

**SELLING TO SENIORS: THE NEED FOR
ACCOUNTABILITY AND OVERSIGHT OF
MARKETING BY MEDICARE PRIVATE PLANS**

HEARINGS

BEFORE THE

**COMMITTEE ON FINANCE
UNITED STATES SENATE**

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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FEBRUARY 7 AND 13, 2008
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**SELLING TO SENIORS: THE NEED FOR
ACCOUNTABILITY AND OVERSIGHT OF
MARKETING BY MEDICARE PRIVATE PLANS
(PART I)**

THURSDAY, FEBRUARY 7, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:10 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Lincoln, Wyden, Stabenow, Grassley, and Snowe.

**OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR
FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. The hearing will come to order.

The book of Leviticus directed the ancient salesman to deal fairly. Leviticus commanded, "Do not falsify measures of length, weight, or capacity. Keep an honest balance, honest weights, and honest measures." Centuries have passed, but the challenge of maintaining honesty in sales continues.

Today we are going to hear how some insurance salespeople are selling private health insurance for Medicare dishonestly. For example, some insurance sales agents canvass seniors' housing complexes to talk about "Medicare benefits." They gain entry into homes because seniors think that the salespeople come from the Medicare program. Once the salesmen get inside, some seniors have a hard time saying no. Seniors often cannot get the salesmen to leave until they sign something. That is usually an enrollment form. Seniors do not realize that they have been duped until they get a "welcome to our plan" packet in the mail.

Another example. In New York, one company parked a sales van outside a senior center and herded seniors toward the van to discuss "new Medicare benefits." The seniors did not understand that they were signing up for a private plan.

Of course, there are some good companies and good agents that want to give seniors an honest deal, but far too many insurance salesmen are misleading seniors when they sell them private Medicare plans. The push to sell Medicare benefits by private plans has been aggressive at best. Too often, it has been abusive or downright fraudulent.

In December, MedPAC said that it found evidence of hard sell tactics in interviews with a dozen groups of beneficiaries around the country. MedPAC's analyst reported "in all 12 focus groups, at least one member mentioned horror stories about marketing abuses."

Last year, the National Association of Insurance Commissioners did a survey of States. Forty-one States responded to the survey. In 39 out of 41 States responding, there were complaints about misrepresentations by insurance agents or companies marketing their Medicare products, and 22 States reported fraudulent activity, like falsifying signatures on applications.

States are preempted by statute from regulating private Medicare plans, but the problems are so egregious and widespread that insurance commissioners convened a task force to develop stronger rules that they will share with the administration. We hope to see the recommendations this summer.

Congress gave the Centers for Medicare and Medicaid Services exclusive regulatory authority over private insurers selling Medicare benefits. The rationale was that a Federal agency should regulate a Federal program with one set of rules. But the rules need to be stringent and the rules need to be enforced, otherwise private companies who care most about profits and earnings will find it too easy to take advantage of the elderly and disabled people just to make a buck. We will discuss oversight of private plans by CMS in a separate hearing.

There are too many problems and abuses, and it is not just in a few States, it is in most States. Ask your State Health Insurance Assistance program and local advocates. They will give you scores of cases where agents have pressured, fooled, or defrauded seniors into buying their plans.

Today I hope we will hear solutions. Let us have a constructive dialogue about the problem and ways to fix it. The Finance Committee has jurisdiction over Medicare, and we will legislate new marketing rules if that is what is needed. We will do what we need to do to protect and serve the people who are entitled to Medicare benefits.

So today we will examine the sales and marketing practices of private Medicare insurance plans. We will see how the challenge of maintaining honesty in sales continues to this day, and we will see if we can learn of any new ways to make sure that seniors get a fair deal.

I would now like to welcome our witnesses. First, we will hear from Mr. Michael McRaith, Director of Insurance for the State of Illinois; second, Mr. George Harper of Mayflower, AR. I am sure at the appropriate point the Senator from Arkansas would like to introduce you, Mr. Harper. In fact, this would be a good place to do that.

**OPENING STATEMENT OF HON. BLANCHE L. LINCOLN,
A U.S. SENATOR FROM ARKANSAS**

Senator LINCOLN. Well, thank you, Mr. Chairman. Thank you again for holding this very important hearing. It is important to our health care system, and to our constituents. I am not really happy about the reason that George Harper is here today. He is

here because he has been taken advantage of by an agent of this program that we call Medicare Advantage. But I am very proud that he is here, and I am always proud when I can share my constituents with my colleagues here in Washington to help us solve the problems that exist out there. I know that that is why George is here.

But it is, indeed, my pleasure to introduce him, welcome him, and thank him for coming all the way to Washington, DC from Mayflower, AR just to tell us his story.

The CHAIRMAN. Senator, if you could just proceed. I have to take a telephone call. Why don't you just go right ahead and introduce the rest of the witnesses, and we will start with you, Mr. McRaith, when you are finished.

Senator LINCOLN. I would be glad to. Thank you, Mr. Chairman.

It is my hope that the power of his story and the other testimony and cases that we will hear today will help to ensure these marketing abuses do not take advantage of other seniors across the country.

Mr. Harper is 73 years old and has been married to his wife, Pauline, for 52 years. They have 7 children, 32 grandchildren, and 15 great-grandchildren. Mr. Harper grew up in a farming family near Mayflower, AR, where the Harpers live today. Their children have all settled nearby. Most live within 3 miles of them. What a blessing. The Harpers spent several years in Kansas City, where he worked for Ford Motor Company for 15 years before moving back to Mayflower to be near their family.

Mr. Harper worked for several companies before retiring from Carrier Air Conditioning. When Mr. Harper retired, he took over the full-time care of his wife from their eldest daughter, who had come by every day to help take care of their mother, as she requires regular dialysis treatments and is blind.

Both Mr. Harper and his daughter are trained in performing home dialysis. Mr. Harper does all the cooking, housekeeping, and cares for both his and Mrs. Harper's health. What an incredible blessing you are to her as well, Mr. Harper.

Mr. Harper, I just want to welcome you and again thank you for your willingness to tell us your story. I think it is so powerful, and I think it is so powerful for people in Washington to hear what it is that we regularly hear from our constituents in our offices in order to be able to understand why it is that we feel so passionately about doing things to correct problems that exist and move forward.

I would also like to take a moment to thank the Arkansas SHIP and its Director, Melissa Simpson, who is also here today with us. You and your staff, Melissa, have offered tremendous support to our seniors and have been very gracious in teaching us about some of what is going on in Arkansas, and I wanted to add that special thanks as well.

So, Mr. Harper, thank you. I am proud that you are here with me and my colleagues today, and we appreciate your willingness to tell your story.

Our third witness is Mr. Peter Hebertson, Director of Outreach for Salt Lake County Aging Services in Salt Lake City, Utah. Wel-

come. We appreciate you being here. Fourth is Mr. Patrick O'Toole, vice president of sales and marketing for Humana.

I want to thank you all for taking the time to speak with us today. As a reminder, just limit your oral presentation to 5 minutes, and your written statements will automatically be submitted into the hearing record.

So, thank you all very much for being here. We will begin with Mr. McRaith.

**STATEMENT OF MICHAEL McRAITH, DIRECTOR OF
INSURANCE, STATE OF ILLINOIS, SPRINGFIELD, IL**

Mr. McRAITH. Senator Lincoln, Senator Wyden, Senator Stabenow, thank you for inviting me to testify this morning. I am Michael McRaith, Director of Insurance for the State of Illinois, and I also speak today on behalf of the National Association of Insurance Commissioners.

In 2005, when introducing Medicare Part D in the Illinois wrap-around program to seniors, I met with the retirement community on the Peoria riverbank. I sat next to a single elderly woman, tiny, spry. She whispered that her husband of nearly 50 years died just months before, that he understood this stuff and that this most basic presentation simply overwhelmed her.

In 2007, an agent worked the halls of a senior high-rise near Joliet and pushed a Medicare Advantage application on an elderly woman. She signed the paperwork, telling the agent to hold the documents until the next day so that she could verify his assertions. By the next day, the agent had already processed the application. She could no longer participate in the Illinois senior drug program, and her long-time physician was now out of network.

Humana generates nearly three-quarters of its pre-tax profit from Medicare Advantage plans and sold those plans in Illinois through at least 67 unlicensed agents, even though we maintain a 24/7 online and publicly available agent database. The problem is national. Of 36 States that replied to a recent NAIC survey, 34 reported complaints in the marketing and sales of Medicare private plans; 21 reported complaints about cross-selling; 32 reported complaints about practices misleading beneficiaries into Medicare Advantage plans; and one-half reported that the situation has not improved within the last year.

Seniors are pushed into Medicare Advantage plans they do not need, they cannot afford, or do not want, but States cannot protect those seniors. Seniors, often the most vulnerable of your constituents, often alone, reliant upon fixed and limited incomes, have fewer protections than we afford conventional private insurance consumers.

Seniors have to fight a company alone or call an 800 number and be put on hold for 20 or 30 minutes before CMS will recognize a complaint. Ad hoc CMS guidelines or call letters issued after media reports do not serve the consumer interest. The status quo is not working. State insurance regulators have the institutional knowledge to improve the marketing practices of private Medicare plans. Each day, we analyze the inherently local questions of provider network adequacy, agent conduct, or accuracy of insurer marketing.

To be clear, State commissioners accept CMS's authority over Medicare's commercial arrangements, review and approval of contracts of bids and premium rates, and, yes, the marketing and sales materials. State commissioners do not advocate for 50 different standards or prior State approval. We do endorse the measured approach described in S. 1883, the Accountability and Transparency in Medicare Marketing Act of 2007.

The Medigap paradigm from 1990 demonstrates that the NAIC can effectively develop national marketing and sales standards that are balanced, but prioritize the consumer interest. We can do the same for Medicare Advantage and prescription drug plans. These standards could then be adopted by the Secretary of Health and Human Services to govern private Medicare plans.

Practices like telemarketing, rebates for enrollment, bonuses for number of submitted applications, cross-selling, cross-branding, tying, sales in senior homes, all must have more clear guidelines and State-based enforcement. With national standards and authority as granted by S. 1883, States can analyze and examine company behavior and impose appropriate penalties. Departments of Insurance can assist seniors if they have been harmed.

