This disclaimer language should disclose that MA enrollees, with certain exceptions, will be locked into their MA plan for the calendar year and that they may not be able to buy their Medigap policy back again if they decide to later drop the MA plan. Given the confusion over how PFFS plans work for people with both Medicare and Medicaid (which can vary by state), there should be disclaimer language specific to this population (re: cost-sharing, access to Medicaid benefits). Marketing material should also direct prospective enrollees to State Health Insurance Program (SHIP) counselors for advice on enrollment decisions.
- *Verification Calls* – In order to eliminate plan bias, verification calls should be performed by an entity independent of the plan. In addition, verification calls must be placed in the primary language of the applicant.
- *Agent Training* – Training requirements should include how MA and other plans interact with other types of insurance (Medicaid, Medigaps, retiree benefits, etc.) and that individuals with certain kinds of insurance are in danger of losing it if they enroll in an MA or PDP. Also, instead of in-plan monitoring, there should be a third

party conducting the training and testing. CMS should mandate use of CMS-developed scripts for training of marketing agents. Training scripts should include clear, unbiased explanations of the coverage options available, including Original Medicare, Medigap supplemental plans, Medicare Advantage, Medicaid and Medicare Savings Programs, as well as marketing guidelines. Training should not be limited to company product lines; the training should enable agents to help beneficiaries make the most appropriate choice among their coverage options.

□ *Additional Protections* – Absent a ban on sales in the home or in senior or disabled housing facilities, CMS should implement reporting requirements that enable the plan and CMS to identify and prevent unsolicited door-to-door sales. All in-home enrollments should be flagged and the agent should be able to document how an invitation for an in-home presentation was secured. Mass enrollments at sale presentations should also trigger increased plan efforts to verify suitability of the product for the new enrollee and should be discouraged or barred in the commission structure for agents. Mass enrollments indicate an absence of individualized attention on the part of the agent necessary to ensure the product sold is appropriate to an individual's needs. Similarly, 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.

- 1 Issue Brief is available at: http://www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf
- 2 "CMS Warns Part D Plans Against Misleading Marketing Practices by Agents and Brokers" *Medicare Part D Compliance News*, January 2007 (Vol. 2, No. 1)
- 3 Quoted in "CMS Warns Part D Plans Against Misleading Marketing Practices by Agents and Brokers" *Medicare Part D Compliance News*, January 2007 (Vol. 2, No. 1)
- 4 See, e.g., *Inside CMS* (Vol.10, No. 11 – May 31, 200) article entitled "Baucus Criticizes CMS Promotion of Medicare Advantage Plans" describing a CMS press briefing on the Medicare Advantage program on the eve of a Congressional hearing examining PFFS plans wherein CMS "defended MA – in particular the PFFS plans – claiming the program provides valuable services to some of the nation's hard to reach patients"; also see, e.g., letters to CMS from members of Congress concerning misleading information favoring Medicare Advantage plans in both the 2006 and 2007 *Medicare & You* publications (April 6, 2005 letter referenced in CHA/MRC report "After the Gold Rush" at footnote 18; October 2006 letter referenced in *Inside CMS* article cited in this footnote).
- 5 "CMS Warns Part D Plans Against Misleading Marketing Practices by Agents and Brokers" *Medicare Part D Compliance News*, January 2007 (Vol. 2, No. 1)
- 6 "Oklahoma Chides Insurer in Medicare Marketing Case" by Robert Pear, *New York Times*, 5/15/07