Our protective focus must always remain on the consumer. We can prevent problems rather than deal with the aftermath. We ask you to promptly enhance the safeguards for vulnerable seniors in your State, and around the Nation. The NAIC stands with this committee, and Congress, as you consider the Accountability and Transparency in Medicare Marketing Act of 2007. I pledge to you NAIC's support for the constructive process that you have continued today.

Thank you for your attention. I look forward to your questions.

The CHAIRMAN. Thank you, Mr. McRaith, very much.

[The prepared statement of Mr. McRaith appears in the appendix.]

The CHAIRMAN. Mr. Harper? I must say, that is one of the best introductions I ever heard given to any witness, when Senator Lincoln was introducing you.

**STATEMENT OF GEORGE HARPER, MEDICARE BENEFICIARY,
MAYFLOWER, AR**

Mr. HARPER. Good morning to the whole panel of Senators. I say to my Senator, Ms. Blanche, it is an honor to be here. I mean, a great honor, because I paid my dues, I thought, in society. I had numerous jobs, like she said. Now that we are in our golden years, I just hope that somehow we can finish them up happily.

So I just want to say, it has been a challenge to this outsider. When you can put so much faith in a person who comes in your house, and try to better your condition, and all it is is false statements, misrepresentation of where they come from. This gentleman entered into my home upon the pretense that he was from Medicare. I told him I had Medicare. At the time, he called me from my brother's house and I told my brother, tell him no.

But he came on anyway. By him coming by—I was wrestling with my wife because she had been home from the hospital for just a few days. He sat there at my table and he promised me and showed me—well, he tried to, I will put it that way—that this pol-

icy was something that us senior citizens were not aware of that we could get. I kept telling him I was satisfied with what I had, and he just kept on talking, kept on talking. I told him over and over that I did not want anything he had to say on it. I was satisfied with what I had.

Through this conversation, he was telling me more about myself than he wanted to know about me. That puzzled me. It irritated me. So finally I guess he recognized it and he left. That was on a Saturday. On Sunday, another gentleman came by. He told me, "Mr. Harper?" I said, "Yes." He said, "Somebody from the insurance was going to come by to see you yesterday."

I said, "Fine." He said, "Did he sign you up?" I said, "No." He said, "I think you ought to look at your papers." He said, "Did he leave any papers with you?" I said, "Yes, he left some forms with me." He said, "I think you ought to go see them." He said, "Can I see them?" I said, "No, you cannot see them." I was leery. I have always been leery about letting him see them.

But anyway, he said, "You need to look at them." He said, "Once you look at them, he said, you need to call the gentleman." I looked at the form after he left. Before he departed he said, "You are signed up." I said, "No." He said, "You call this gentleman." Okay. Fine. Monday morning, I call him. He told me, no, I left those forms, and like I told you, if you did not want it—if you decide to take it, I will fill them out and send them in, the forms.

I wrestled with this for that whole week, trying to get in touch with him again, which I never could. He told me to call the office, he took care of it, blah, blah, blah. Anyway, a week's time I wrestled with this. I went from A to B, from B to A, back and forth. And I have been trying, up until Social Security finally called me and let me know that I was back into Medicare.

But in between times, when I went to get our prescription drugs, that was the first name that popped up and I could not fill the prescription because the pharmacy did not know how to fill it, under what plan. I go to the hospital. They did not know how to bill anyone, because when they keyed it in it would be the first company to pop up. We finally got it straightened out. So finally I asked him to send me my money, which I have never gotten.

Up to today, I am still fighting these people. I just ask this panel today, give us a little freedom as old people, before you bury us, give us a little joy. That is all I ask, and I hope and pray to God that you understand where I am coming from. I cannot say everything today, but this is my closing of my conversation. Thank you very much.

The CHAIRMAN. Thank you, Mr. Harper. It was very compelling.

[The prepared statement of Mr. Harper appears in the appendix.]

The CHAIRMAN. Next, Mr. Hebertson. Why don't you proceed?

STATEMENT OF PETER HEBERTSON, DIRECTOR OF OUT-REACH, SALT LAKE COUNTY AGING SERVICES, SALT LAKE CITY, UT

Mr. HEBERTSON. Good morning, Chairman Baucus and distinguished members of this committee. I really appreciate this opportunity to spend a few minutes in telling you what we are seeing on the streets in Salt Lake. Mr. Harper's story is all too common,

and we get to deal with people who have these experiences every day.

One of the programs that I have the opportunity to manage is the State Health Insurance Information Program. This is the program—and ours is based through an Area Agency on Aging—where we help people understand their Medicare benefits. We do that in several ways—by providing information and assistance, we provide screening assistance—but one of the things that is starting to really creep into our daily lives is handling complaints just like Mr. Harper described here today. Those are taking more and more of our time and really making it difficult for us to get to the information and assistance that we would like to get.

Nonetheless, we are very proud of what we do. Salt Lake County has 95,000 people with Medicare, and that number grows every year. Part of the success that we have had, and I just need to mention this, is that we have developed an Access to Benefits Coalition where we have brought together a lot of interested stakeholders in the Medicare issue, so we meet monthly with CMS, Social Security, nonprofit State agencies.

Part of the other group that we have brought to that table is the private plan insurance companies. So I work very closely with a lot of these private plan companies, and we are all trying to impact positive changes for seniors and people with Medicare to understand their benefits.

I think, fortunately, Salt Lake has worked with the private plans, and I do not know that we have seen a lot of the systemic abuses that we see throughout the country, but we still see a lot of issues. As a matter of fact, we are getting daily reports of seniors who are being misled about the Medicare Advantage programs.

So let me tell you some of the kinds of issues that we are seeing. These are really complaints that we have gathered from seniors. One of the first things is just the quantity of mail that people receive. All right. This is not illegal, but what it tends to do is it becomes very confusing to people. So we see them come in with stacks of 2 to 4 inches of mail, and they are confused.

What we have experienced is, people who are confused tend to make poor decisions. We have had seniors who will throw away very important correspondences, particularly from the Social Security Extra Help Program, because they got that confused with the mailing, and because of that they have lost their coverage of the Social Security low-income subsidy, and that has been a problem.

Another problem that we see a lot is the aggressive telemarketing from the agents. These are people who somehow get the seniors' name on a call list, and they just keep calling and calling them. They are very aggressive in their attempts to get into the individual's house. We had a couple, both in their late 80s, who received multiple marketing calls from an agent trying to sell Medigap.

Finally they relented and let the person come out to the house. Again, like Mr. Harper, it was a very similar story. It was a lot of pressure on them. They ended up making a change. Then when they realized that that change was not benefitting them, they called us. We got the problem fixed, but this particular agent still continues to aggressively market to these people, even though they

had told him no after he enrolled them into a plan that was not best meeting their needs.

We have significant independent agent problems. I think a few of those include the agents who do not fully understand the Medicare plans that they are selling. We have agents who do not understand certain types of coverage issues, what enrolling somebody into a Medicare Advantage plan is going to cost, whether it is best for their drug coverage or not. The SHIIPs spend a lot of time trying to fix these issues.

Currently, that is very difficult because of the amount of resources that we get. I want to be out there helping educate people, helping them take an opportunity. We see all the choices that individuals have under this Medicare system, and if we screen them correctly they actually can save money. The problem is, the way the system is set up is, it is set up to market so that the people are pressured, like Mr. Harper, where they are only seeing one of the many options that are available to them.

We need to have a marketing system that I think upholds the intent of Congress and has people look at all of their options. As we talk, I think one of the issues that maybe we can talk about in the question and answer period is, one of the fundamental problems is the way the commissions are paid to the agents. I think that the decisions are being made based on the commission of the agent, not necessarily what is best for the individuals.

I will be happy to answer questions as the hearing proceeds.

The CHAIRMAN. Thank you, Mr. Hebertson.

[The prepared statement of Mr. Hebertson appears in the appendix.]

The CHAIRMAN. Mr. O'Toole?

**STATEMENT OF PATRICK O'TOOLE, VICE PRESIDENT,
MEDICARE SALES, HUMANA, INC., LOUISVILLE, KY**

Mr. O'TOOLE. Mr. Chairman, Senator Grassley, and committee members, I am Patrick O'Toole, vice president of Medicare sales for Humana.

Humana has over 20 years' experience offering Medicare beneficiaries affordable health plan coverage through a variety of plan products. We provide health benefits and related services to over 11.5 million members.

My written testimony details the Medicare Advantage programs, initiatives that Humana and our industry have undertaken to ensure marketing compliance, regulatory agent oversight, lessons learned, and recommendations for necessary program improvements, including more stringent Federal standards and increased Federal and State cooperation.

We believe that MA plans should be required to appoint agents. Humana appoints agents. HHS should limit the total commission compensation paid to agents to a fixed percentage of premium. There should be level commission payments year over year for both renewal or replacement sales.

HHS should establish a registry of agents where data on verified sales practice violations are maintained. This protects beneficiaries and plans. CMS should continue to work with State regulators on increased debit exchange and enforcement actions. There should be

Federal standards related to cold-calling, cross-selling of non-health related products, consumer disclosures, uniform agent training and certification, co-branding, and more easily understood plan descriptions, to name a few. While we do not support benefits that limit choices for seniors, we do strongly support clear and understandable benefit terms.

Humana currently employs about 2,300 agents. Seventy-five percent of our agent sales come from our employees. We also partner with reputable sales organizations such as State Farm, USAA, and Thrivent. Last year, we reduced the number of contacted agents by 43 percent and the number of agents used by 29 percent in order to strengthen agent oversight and compliance outcomes.

Our agents must be licensed, appointed, certified to sell our Medicare products, and meet all regulatory and company requirements. They are background-checked and their licensure status is monitored monthly. All agents must participate in structured training in annual recertification programs, and their activities are monitored monthly.

Every agent signs a code of ethics that prohibits door-to-door marketing, cold-calling, high-pressure sales tactics, failure to fully disclose plan benefits or rules, inappropriate enrollment in a plan that does not meet the beneficiary's needs, falsified application forms, gifts or financial inducements, enrolling beneficiaries not competent to make an enrollment decision, any misrepresentation by agents of whom they represent, and health screening, to name a few.