- 7 "As PFFS Gains Popularity in MA Market, Regulators Keep Watch on Sales Efforts" *Medicare Advantage News*, Atlantic Information Services, Inc., February 8, 2007 (Vol. 13, No. 3)
- 8 See, e.g., Mississippi Insurance Department press release entitled "Abusive Medicare Insurance Sales Practices Spreading Throughout State" (4/11/07) at: <http://www.doi.state.ms.us/pressrel/pressrel041107b.pdf> ; Louisiana Department of Insurance notice to insurers and brokers entitled "Unlawful Marketing and/or Sales Practices of Medicare Related Products" (3/15/07) at: http://www.lidi.la.gov/docs/commissionersoffice/legal/Bulletins/Bul07-02_Cur_UnlawfulMarketingAnd.pdf ; press release by Kansas Insurance Department entitled "Consumer Alert: Medicare Recipients Warned to Resist Aggressive Marketing" (2/27/07) at: <http://www.ksinsurance.org/gpa/alerts/MedicareAdvantageAlert.pdf> ; press release by North Carolina Insurance Commissioner entitled "Medicare Recipients Warned to Resist Aggressive Marketing" (2/22/07) at: <http://www.ncdoi.com/media/news2/year/2007/022207b.asp> ; Wisconsin Commissioner of Insurance press release "OCI cautions seniors about Medicare Part D marketing practices" (11/16/06) at: <http://oci.wi.gov/pressrel/1106medptd.htm>
- 9 Mississippi Insurance Department press release entitled "Abusive Medicare Insurance Sales Practices Spreading Throughout State" (4/11/07) at: <http://www.doi.state.ms.us/pressrel/pressrel041107b.pdf>
- 10 Press release by Kansas Insurance Department entitled "Consumer Alert: Medicare Recipients Warned to Resist Aggressive Marketing" (2/27/07) at: <http://www.ksinsurance.org/gpa/alerts/MedicareAdvantageAlert.pdf>
- 11 See 72 *Federal Register* 29368 (May 25, 2007); also see CMS's 5/21/07 Press Release at: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2175&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>
- 12 The Final 2008 CMS Call Letter is available at: <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>
- 13 See CMS website at: <http://www.cms.hhs.gov/PrivateFeeforServicePlans/> under "Ensuring Beneficiary Understanding of Private Fee-for-Service Plans"
- 14 See 6/15/07 press release on CMS website at: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2214&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>
- 15 AHIP Comments on Draft CY 2008 Call Letter (April 3, 2007); re: outbound verification calls: "Under the draft, PFFS plans would be required to call all new applicants signed by a broker/agent to confirm the beneficiary's understanding of the plan's features and intent to enroll. It is our understanding that some organizations may also use inbound calls from the beneficiary and broker/agent to confirm the beneficiary's knowledge and intent prior to enrollment. We recommend that the draft be revised to provide flexibility to permit plans to make use of alternate strategies to confirm beneficiary understanding and intent to enroll" (p. 9).
- 16 6/15/07 CMS press release on CMS website at: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2214&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>
- 17 See Oklahoma Insurance Department Limited Market Conduct Report of Examination of Humana Insurance Company for the period as of September 15, 2006.
- 18 See AHIP marketing principles – May 2007: <http://www.ahip.org/content/fileviewer.aspx?docid=19761&linkid=170189>
- 19 CMS Warns Part D Plans Against Misleading Marketing Practices by Agents and Brokers" *Medicare Part D Compliance News*, January 2007 (Vol. 2, No. 1)
- 20 See <http://www.gormanhealthgroup.com/enews/Certificationlowres.pdf>