During 2007, we investigated about 1,595 MA sales allegations, 0.59 percent of our total agent-assisted sales. About 258 were confirmed, and corrective action was taken. In 2006, Humana terminated approximately 98 agents, and in 2007 terminated an additional 44. When we hear or identify issues, we take action.

Some of our marketing program improvements have included: educational outreach and special toll-free numbers and contacts with the State regulatory agents, SHIIPs, and beneficiary groups; a post-sale outbound enrollment verification process to confirm the beneficiary's intent to enroll; expanded instructional training; expanded employee field sales management's oversight of contracted agents; monthly management and monitoring reports on disenrollments, cancellations, and compliance; and secret shopping initiatives.

The MA program is governed by CMS, with State oversight for licensure and solvency issues. Last summer, Humana and other large plans voluntarily agreed to cease MA private fee-for-service sales and improve sales and marketing efforts. We also provide CMS with bi-weekly marketing reports and have regular calls.

CMS secret-shops MA plans' call centers and sales presentations. Two State Department of Insurance agent licensure issues arose in 2005–2006 and have been remedied system-wide.

In May 2007, our trade association board adopted a set of industry principles to protect Medicare beneficiaries and has been working with beneficiary groups and broker groups for strengthening marketing programs that are detailed in my testimony. We in our trade group are active participants in the NAIC's Medicare Private Plan Workgroup to reach consensus among State and Federal regu-

lators, beneficiary groups, and plans on strengthening this program.

As our recommendations indicate, we believe Federal standards should be strengthened to protect beneficiaries. There should be no tolerance for sales practices that do not meet the highest standards of ethical conduct.

Finally, I encourage you to preserve the competition, choice, and innovation that have played such a crucial role in delivering savings and value to our Nation's Medicare beneficiaries. Our members depend on, and want to continue, receiving quality, affordable coverage.

Thank you.

The CHAIRMAN. Thank you, Mr. O'Toole, very much.

[The prepared statement of Mr. O'Toole appears in the appendix.].

The CHAIRMAN. I would now like to turn to Senator Grassley at this point, if you would like to make a statement.

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Yes. I would like to make a statement. Usually when I am late, I put it in the record. But before I go to my statement, I want to say, over a period of the years and history of Medicare Advantage, I have considered myself a friend to Medicare Advantage. I am still a friend of Medicare Advantage, and I want to continue it.

It happens that I am more of a friend to Medicare Advantage when it includes all 50 States instead of just Florida, Texas, California, et cetera. For years, that was true, except for Pottawattamie County, out of 99 Iowa counties, which was across from Omaha. Those 4,000 Iowans had the benefit of it, but nobody else in Iowa. So in 2002–2003, Senator Baucus and I set out to make sure that this was a program that was beneficial to rural America, as well as a few States.

We wrote the provisions that are presently in the law that made it possible to be in rural America. But we learned sometimes that, when we think of things to do it right, we might not always get it right. So the last hearing, this hearing, and one more hearing, we are reviewing the things that show what is right or wrong about Medicare Advantage.

So I hope when we are done, at least I am going to work towards solutions to these problems in a way to make sure that we still have Medicare Advantage in rural America, because it is a national program and we ought to have it for everybody. Iowans have always been asking me before 2005, how come we cannot get Medicare like they have in places like Florida and Texas?

I presume Iowans want to get out of the cold, and they go to Florida and they find out. You know, it is not right. They are getting things on Medicare in Florida that I cannot get in Iowa. So, we have some equity and we want to keep that equity, but we also want to make sure that we are good caretakers of the taxpayers' money.

So with that ahead of what I am saying, Mr. Chairman, first of all, thank you for your leadership to look at things that are not

quite right about this and try to correct them, and particularly as it relates to fee-for-service. In Iowa this past December, some of my constituents found that they had been sold Medicare Advantage plans that their doctors did not take. I have heard from some people that “the salesman told me all the doctors took the plan.” That is not right, and the agent should not have said that.

The agent may not have intended to mislead my constituents, but they ended up in a plan that did not work for them. It made me wonder about the agent’s training and incentives. I am hearing that seniors, who are perfectly happy with their health coverage, are getting a hard sell to change plans each year. I am hearing stories about agents visiting homes of elderly sick with the flu and insisting on enrolling them in private Medicare plans.

I am hearing that health plans are buying beneficiaries lunches and dinners as part of the sales pitch. Some people feel obliged to enroll as a result. I am hearing that seniors who ask for Medigap coverage have ended up in a Medicare Advantage plan. They are stunned to find out, usually about the time they receive bills for cost-sharing that they thought Medigap covered.

Now, some of this may be the result of Medicare beneficiaries not examining their choices carefully, and these are anecdotes that implicate only a few of many agents and plans working with Medicare beneficiaries on their plan options. Nonetheless, it appears that some Medicare beneficiaries were subject to abusive sales practices just months ago. There were a number of shocking stories in 2006 about Medicare Advantage and Part D plan sales activities.

While I am a proponent of the Medicare choices, it was clear this was an area that needed close scrutiny. As a result of these start-up problems, in 2006 CMS clarified its policies. It has continued to tighten up sales requirements for plans, and anecdotal evidence suggests that the worst of the abuses may have ended. I commend CMS for those steps.

But there are some areas that CMS did not address. Commissions, for example, continue to give agents the wrong incentives. I have here an ad that was posted. Do we have that ad? All right. I have an ad posted on Craigslist on the Internet a few days ago. It is an ad for agents to sign up seniors to Medicare Advantage programs. It suggests that Medicare Advantage is just an add-on to Medicare. It suggests that all Medicare Advantage plans—I have had a chance to read that, but it was a couple of days ago. But anyway, this is what I am referring to. It suggests that all Medicare Advantage plans are free. It says that enrolling the beneficiary is really not a sale. They sign up and you get the commission. Mr. Chairman, I would ask consent that that be inserted in the record.

The CHAIRMAN. Without objection.

Senator GRASSLEY. Maybe you have already done that.

The CHAIRMAN. No, not yet.

[The advertisement appears in the appendix on p. 70.]

Senator GRASSLEY. This ad tells me that something is wrong with how the agents, and perhaps the plans, are looking at Medicare Advantage. That ad makes it clear that not everyone out there is acting with the beneficiary’s best interests in mind. I have heard from insurance agents that some plans’ commission structures were providing incentives to urge seniors to switch plans each year.

The plans themselves have told me they wish someone would intervene to regulate commissions. Another problem is that some agents tell beneficiaries that they are from Medicare. This is a violation of Federal regulations, but it continues to happen. Door-to-door salesmen are barred in Medicare. Cold-calling is not allowed. An agent may visit if a beneficiary has indicated interest in meeting with an agent. You can see how a senior might agree to a meeting just to get an agent to stop calling.

CMS has tried to get a handle on abusive sales activities. Last summer, it suspended marketing by seven private fee-for-service plans until they instituted key reforms, such as improved agent and broker training. Last December, CMS suspended sales and enrollment by an overly aggressive Medicare Advantage plan. The States agree that they have authority over insurance agents, yet they complain that they lack the authority to hold the Medicare Advantage plans accountable when there is a pattern of abusive sales practices. They also say that CMS lacks experience and staff to oversee plans' sales activities.

So a key question is whether the current CMS guidance and enforcement actions are adequate to protect beneficiaries from abusive sales tactics. While we are not hearing today from Kerry Weems—that is going to be next week—I am glad that we have these witnesses before us today to shed light on this. I was only able to hear half of the witnesses because I was at the prayer breakfast this morning, which is a once-a-year event. Thank you very much.

The CHAIRMAN. All right. Thank you, Senator Grassley.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. I have a chart here, and I would just like you, Mr. Hebertson, to comment on it. I know the print is quite small here, but you did refer to commissions in your statement. I will try to read it to you.

[The chart appears in the appendix on p. 65.]

The CHAIRMAN. This is Humana. As I understand it, it is the commission structure. It is green. I do not know if that is supposed to represent money or environment, I am not sure which. But essentially, I will explain it to you. It explains to agents that they will receive certain bonuses, and increased bonuses depending upon the number of applications approved.

Basically, it is \$1,000 for the first 25, and they will receive an additional \$1,000. When you get up to the hundreds, the agent receives an additional \$1,500. When it gets up to 125, the agent gets a bonus of \$2,500. At 150, it is a bonus of \$3,000. If you get to 150, you get an additional \$10,000 bonus.

I might say, I do not know if it is totally coincidental, Humana received about \$4 billion, I think it is, either profits or sales in Medicare this last year. It is a big company, and they have a lot of bonuses here.

So could you comment, please, on the degree to which this kind of compensation structure is part of the problem?

Mr. HEBERTSON. Yes. I think when we were discussing this back in Utah, I got together with our coalition, which includes the Medicare Advantage plans, and they are the ones who will admit to me

that the way the commission structure is paid to people is the problem, because the agents are looking at that chart saying, how can I maximize what I am making, versus taking a look at the consumer and saying, what is going to be in that individual's best interests? So, because the incentive is to get the commission, we have agents—and not all agents—who are out there looking at that incentive versus looking at the incentives that all of these choices offer which could be a real benefit to the consumer.

The CHAIRMAN. All right. I might ask Mr. O'Toole, is this same bonus structure applied to commercial sales as opposed to individual?

Mr. O'TOOLE. They have bonus programs, but I am not familiar with what occurs on the commercial end.

The CHAIRMAN. You do not know whether or not they are the same.

Mr. McRaith, could you comment on the structure and the degree to which you think it is part of the problem?

Mr. McRAITH. Mr. Chairman, I think you have identified the economic dynamic perfectly. We have a very large company that is shareholder-owned, has responsibilities and duties to its shareholders. Then we have the individuals who are on the street selling the policies. They have their own economic incentives. The chart, the board that you posted, is an example of how companies are incentivizing agents to generate volume. It is not necessarily quality.

There was one company that offered 3-night vacations in Las Vegas for its agents based on the number of applications they submitted. So, there is a real incentive to generate volumes regardless of quality in many cases, unfortunately. We have seen seniors suffer as a result of that incentive package.

The CHAIRMAN. What do you think we should do? There is this bifurcation between CMS regulation and State Insurance Commissioners and the others. You said you feel there should be certain national standards. If I heard you correctly, you felt that States should have a little more authority, I guess, to look into and investigate the practices of agents. Is that correct?

Mr. McRAITH. Well, Mr. Chairman, you did hear correctly that we do believe that more authority at the State level is absolutely essential. We are not looking for 50 different standards, however. There needs to be one national, uniform standard for marketing and sales materials that CMS can then implement as it reviews programs submitted by the plans. However, right now we have a gap.

We have companies pointing the fingers at agents, we have agents pointing the finger at companies, and somewhere in the middle is a senior like Mr. Harper who has a complaint about a company, and to deal with that problem he cannot go to his local State regulator to help him work through the issue with the company. He has to deal with CMS, and sometimes that process, in and of itself, is difficult.

The CHAIRMAN. So what additional authority do you think a State Insurance Commissioner should properly have to basically remedy the problems that Mr. Harper and so many other people experience?

Mr. MCRAITH. Mr. Chairman, right now, when we see a pattern of complaints relating to one company, we are able to go into that company, conduct a thorough examination from top down, understanding what is the source of the problem. We can then take or require the company to take corrective action. In the event they do not take corrective action or the action they take is too small, then we can impose appropriate penalties and fines. That in itself is a deterrent that generates more appropriate conduct by the companies.

The CHAIRMAN. So how would you apply that here? That is, let us take whatever company it is that Mr. Harper was having difficulty with. I mean, CMS has its rules and standards for the companies.

Mr. MCRAITH. Right.

The CHAIRMAN. But then there is a certain practice here that is clearly abusive and fraudulent. So ideally then, what authority would you want to have to look into problems like Mr. Harper is having?

Mr. MCRAITH. We would want the authority to go into the company, not just look at the agent, the individual licensee that is selling the policy to Mr. Harper. We want to know, what is the company behind that sale? What is the commission or incentive structure that the company is using to incentivize the agent? We want to know, what are the sales materials the company has produced, and are they accurate for that region? To have one national standard allows for regional differences, or fails to account for regional differences that we know exist.

As Senator Grassley pointed out, differences between suburban and rural areas—for example, the adequacy of provider networks when a consumer like Mr. Harper buys a Medicare Advantage plan. Is he buying into a network that includes his long-term physician? It is the local regulators who understand that dynamic better than the Federal regulators.

The CHAIRMAN. I appreciate that. Thank you very much. Senator Grassley?

Senator GRASSLEY. Senator Baucus asked questions along the lines of what I was going to ask, so I am moving on to something else.

To Mr. O'Toole, in your testimony you suggested that level commissions each year at a fixed percentage of premium would increase agents' incentives to make sure that beneficiaries are sold a plan that meets their needs.

Will you explain why you think this will help change agent behavior and improve service to beneficiaries? Then I would ask Mr. McRaith to follow up with whether or not he agrees with what Mr. O'Toole says about fixed and level commissions.

Mr. O'TOOLE. Yes, Senator. In line with our recommendations, fixed, level commissions based on a percentage of premium, year over year, on new sales as well as renewals, we think that that recommendation alleviates exactly that type of problem. It creates a level playing field. All carriers are in line and on a level playing field. We think that, in and of itself, will solve the issue.

Mr. MCRAITH. Senator, I think it is an excellent question that the Medigap regulations currently govern to some extent and that

the State is allowed to regulate, or that the States actually regulated under Senator Wyden's leadership back in 1990. But the fixed and level commission percentages deal with one specific issue, and that is the issue of churning. Is an agent going to be incentivized to place a consumer in a different policy in each different year to generate higher commissions? The fixed and level percentage commissions will address that issue, but not the much wider-spread issues.

The CHAIRMAN. Is that because of short enrollment periods?

Mr. MCRAITH. That is part of it, yes. That is part, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator GRASSLEY. I would follow up with you in a little bit different direction, the fact that many States require health insurers to notify them as to which agents the insurer has appointed to sell its products. CMS does not require what we call appointment, as it is called for the Medicare private plans. So for you, Mr. McRaith, would it help the States to oversee agent behavior if the plans had to meet State appointment laws? Would it have the same impact if CMS collected the names of appointed agents and shared them with the States?

Mr. MCRAITH. Senator, not every State requires appointment of agents. For example, in Illinois we do not require that agents selling Humana products, for example, be appointed by that company. I think there are six or seven States like Illinois that do not require appointments. The critical issue is, will the company, as the principal in that relationship, be held responsible for the conduct of its agents? That is the critical issue. That is why requiring appointment is essential. But more importantly, the companies, the insurance companies, should be held accountable for the conduct of the agents they have engaged to sell their products.

Senator GRASSLEY. In your State, do you have a better approach? Because you said you do not use the appointment process.

Mr. MCRAITH. We require that all agents be licensed. The issue that we had with Humana was they had used 67 unlicensed agents to sell their plans. However, if we find a licensed agent that is acting not in compliance with our consumer protection laws, then the company can be held responsible for the actions of that agent.

Senator GRASSLEY. I would ask Mr. Hebertson and Mr. O'Toole to listen to this question. Last week, we heard that beneficiaries often do not understand how their private fee-for-service plans work. Mr. Hebertson, you and your colleagues often attend Medicare private plan presentations. Do the agents, in your experience, accurately describe how the plans work, detail the cost-sharing requirements, and point out that beneficiaries need to check to make sure that their doctors will accept the plan?

Then Mr. O'Toole, following him, as the biggest seller of private fee-for-service plans, how does Humana make it clear to beneficiaries the limitations of that product?

Could you start out, Mr. Hebertson?

Mr. HEBERTSON. Sure. I am going to say not always do the agents know exactly what they are selling or take the time to go into detail to make sure the person understands what they are getting in these seminars. It happens pretty much yearly. This year we went into a seminar where they were doing exactly that, where

they were representing themselves as from Medicare. In the comparison, when they were comparing the particular fee-for-service plan, they were comparing it to Medicare, traditional Medicare, without factoring in that the person might have a Medicare supplement. So the cost savings looked very high to the senior, not realizing that if they factored in what the Medicare supplement plan would be, that it would be more level.

Then we have had experiences where we have asked them questions about a particular plan and they were not able to provide accurate answers. So, we do, indeed, see these types of sales presentations where the folks who are selling the private fee-for-service plans really do not understand it. That tends to be more of a problem when new plans are moving into the market and we do not have a close relationship with them. So, we work very diligently to maintain those relationships so if we do see these kinds of issues we can provide feedback to the plans or to the insurance commissioners, as needed.

Mr. O'TOOLE. Yes, Senator. First of all, Humana's position is, we do a lot of outreach to reach out to organizations such as Mr. Hebertson's to improve our relationship with the local regulatory entities. But agents who are selling the Humana product go through a comprehensive training program. We go into a lot of details regarding the different products that we offer, and we stringently follow the marketing materials that have been approved by CMS.

We have made a recommendation, and we support our trade association's recommendation, of improved model language to make some of the materials a little bit more consumer-friendly, if you will. That potentially could be some of the issue with beneficiaries not fully understanding things.

The CHAIRMAN. Thank you, Senator Grassley.

Next, Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

It seems to me, listening to your very powerful presentation, Mr. Harper, that the country is right back in the situation where we were prior to the enactment of the bipartisan Medigap law. Once again, you have vulnerable seniors, once again, there is big money, and once again there are these rip-off sales practices.

I have said it is pretty much like Dodge City before the marshals showed up. What is really needed is corrective action. The Federal Government has been dragging its feet. The Centers for Medicare and Medicaid Services have not demonstrated that they are willing to deal with the problem. I, with the leadership of Chairman Kohl and Senator Dorgan, as you have indicated, Commissioner McRaith, we have introduced S. 1883 because we would like to clean house and get this situation corrected.

Now, what the industry says is, they are taking all of these various steps to deal with the problem, and that we do not need this legislation. I want to make sure that the record is clear that these problems are still ongoing as of today. In other words, it is not correct to say that everything has been settled in terms of the State suits and the abuses have been cleaned up, but you and the NAIC believe that these problems are continuing today. Is that correct?

Mr. MCRAITH. Absolutely correct, Senator. Yes.

Senator WYDEN. And second, in the legislation Senator Kohl and I and others have worked on—and we want to work with Senators Baucus and Grassley—the heart of it is to cut the shackles off the States so that the States can go out there, consistent with this uniform kind of model that you are discussing, and make sure that we are actually doing good oversight at the State level with respect to both companies and marketing practices. Is that not the key to really getting this done right, cutting the shackles off the States?

Mr. McRAITH. I completely agree, Senator. In the summer, as has been mentioned, there was a moratorium. Seven of the plans adopted a moratorium on private fee-for-service. That was after a series of media reports. At the State level, we have dealt with these issues for decades. We understand them. So, up front there needs to be appropriate proscriptions on sales and marketing materials that Federal CMS can then implement nationally.

But on the back end, there needs to be a regulator who is able to respond to an individual complaint and go and look at a company or respond to a pattern of complaints, as almost every State has received, and look at a company and really scour that company and its business practices to understand and evaluate, is it complying with the national uniform standards.

Senator WYDEN. Mr. O'Toole, I think what is going on, particularly in the area of these abuses where you have had to pay these very large fines, I think this is giving the private sector in health care a bad name. Now, Mr. McRaith has indicated that the problems are ongoing. They have not been corrected as of today. Will you support the legislation now, S. 1883, that he has spoken favorably of, championed by Senator Kohl, the chairman of the Aging Committee? Will you commit to supporting that bill this morning?

Mr. O'TOOLE. Senator, it is our position that CMS and the States should work more collaboratively to oversee the—

Senator WYDEN. No. The question is, will you support the bill this morning? Mr. McRaith says that the problems are ongoing. It is a yes or no answer.

Mr. O'TOOLE. In that case, I would like to answer in writing.

Senator WYDEN. All right. I appreciate that, and I appreciate your candor.

Many then say, what is wrong with the concept that we are advocating with the leadership of Chairman Kohl to have this uniform approach—they do not have 50 standards—with respect to marketing, with respect to authority over the companies, in giving the States the ability, as we did with Medigap, to play a key role in enforcement? What is wrong with that? We think you have a valid point with respect to not having 50 State standards. So Mr. McRaith and our consumer coalition says one standard, but also we give the States the authority. What is conceptually wrong with that?