- 21 See, e.g., 5/22/07 testimony of Abby Block “Certain plans also are currently required under corrective action plans to call-back beneficiaries after an initial enrollment to confirm the intent to enroll.” <http://www.hhs.gov/asl/testify/2007/05/t20070522a.html> ; also see, e.g., as a result of an audit in March 2007, CMS “delivered a firm compliance message” to WellCare and imposed certain requirements that the plan had to follow – 3/21/07 letter from CMS Acting Administrator Leslie Norwalk to Rep. Pete Stark; also see, e.g., “Sales Tactics Unhealthy for Care Plans” by Victoria Colliver, *San Francisco Chronicle*, 5/16/07 – stating that Medicare had “forced UnitedHealth Group to start verifying enrollments late last year because of complaints about marketing techniques for its SecureHorizons fee-for-service plan.”
- 22 Abby Block, CMS, Center for Beneficiary Choices, quoted in the *Washington Post* at: <http://www.washingtonpost.com/wp-dyn/content/article/2007/06/15/AR2007061501943.html>
- 23 “Special Analysis Report: New Agreement on Medicare PFFS Keeps Critics At Bay” by Roy Moore, HealthLeaders-InterStudy; see: <http://home.healthleaders-interstudy.com/index.php> ; also, e.g., as noted by Robert Laszewski, head of Health Policy and Strategy Associates, the spectacle surrounding the voluntary suspensions have allowed companies to turn around a “public relations debacle” without harming their bottom line (see: <http://www.bloomberg.com/apps/news?pid=20601087&sid=aoXwEooUGzwE&refer=home>)
- 24 “Special Analysis Report: New Agreement on Medicare PFFS Keeps Critics At Bay” by Roy Moore, HealthLeaders-InterStudy; see: <http://home.healthleaders-interstudy.com/index.php>
- 25 See, e.g., statement of Universal American Financial Corp. Chairman and CEO in a 6/15/07 press release: “We already have in place most of what CMS is requiring...” and corresponding document wherein Universal American declares: “Because we are already in compliance with most of the 2008 requirements today, we believe we are in a position to satisfy all 2008 CMS requirements quickly.” Also see, e.g., 6/15/07 WellCare press release stating “WellCare has previously announced enhancements to its compliance program for its PFFS products, including an inbound telephone enrollment and verification process and a “secret shopper” program using an independent organization to anonymously monitor field marketing activity. These enhancements are in addition to extensive compliance efforts already in place for independent sales agents” - available at: <http://biz.yahoo.com/bw/070615/20070615005661.html?.v=1>
- 26 “The Cost of Privatization: The Extra Payments to Medicare Advantage” Brian Biles and Emily Adrion (May 1, 2007)
- 27 See, e.g., MedPAC Report, March 2007, finding that MA program payments are 112% of original Medicare fee-for-service levels, and PFFS payments reached up to 119% -- report available at: http://www.medpac.gov/chapters/Mar07_Ch04.pdf
- 28 See, e.g., Coventry/Advantra Freedom memoranda to “Advantra Freedom Agents” entitled “Private Fee For Service Dual Eligible Enrollment” that states: “Coventry Health Care believes that our Private Fee for Service Advantra Freedom products may not be the best health care coverage solution for Medicare beneficiaries who have both Medicare and Medicaid coverage (dual eligible).” The memo goes on to state several reasons for this conclusion, including: “[o]ur Advantra Freedom products will in many cases increase their financial exposure for covered services in the form of increased co-pays or coinsurance”; “[c]oordination of benefits with most states is often arduous and in some cases, state Medicaid departments prohibit coordination of benefits with Medicare Advantage plans.” Memo available at: <http://www.advantrafreedom.com/content/plan/91/DPDualEligibleGuidance.pdf> ; a companion memo concerning institutionalized individuals is available at: <http://www.advantrafreedom.com/content/plan/91/FCInstitutionalMembers.pdf>
- 29 Presentation by Veridign Health Solutions Vice President Mike Rae – “Breaking Down Barriers to Growth: Innovations in the Marketplace” (Undated – late 2005/early 2006?), available at: http://www.iirusa.com/upload/wysiwyg/P1177_files/IIR_P1177_Rae.pdf (see specifically slides 10 and 18; also see slide 20 re: keeping “CMS happy” and slide 25 re: targeting people aging into Medicare at age 65 as “[f]irst eligibles [as] the main source of younger (healthier) sales. Younger members provide for higher lifetime value.”)
- 30 See excerpt of *Medicare Advantage News* (11/10/05) at: http://www.gormanhealthgroup.com/articles/leadership/MAN-05_11_10.pdf ; also see, e.g., advertisement for an April 2006 Atlantic Information Services (AIS) audioconference entitled “Strategies for the May 15 Medicare Part D Lock-In” at: http://www.aishhealth.com/Products/cmspl_042006.html ; an excerpt from the text reads: “With many Part D implementation issues now behind them, plan sponsors and their partners and vendors now must focus on retaining their new members in the face of potential “poaching” that is expected from competitors as the May 15 lock-in date approaches. And aggressive member-retention strategies will be needed after May 15 as well, since it is “open season” all year long for Medicare-Medicaid dual-eligible members who are auto-enrolled into Prescription Drug Plans (PDPs) and not subject to the lock-in.”
- 31 See Joint Comments to CMS’s 2008 Call Letter submitted by National Senior Citizens Law Center, Center for Medicare Advocacy, Inc., Families USA, Medicare Rights Center, California Health Advocates and Pennsylvania Health Rights Project; some of these Joint Comments have been incorporated in the recommendations outlined in this report; the Joint Comments are available at: http://www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391/article.2007-04-26.0125948225/at_download/attachment