Mr. O'TOOLE. Senator, I believe the situation exists where CMS, working in collaboration with the States, improving their memorandum of understanding, can achieve the same outcome.

Senator WYDEN. Mr. McRaith has told us the problem has not been corrected. I will look forward to your answer for the record, and I hope that your company, given the huge fines that have been levied on you all for these marketing abuses, given what Mr.

McRaith has said in terms of the problem ongoing, I hope you will support the legislation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Wyden.

Now, Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. We are pleased to be having this hearing today. As Senator Wyden has mentioned, we heard about it in the Aging Committee, working with Senator Kohl. We heard about it in the press, and hundreds of articles, as has been mentioned. But most importantly, we are hearing from our constituents. I think the important point here today is that this is not an isolated issue. This is a systemic problem, and it is ongoing. In 2007, I know my office was dealing with more than 100 calls—hundreds of calls—in terms of this issue.

All of the other members of our delegation are doing the same. Our SHIIP office is dealing with it, the Area Agency on Aging. We are having a lot of these problems, and it is not going away and has not been cured. We need more accountability and oversight in marketing and sales of Medicare private plans. Mr. Harper's story is not unique. We could bring many, many who are constituents in here. We are hearing about the same abuses that are happening over and over from State to State.

In my State, a State with only about 10 percent of our seniors enrolled in MA, and of those mostly in private fee-for-service plans, we are hearing mostly that seniors are confused by their plans. But without a doubt, with these marketing practices, just the other day we had a woman who had an agent come in dressed in scrubs with a stethoscope around her neck to sell this woman a plan. The elderly woman let her in, I am sure, because she assumed that the woman was coming there to give her care. But these are practices that are inexcusable, and we have to do more.

I know from my home situation, my mother called the other day. She had a call similar to Mr. Harper's, someone who identified themselves as being from Medicare. She visited with the gentleman on the phone. He was very nice. As she began to give information, she became alarmed, then she became frightened, and then she got mad and hung up on the guy and called me. But the problem being, these are practices that are unacceptable. Again, I want to thank Mr. Harper for being here, for his testimony.

And since you have been a caregiver, Mr. Harper, just as my mother was for 10 years with my dad as an Alzheimer's patient, you have been caring for your wife. I know you have had many responsibilities, and would imagine that you have learned probably the hard way, just as we did in many instances, to be inquisitive and to get all the facts from people who are questioning you and going there.

I would just like for you to tell the committee and others how you felt, how you feel once you find out that, despite all of your precautions and all of your questions and all of your opportunities of saying, no, no thank you, no thank you, you are still defrauded.

Mr. HARPER. Well, thank you again. The key part of my problem was, after I talked to the gentleman as kindly as possible, because like I said, I was in turmoil with my wife just coming home and everything, I did not give him authority to enroll me in anything.

I did not find out that I was enrolled even after talking to the other gentleman the following week until I went the next month when I got my check.

When I saw this other deduction out of my check, it tore me up so, it took me about 3 or 4 days before I could clear my head and find out what this was about. I went and called Medicaid after I called these people, and they wanted to know, why did I sign from Medicaid over into this plan. I wrestled with Medicaid that I had not. Like I said, when I went to the hospital for my wife's treatment, this company flashes up. I couldn't even fill out the papers because they didn't know where or who to bill, blah, blah, blah.

It has been like this. It went on for about 2 months. The next month we got our check, and there was another deduction for this company. We did not sign anything. This man left just like he came in. I treated him properly. He left. Like I said, I didn't know anything about this until the next month.

Senator LINCOLN. So you went to your provider.

Mr. HARPER. Right.

Senator LINCOLN. Which is the other issue that we want to make sure we point out. Lots of times our seniors are not even finding out what has happened to them until they seek the health care that they need from their providers. Then all of a sudden when you need something, it is not there.

Mr. HARPER. It does not come. Tough luck. You do not have anything, because Medicaid does not know what to do, because these people are claiming that you belong to them. So Medicaid cannot do anything for you until you get it straightened out. Until I talked to this lady at you all's office, she got me on the right track. Eventually, here I am. I thank you all, and I thank God that I had this opportunity.

Senator LINCOLN. Well, thank you, Mr. Harper. And I think all of us agree that that is no way to treat our seniors, so we appreciate you coming and sharing your story, without a doubt.

Mr. HARPER. Thank you.

Senator LINCOLN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Lincoln.

Senator Stabenow?

Senator STABENOW. Thank you. Welcome to everyone for being here today. Mr. Harper, thank you for making the trip.

As my colleagues have indicated, this is certainly not a story that is unique. We have had hundreds of calls in Michigan and very, very similar situations. I would just share one of literally hundreds, a gentleman named Evan Edwards of Ruby, MI. He now owes a debt collection agency over \$800 in bills that were run up after he was enrolled in an HMO by a saleswoman who told him it was a special MA plan for veterans and that he was not going to have to pay anything. There was no such plan. No such plan exists. The actual plan that she enrolled him in had all of the usual HMO charges and so on. That is a very common call that I get.

So, Mr. O'Toole, first, I would ask, in a situation where someone is fraudulently enrolled and they try to disenroll from a Medicare Advantage plan, I have heard it takes CMS up to 6 months. Oftentimes the charges continue, the costs continue. What, in this kind of a situation, would you and your company do to help someone

who has been fraudulently enrolled in a Medicare Advantage program against their wishes?

Mr. O'TOOLE. First of all, Senator, I would like to extend to Mr. Harper, my heart goes out to your story. That was a horrible occurrence. To your story, Senator, I am a veteran myself. I spent an extensive period of time in the Army. A lot of the things I learned about leadership and doing the right thing I learned from the Army, so certainly representing Humana, as Humana's Medicare sales leader, I am committed to ethical sales practices and will take a very no-nonsense approach to making sure that people do the right thing for the right reasons. I think a lot of our recommendations have been a step in the right direction to help improve what transpires in our industry today.

As far as your particular question, Senator, I mean, certainly we would work with the beneficiary to try to expedite that process. We have to work within the framework that exists with CMS today, but certainly we would work as the member's advocate to try to get them properly back to the coverage that is best suited for them and help them through that process the best that we can.

Senator STABENOW. Would you ever refund any of the dollars that were coming to the company through fraudulent sales practices?

Mr. O'TOOLE. I believe our position would be, yes, we would do that.

Senator STABENOW. One of the things that is difficult for me in all of this is to look at, obviously this is big business. There is a lot of money made, as the chairman's bonus chart showed, making \$10,000 in bonuses. It is good business, making a lot of money off of this kind of health care. We certainly want businesses to be profitable. But I have a lot of questions about where we are going on Medicare. We heard yesterday from the Secretary that people want choices. That is what they want, they want choices.

I am wondering, Mr. Harper, in your mind, as someone who is relying on health care for yourself and your family, what is most important to you: having Medicare, having health care available to your family, or is uppermost on your mind having lots of choices?

Mr. HARPER. In my opinion, Medicare is the best program once you retire. I would rather stay with what I have. It may not be all we need, but I am well-satisfied until it will be improved, which it will hopefully. But all these choices, when you get my age, you cannot think about all these choices. You have to take one at a time and lock in. If it is providing what you need, you do not have enough room to worry about anything else. Excuse me, but that is just the way it is. It is kind of empty up there, not like it used to be.

Senator STABENOW. Well, you sound pretty good.

The CHAIRMAN. You are not alone, believe me. [Laughter.]

Senator STABENOW. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Thank you, Senator.

Maybe someone can answer this. First of all, I would say, Mr. Hebertson, I am very impressed in Montana with the SHIIP organization. They do a super job. I had an earlier CMS director come to Butte, MT, basically at the beginning of the Part D benefit program. I was very impressed with the SHIIP people in Montana.

They are very dedicated. They work very hard and provide a real service, and I just want to thank you for what you, and all of them, do.

Second, maybe someone can tell me, how many different insurance plans are there? How many plans?

Mr. HEBERTSON. We have 54 different options in Salt Lake County.

The CHAIRMAN. If you have plans and variations and other choices, how many different choices?

Mr. HEBERTSON. That is the 54.

The CHAIRMAN. Fifty-four.

Mr. HEBERTSON. Yes. Then of course you have the stand-alone Medicare drug plans on top of that, which is another 50-plus. That is just in Salt Lake County.

The CHAIRMAN. Right. As you know, the differential that the Medicare Advantage plans receive is about 12, 13 percent higher than paid under fee-for-service. The fact is, basically, Medicare Advantage plans take the rates that Medicare pays and build up, and then either they get the additional 13-percent benefit, roughly, and then they pay back to the provider either more or less what Medicare pays that provider.

So, several points here. Number one, taxpayers have paid for all the work that Medicare has undergone in trying to figure out what the reimbursement rates should be for lots of different procedures. The plans do not do that. They have other resources. They have no idea. They just start the base as the rates that Medicare pays and reimburses, with all the work they have done. So basically the plans are getting a free ride in that respect.

My bigger question is this. Maybe you could answer it, Mr. O'Toole, or maybe Mr. McRaith, because all of you have experience in all this. Do plans pay 13 percent more in benefits for beneficiaries since they get 13 percent greater payment from Uncle Sam? Do they turn that back and do plans pay 13 percent more to beneficiaries than the beneficiaries would receive under Medicare?

Mr. O'TOOLE. Senator, my understanding of this particular area is, with the money that is provided to us by CMS, we provide the Medicare benefit and generally a benefit that is in excess of Medicare, also, coordinate care, provide case management, disease management programs, and do that with a profit target that—

The CHAIRMAN. Can anybody quantify the degree to which there may or may not be additional net benefits that beneficiaries receive under plans compared with what beneficiaries receive under Medicare? American taxpayers pay the plans 13 percent more, so our beneficiaries are getting, in fact, 13 percent more in benefits.

Mr. O'TOOLE. I believe that has been quantified, but I would prefer to respond for the record in writing on that.

The CHAIRMAN. All right.

I have to go now, but I will turn it over to Senator Lincoln and Senator Stabenow. You two can finish up.

Senator LINCOLN. Thank you, Mr. Chairman. I think Senator Snowe is going to re-join us.

The CHAIRMAN. Thank you all very much, too. This has been very valuable testimony that all of you have given. I appreciate it very much.

Senator LINCOLN. I was nodding my head because we have, I think, 54 prescription drug plans in Part B in Arkansas that seniors choose from, and then we have at least 20 of the Medicare Advantage. So, it is a lot of plans out there for them to go over.

Mr. O'Toole, I think you indicated that in 2007 you reduced the number of delegated agents selling your products by 43 percent, and that 75 percent of Humana's agent-assisted sales are by employee or career sales agents. But you have also said that delegated agents are harder to control in terms of, I guess, quality, or however you want them to present themselves for your company. I do not know.

So what is your rationale for continuing to use delegated or contractual agents? Are they needed more in certain areas? Is it something like that? What plan types do these types of agents tend to sell, and is it mostly private fee-for-service, these delegated agents?

Mr. O'TOOLE. Right. Senator, when the MMA passed and this opportunity for choice was expanded across the country, it was the best way to cover the footprint of opportunity that consumers had, with local agents that were local to their community. So that is really why we first got into the business of working with contracted agents.

Senator LINCOLN. Do you ask how long an agent has been in that area, a delegated agent? I mean, do you specifically look for agents who have roots in the community?

Mr. O'TOOLE. Generally, we would contract with a managing general agency that actually had a presence within a local community, or a State, or a place.

Senator LINCOLN. But not necessarily specifying a long-time agent.

Mr. O'TOOLE. Not necessarily. Someone who is familiar with the area. I believe we probably have the largest number of employed agents within our industry, or certainly close to the largest. I would not say, and I am not precisely sure what you were referring to about contracted agents being more difficult to control, but certainly when you have an employed agent that works under the employment of the company with an employed supervisor, that is certainly a favorable arrangement.

Senator LINCOLN. Sure. I think that comment was made either by you or someone else at Humana, that those delegated agents were harder to control.

But I am just curious to know what plan types those different delegated agents tend to sell. Are there any numbers in terms of, are they mostly fee-for-service? Do they lean towards one plan type or another? You have discussed a number of reforms that you have made or plans make, and they do look like steps in the right direction, and that is a good thing.

But I would just like to ask you, how do you ensure that they are enforced? I mean, you are the director of the marketing. You mentioned your secret shopper program. I have heard about that in our State as well. How does the secret shopper program catch agents who are going into seniors' homes? Would that be appro-

ropriate for the kind of door-to-door problems that we are having in our State?

I just wanted to know, what about the targeting of certain populations, particularly for us in Arkansas, dual eligible beneficiaries? Is there anything in your proposal that ensures that agents will not do this, directly targeting dual eligibles?

Mr. O'TOOLE. Senator, you threw a lot of questions out at one time.

Senator LINCOLN. I know.

Mr. O'TOOLE. I will try to work from the beginning and go forward.

Senator LINCOLN. They should be pretty quick answers.

Mr. O'TOOLE. If you look at our recommendations, we address cold-calling. In the broad sense, cold-calling does not necessarily refer to a—

Senator LINCOLN. And I am assuming when you say “recommendations” you use these techniques in your own company, not just suggesting them to the broader array.

Mr. O'TOOLE. Yes. It is our policy that, prior to an agent coming to a beneficiary's home, that they have a pre-scheduled appointment. So I think that covers a number of your questions right there.

Senator LINCOLN. All right. And do you have anything in there that prevents or ensures that the agents are not going to just target dual eligibles in your policies?

Mr. O'TOOLE. Not specifically. Not specifically, but some of the comments that you have made about particular type facilities and such—

Senator LINCOLN. Do you know if Humana has ever sponsored a dinner for seniors?

Mr. O'TOOLE. Sponsored a dinner?

Senator LINCOLN. Yes. That is also something we have seen.

Mr. O'TOOLE. We actually do a number of informational seminars, and in some instances a meal or refreshment may be served.

Senator LINCOLN. That would certainly be some of the different kinds of events that you might have.

Mr. O'TOOLE. Correct. It is all built around information.

Senator LINCOLN. All right. Thank you.

Senator Stabenow?

Senator STABENOW. Well, thank you very much. Thank you again for all of your questions.

I would like to talk about something a little bit different, and that relates to employers that are using Medicare Advantage to be able to provide the same kinds of coverage for their employees 65 or older, as they do for others below age 65. Both Mr. O'Toole, if you might answer as well, and then anyone else. Mr. McRaith, if you would have any thoughts on this as well.

I am wondering, have there been complaints of deceptive marketing practices in the group market similar to what we have heard today? Is there any difference between the group market and the individual market? Mr. O'Toole, could you describe any differences in marketing and sales practices in your individual products as opposed to the group products?

Then, finally, what responsibilities do employers have to educate beneficiaries about the type of product versus what the plan has? So, asking basically differences between marketing responsibility, any deceptive practices. Are there any differences between the group plans provided through an employer versus the individual plans?

Mr. O'TOOLE. Fundamentally, there are not. Generally when we are working in the employer-sponsored space, oftentimes you are dealing with either the employer or some other intermediary. But the over-arching CMS marketing guidelines would apply. There would not be, necessarily, a difference.

One thing I failed to include in the record in my last question is that, if there is a refreshment or meal that is served, it is limited to \$15 or less by the CMS guidelines.

Senator STABENOW. All right. Thank you.

Mr. McRaith, from your perspective, have you seen any differences in terms of deceptive marketing practices or other kinds of differences between the individual market and the group market?

Mr. MCRATH. Before I answer that question, if I could back up real quickly to your story about Evan Edwards.

Senator STABENOW. Sure. Yes.

Mr. MCRATH. And the \$800 that he owes. This ties into questions that Senator Wyden asked earlier. There are those who argue that CMS should, alone, regulate or be in this space regulating the companies because it is Federal money. That is an example, and Mr. Harper's story is an example, of how there is consumer senior money that is also a part of the Medicare Advantage program.

Senator STABENOW. Right.

Mr. MCRATH. And that is why States need to be involved on the regulatory front lines. So I am sorry for going back, but I just wanted to add that perspective.

Senator STABENOW. No, no. That is an important point. Sure.

Mr. MCRATH. From where we sit, the level of complaints or concerns are not the same with employer groups because typically an employer is going to have a more sophisticated informational presentation to its employees and can sometimes serve as a screen to kind of pick through the debris that floats out there sometimes, and just present the employees with a more understandable and appropriate benefit package.

I do think it is an illustration of the larger health care and health insurance dilemma that we confront as a country, where 65 in some ways is like the new 21 and people are hanging on until they are 65 and can participate in Medicare.

Senator STABENOW. Thank you.

And then, Mr. Harper, finally, I am wondering what happened to the agent, Bill Perkins, who fraudulently enrolled you in this program. Do we know what happened to him? Did the Federal Government investigate at all? What ended up happening to this?

Mr. HARPER. Well, I have not heard from either one of them, Mr. Perkins or his office, since the last time that we had communication. So I do not know, is he still with the agency or what. After I got in touch with Senator Lincoln's office in order to get some results, all I know is, the investigation is still ongoing.

Senator STABENOW. But he represented Medicare. I am just wondering, did anyone tell you about any place to go where you could file a complaint yourself? Is that what was done through Senator Lincoln's office? I am not quite sure.

Mr. HARPER. Right. Yes.

Senator STABENOW. All right.

Mr. HARPER. That is correct.

Senator STABENOW. Thank you.

Mr. HARPER. But I know it is still under investigation.

Senator STABENOW. Thank you very much.

Mr. HARPER. Thank you.

Senator STABENOW. And thank you, Senator Wyden.

Senator WYDEN. Thank you, Senator Stabenow.

Mr. McRaith, Kim Holland is the State Insurance Commissioner of Oklahoma, and she described, in May, Humana's sales practices, in her language, "as creating an atmosphere of lawlessness." That is pretty strong language from a State Insurance Commissioner.

Can you tell us what you think the most flagrant sales and marketing abuses are that are causing your commissioners to continue to use that kind of language? They are not talking about it in the past tense. But what do you think are the most serious of these anti-consumer practices that are still ongoing?

Mr. McRAITH. Sure. Senator, there are a number of companies about which we have concerns. Humana is not the only one. But it is interesting to note that Oklahoma is also the State that found Humana using unlicensed agents to market its plans. Now, I believe that, in part, companies will engage agents they would not normally engage because of the shorter enrollment period. There is so much pressure on companies to generate sales in a relatively short time period, and that compressed enrollment period generates so much intensity of competition, that the agent community is driven to conduct itself, and companies in fact are driven to engage agents to conduct themselves, in ways that would not normally be acceptable under any circumstance.

I think also the commission structure is important. As we talked about, commissions that reward agents for volume of submitted applications, that is a serious problem. I think the lack of disclosures, sufficient disclosures in the products—there should be mandatory disclosures.

One of the things that I am very pleased to hear is the industry is now embracing having the title of the product itself or the name of the product itself in the title of the product that they are selling, to eliminate the idea of a Medicare Advantage Gold, or some kind of rewards policy, that kind of thing. The more clarity that we can provide consumers—as Mr. Harper said, we are struggling with complicated decisions—the better decisions those consumers can make. So I could list for you problems with cross-selling, cross-branding, tying, sales in senior homes, all of those things. They all need to be addressed, Senator.

Senator WYDEN. That is very helpful. I think that would be an area where, if you could give us further amplification, that would be very helpful.

Now, the second area I want to explore with you are the recommendations that Humana is giving again today for dealing with

the problem. When we look at them, it basically strikes you that their recommendations are pretty much about keeping the States out of the serious enforcement business. That is the bottom line of the five recommendations furnished by Humana today—to keep the States out of serious enforcement. That is not going to cut it. It is not going to cut it for Chairman Kohl and myself, and all of those who want to change this.

But your views will be helpful, for the record, on your reaction to the five recommendations that Humana is making for dealing with this.

Mr. MCRAITH. I applaud Humana's openness to the discussion and the acknowledgement that change and reform does need to occur.

From where I sit, as I alluded to earlier, we have the companies essentially saying it is an agent problem and the agents saying it is a company problem, and in between we have Mr. Harper and the thousands of consumers around the country like him. We need a comprehensive approach. We need a national standard on marketing and sales programs. We need the ability, on a State-by-State level, to get into the companies to understand better, how are the companies operating in each State or within a region within each State.

Senator Grassley referred to the desire to have Medicare Advantage benefits or programs in rural areas. Absolutely. Absolutely. We should have as much competition as we can in every part of every State. But at the same time, we have seen a proliferation of problems in rural areas because those rural areas do not have the provider networks.

In the State of Illinois, we understand what plans have what provider networks. We know that. So when we see a complaint or a pattern of complaints, we can go into a company immediately, evaluate the marketing and sales materials, evaluating how it is working with its agents, and evaluate, is it actually living up to the consumer protection standards that the Federal Government, in this case, could provide.

Senator WYDEN. So, on the point of ensuring that there is a beefed-up State role, which is not included in the enforcement and ideas advanced by Humana, you would continue to be in support of that beefed-up State role?

Mr. MCRAITH. That is absolutely correct.

Senator WYDEN. All right.

Now, Mr. O'Toole, you talk about the memorandum of understanding between the Centers for Medicare and Medicaid Services and the States, and that that is enough to improve on this. But you did not mention any need to return to the States any of the authority that was taken away in 2003, which is of course what our legislation would do.

But we are hearing still that it can take months for a senior to be put back on the right plan under the structure that you are advocating in this memorandum of understanding approach. Is it not too long for seniors to have to wait, and wait, and wait to be put back on the right plan, which is what seems to be coming with this memorandum of understanding approach?

Mr. O'TOOLE. Well, Senator, I am convinced there could be really favorable outcomes with this improved collaboration and cooperation between CMS and the States. Certainly there needs to be improvement from the Federal position in ensuring that there is more timely caretaking of beneficiaries. I had not heard of months and months of problems getting back to your prior health program, but, if that is the case, certainly that is an area for improvement. I am not sure that returning that jurisdiction to the States is going to be the solver to that when we are talking about a Federal entitlement program, paid for with Federal money.

Senator WYDEN. Nobody is talking about kicking the Federal Government out of the process. What we are talking about, as advocated by Mr. McRaith, is a State supplemental role, just as we have had in the Medigap area. Clearly, it makes no sense in a national economy, one like ours, to have 50 standards. I think Chairman Kohl and our whole group that has worked on this has felt strongly about that from the outset. But while we want a uniform approach with respect to marketing and we want a uniform approach with respect to authority over the companies, we do want to give the States serious enforcement authority.

I am looking forward to the written views you will give us on S. 1883. I remember during the Medigap days we had to do a lot of back-and-forth between consumer advocates and people in the industry and the States. I think we are in the same position today as we try to advocate for legislation that is actually going to fix this. So, I am hopeful we will get a favorable response from you all on S. 1883.

That is really my last question for now. I would like to hear from any of you who would like to comment on this. One of the things that has pleased me about Medigap—and I go back to the days when I was co-director of the Oregon Gray Panthers and I had a full head of hair and rugged good looks and all that [laughter]—is the Medigap law has really worked. It has worked for the senior citizens. They do not have these abuses that Mr. Harper has talked about so eloquently.

We do not get complaints from people in the industry. You can walk in to pretty much any senior citizen's center in the United States and the counselors can take you through your choices, the standardized choices in the Medigap area, and it has really worked for everybody concerned, for seniors, for their families, for regulators, for the many responsible people in private insurance.

One of the reasons I want to clean house here, Mr. O'Toole, is I am one of the people in the U.S. Senate who thinks that there should be a very significant role for the private sector in fixing health care. It is right at the heart of our Healthy Americans Act. We have six Democrats, six Republicans for this first bipartisan universal coverage bill that we have had in the U.S. Senate in decades. But if the private sector continues to engage in these exploitative practices, it gives the entire industry a bad name and will hurt our effort to forge a bipartisan coalition.

So my question, and I would like to throw it open to any of you who would like to comment, maybe start with you, Mr. McRaith, has the Medigap law not worked for the reasons that we have been

talking about this morning? Does that not serve as a pretty good model now for proceeding?

Mr. MCRAITH. Senator, the Medigap process and the Medigap regulation, in the current regulatory environment, has worked extremely well for Illinois seniors, and it is my understanding from discussions with my colleagues around the country that the process of a uniform benefit design, as well as uniform sales and marketing information, has been extremely well received by the senior community.

Then in the event there is a problem, the fact that State regulators are able to participate and work with seniors to resolve those problems has been especially helpful. You described the situation that we have encountered in the State of Illinois where, if a senior has a problem with a plan, it takes months to get it resolved. Under the—

Senator WYDEN. Under the memorandum of understanding.

Mr. MCRAITH. Under the memorandum of understanding that would continue. Under S. 1883, which would empower the States to enforce, we could do what we do every day with private health plans, and that is call on behalf of a consumer, resolve a problem, and often those problems are resolved within one phone call. So that approach, converting to the Medigap model, take that as a template, apply it to this situation, we think would work very well.

I want to take issue with one comment that, respectfully, Mr. O'Toole said. This is not an entitlement program. Medicare Advantage and the prescription drug plans are private insurance programs in which people like Mr. Harper and Senator Stabenow's constituent pay premiums. These are not entitlement programs. These are programs where vulnerable consumers need protection, and that is what the States can provide. We do it every day, and we have been doing it for decades.

Senator WYDEN. Mr. Hebertson, you are on the front lines. I go back a lot of years with the Area Agencies on Aging. I think they perform an invaluable service. Have you found that the Medigap model has been a good one and has worked for all of those associated with your good programs?

Mr. HEBERTSON. Yes. Absolutely. The reason why is because it is standardized and we can explain it to people in a way they understand. Then they can make their decision based on their understanding, given their income and health needs. That is why it works. It is very difficult, particularly for a senior on their own, to have that same kind of understanding through the Medicare Advantage products. So, to make it so we can assure that they can have that same type of understanding again so they can make that decision based on their health needs and their life and their income, that would be terrific.

Senator WYDEN. That is such an important point. I remember, prior to the enactment of Medigap, that I would very often get calls from somebody who would be a lawyer or an accountant in their 40s, and they would say, Ron, I am working with my mother on her Medigap policy and I cannot figure this out. Now we have much the same thing with these private fee-for-service policies. In other words, history has repeated itself.

When Mr. Harper comes and speaks for the many older people who are being taken advantage of out there today, it sounds very, very reminiscent of the kind of things that I heard in the days when I was co-director of the Gray Panthers, and we thank you.

So a question for you, Mr. O'Toole. Has your company had any problems with Medigap? I mean, I talk to folks in the private insurance industry. I have not heard of people at Humana saying that Medigap is going to cause a lot of heartache. In fact, we have not had any concerns about Medigap now for years and years. I want to give you a chance to comment as well.

Mr. O'TOOLE. Well, Senator, I can speak not just as a vice president with Humana, but I was a licensed producer in the State of Florida. In my opinion, Medigap is a great program, but it does not provide the type of choice and innovation, nor the opportunity for innovation, that the Medicare Advantage programs provide. Like any program, there is always an opportunity for something to go wrong. I have been in the home of more than one Medicare recipient who actually had multiple Medicare supplement plans. They did not realize it happened.

Senator WYDEN. Well, that is a violation of the law.

Mr. O'TOOLE. Absolutely.

Senator WYDEN. And you can tell me in more detail, Mr. McRaith. We wrote the Medigap law so that, except in very rare circumstances, as a matter of law, someone could only have one Medigap policy. So, if it does not fit into that area where it specifically involves people with these unique needs, it is a violation of the law and we ought to come after those people with hob-nail boots. So, if you see instances of that, please get that to Mr. McRaith and the commissioners.

Mr. O'TOOLE. The point being, Senator, that there are imperfections with everything. I think, with a strong collaborative relationship between the Federal Government and the States through this aggressive memorandum of understanding, we could really accomplish a lot of really good things.

Senator WYDEN. The only thing I would differ with you on is that we have acknowledged from the very beginning, in working with the NAIC and Chairman Kohl and others, this is a different product than Medigap. Medigap was a private product to supplement Medicare, and this is clearly a Federal program. But in terms of the basic principles of consumer protection, the issues remain the same. Is that not correct, Mr. McRaith?

Mr. McRAITH. That is correct, Senator. The key is, is the consumer purchasing a policy that is appropriate for that consumer, as Mr. Hebertson said.

Senator WYDEN. So we are going to continue to keep our doors open to you, Mr. O'Toole, and all of those in the private sector so we strike the right balance. We think you have a valid point with respect to not wanting to have 50 States out there with different programs as it relates to marketing abuse and different programs with respect to authority over the companies, which is why S. 1883 does focus on uniformity in that area. What we have to resolve is getting these tools to the States that are so important for all the reasons that we have outlined.

Mr. Harper, I have gone on for a pretty fair run here, and I want to give the last word to you. What it always comes down to, it seems to me, is not just legislators and lawyers and legalese and the like. When it comes to the legalese, a lot of this is pretty hard to follow, but it really comes down to the points that you have been talking about, which is that older people deserve a fair shake. So you have had a chance this morning to listen to this, and I would like to give you the last word for this morning.

Mr. HARPER. Well, thank you, Senator. I do not have too much more to say, other than I really appreciate you all taking time out and giving me this opportunity to be here and to speak freely about what I feel. As a senior citizen, we do need someone to keep us safe in the few days of life that are left. We do not ask for much, just enough to get by and be happy. I thank you very much.

Senator WYDEN. I thank you. I think Senator Snowe, who has been a wonderful advocate—here we are. The last words, for purposes of today's hearing, are going to come from our colleague from Maine, who has been a real champion for the cause of senior citizens for a lot of years. So it is great to have you here, Senator Snowe, to conclude the hearing.

Senator SNOWE. Thank you. I appreciate it, Mr. Chairman. Thank you for being such a great advocate. I appreciate it. I will not delay the committee hearing any further, but I do want to ask some questions because I think this is a critical issue for so many seniors in trying to get it right.

The very nature of the program and its complexities is illustrated by this manual. When you talk about the private fee-for-service, which is another 28 pages beyond that, specifically, there are more than 110 pages. I think that it is pretty remarkable that we would expect seniors to have to work their way through this maze of issues and provisions in order to decide which plan works for them.

I know that, Mr. Harper, you were talking about the fact of the difficulties that you had in trying to discern which program works for you. I know you had problems with people making those cold calls and approaching you, but were you able to go through and sort through all of this in order to make decisions for your own coverage?

Mr. HARPER. You mean, in the papers that he brought, the forms? Is that what you mean?

Senator SNOWE. Yes.

Mr. HARPER. Well, I really did not have time because, as I stated, my full time was devoted towards my wife mostly. And I did not even read anything that he brought and left until the gentleman came by the next day and explained to me. Then I picked them all up and read the most important part of it. This one point on the paper that he left really stuck out. On these forms, there is a picture of your Medicaid card. In that Medicaid card, you're supposed to sign your name and your Social Security number.

The papers that he left, I still have them. I never did sign anything. When I requested them to send me a copy of the paper as proof that I had signed, they missed where the form was filled out. The Social Security number that was on this form was not my Social Security number, and it was not my wife's or my signature. Then I read what the thing said, the form that he left. That is the

way it went until I got in touch with Senator Blanche's office because I could not reach him any more. Also, they sent me the papers and it just did not correspond with anything that he brought previously.

Senator SNOWE. Well, in our State of Maine, we passed, recently, legislation to ban cold calls and door-to-door or cross-selling of products. Frankly, that is probably something that we ought to consider on a national basis. I do not know if you have addressed that at all, but would you agree?

Mr. MCRAITH. I absolutely agree, Senator. If I could follow up really briefly, I think the booklet you have just shown emphasizes the importance of agents in any kind of insurance transaction. It also emphasizes the importance of properly regulating the relationship between the agent and the company. It also emphasizes the importance of accountability. The companies need to be responsible for the actions of their agents. Even sophisticated lawyers have trouble reading a 110-page document to understand the benefits of their health insurance policy.

Senator SNOWE. Yes. This is virtually impossible. It makes it inordinantly difficult. I know I have heard from my constituents as well, and sorting through to make the right decisions for themselves. You are right that the companies have to be accountable for those agents and responsible for how they conduct themselves, and the information they transmit.

Mr. O'TOOLE, that leads me into the question I was going to ask you anyway, because Humana has had, in essence, more than a million enrollees, as I understand it. You are one of the seven major providers of Medicare Advantage plans, and you have agreed to voluntarily suspend marketing private fee-for-service since 2007. You mentioned in your own statement that there were 1,595 Medicare Advantage sales allegations last year, and the State of Illinois determined in the 2005 and 2006 examination period that 84 of your 2,237 agents who sold Medicare products did so without even a proper Illinois license.

How is it that, with your experience, your company's experience in the industry for more than 20 years, you would have unlicensed agents selling this product on behalf of Medicare, given your track record in Medicare overall?

Mr. O'TOOLE. Well, Senator, I would say we certainly have learned from our experience, and, with the expansion of these plans through the MMA, I think the response and the growth in membership in those plans was probably more than anyone expected, us included.

Just to clarify for the record, we had some issues in Oklahoma that were referenced earlier that really were not about unlicensed agents, they were about sales occurring in border areas where an Oklahoma resident would go into Texas or a surrounding State and the sale was actually facilitated by a licensed agent in that State, but they were not properly licensed in the State of Oklahoma.

In Illinois, we did have some infractions that actually involved unlicensed agents. As a result of that, we took a good, hard look at our systems and made the necessary internal improvements to safeguard against that occurring again, to safeguard the Medicare beneficiary and to protect the integrity of the sales process.

Senator SNOWE. So if your policy, as you stated from the outset, was to appoint and license your agents, what went wrong?

Mr. O'TOOLE. There was a breakdown in some of our internal systems. I could not comment at all on the specifics and would be happy to supplement the record in writing, but we had some issues there that have been subsequently corrected.

Senator SNOWE. Have you ever had any other non-compliance issues? I know CMS in general has said that there have been non-compliance issues with HIPAA standards, for example, or beneficiary security breaches. Have you had problems in either of those areas over time?

Mr. O'TOOLE. I would have to answer that question in writing.

Senator SNOWE. All right. Please do that.

Also, you mentioned the fact that commissions are withheld if the beneficiary cancels their coverage within 90 days. But you also point out, it is likely past the open enrollment period. Frankly, I think that may well work if you are within the enrollment period, but unfortunately the beneficiary is stuck with the plan if it has gone beyond that time. So, frankly, it is not helpful in that regard for the beneficiary.

I happen to think that a cooling-off period, perhaps of 60 days, might be worthwhile to consider as well for legislation, simply to give people an opportunity, given the complexity of this program and all the rules and regulations and different enrollment periods, depending on which category you are finding yourself in, or which program, it might be worthwhile to have a cooling-off period so that people can adjust and shift if there was a mistake in the process. Would you agree?

Mr. O'TOOLE. Senator, I am not sure I entirely understood your statement in reference to the cooling-off program.

Senator SNOWE. Well, so that if people went beyond the period of enrollment, that there would be a cooling-off period so that, if they signed up for a specific program and they found out that was not exactly what they wanted, that they would have the opportunity. For example, if a beneficiary canceled, therefore, you said that commissions are withheld. But it is not helpful for the beneficiary if they have already gone beyond their enrollment period.

Mr. O'TOOLE. All right. I think I follow you now, Senator. First of all, the way our structure is in terms of internal compliance monitoring, and also our charge-back policy on commissions, we certainly feel as though we do not incentivize an agent to do an improper thing. So just to make that clear, we do not incentivize the wrong thing.

But second of all, if, in the event there is an issue where, for whatever reason, a beneficiary is inappropriately enrolled in a plan or makes an improper decision, either on the part of the agent or some form of misinformation or misunderstanding on the part of the consumer, there are protective measures, as established by CMS, that allows them greater flexibility beyond the open enrollment period.

Senator SNOWE. Can they switch plans?

Mr. O'TOOLE. Under certain circumstances, and certainly as would be defined by what you are saying, yes. There are protections built in to allow them flexibility.

Senator SNOWE. In that instance, do you know, Mr. McRaith, if that is true?

Mr. McRAITH. I think Mr. Hebertson probably can answer that better than any of us.

Mr. HEBERTSON. I know that we have helped people who are outside the enrollment window switch back through an appeals process through CMS, but we can certainly get you some more information on that on the written record. So I think he is correct that there are some ways to appeal that if certain guidelines apply, if the person was misled or not understanding the policy that was explained to them. But we can certainly get you information for the record.

Senator SNOWE. Yes. But you have not used that process to determine whether or not it is workable or not.

Mr. HEBERTSON. No, we have.

Senator SNOWE. And it has worked?

Mr. HEBERTSON. We have helped some people, but it is not a lot. I would like to get more information for you.

Senator SNOWE. So maybe a cooling-off period is necessary. I guess the point here is giving people an opportunity to be able to shift in the event, from the time in which they discovered that this was not their plan, or they misunderstood, or it was misrepresented, or whatever the case may be, they had a period in which they could shift.

Mr. HEBERTSON. Yes.

Senator SNOWE. So I think that is the point here. So maybe it is a workable system. I do not know. I will look into it. But that is the question, whether or not they should go beyond that. Especially for the agent misrepresenting what the situation is, what the plan represents to the consumer, that they would have the opportunity to make that shift, if it is beyond the enrollment period, for example. If we have a system in place that is workable, then fine. But if not, there may be another way of addressing it through a cooling-off period of 60 days.

Mr. O'TOOLE. Senator?

Senator SNOWE. Yes?

Mr. O'TOOLE. There are special election provisions that exist presently, and we would be happy to supplement the record in writing just to better inform the committee of those provisions.

Senator SNOWE. Now, in the enrollment period, speaking of enrollment periods, one final question. I understand the Medicare Advantage enrollment period has now shifted to the first quarter of the year, but the Part D prescription drug program is still going to be into the November–December period. Do you think that there should be a shift as well for that enrollment period, or do you think it is fine as it is?

Mr. McRAITH. Senator, I would suggest, first of all, that a cooling-off period would be appropriate, given the significance of the decisions and the relative lack of resources that many of the people making those decisions have. They should have the opportunity to meet with a SHIP volunteer nearby, or reach out to someone who might have a more sophisticated understanding and can counsel them. A cooling-off period is a good idea.

In terms of the enrollment periods, I think what is more important to us as State regulators is to see an expansion of the current 45 days at the end of the year over the holiday season, where it puts an awful lot of pressure on people to make very significant decisions, because they cannot change those decisions easily. It is a laborious process that requires somebody with limited resources already to now have to kind of swim upstream and reverse course; very difficult to do.

I would add, I want to clear up something. I alluded earlier to an Oklahoma problem that Humana had. They did have 68 unlicensed agents operating in the State of Oklahoma at that time, and in Illinois they had 67.

Senator SNOWE. All right. Thank you. I appreciate your comments. When I hear an appeals process, it sounds to me so complex, arduous, and rigorous. Really, most people are not going to avail themselves because it is that difficult and, as you say, the resources of time and wherewithal to be able to do it, as a senior citizen to get out there and do it—I just know the difficulties in making the decisions they do in choosing their plans from year to year. Also, even determining the enrollment period. I mean, there are so many different enrollment periods, it is extremely confusing for anyone under the best of circumstances. So, I appreciate that.

I thank you all very much for taking the time and for being here today.

Thank you, Mr. Chairman.

Senator WYDEN. I thank my colleague.

I just had one last question to Mr. O'Toole because of a response you gave to Senator Snowe. She asked about this issue which she described as a cooling-off period. You said, "We do not incentivize our agents to do the wrong thing." Well, the chart that Senator Baucus is talking about is, in effect, an ongoing program. The incentive program is green, really green. It is clear that that is going on today because the dates, essentially, are from January to April.

So given the fact that you told Senator Snowe that there are no incentives for doing the wrong thing, I gather that you believe that there is nothing wrong with this ad and this is part of an approach that has the correct incentives. Is that right?

Mr. O'TOOLE. Senator, I am glad you asked that question. First, I would submit to you and the committee that, if we adopt the recommendations of the standardized level based on a percentage of premium recommendation that we made in our written and oral testimony, that issues like this would go away.

Now, in speaking to that specifically on behalf of Humana, if you were to look at our individual contracted agent compensation inclusive to this bonus program, we would still be, based on the information available to me, in the bottom third of the industry.

Senator WYDEN. So you think the ad is part of the right message that you want to send?

Mr. O'TOOLE. No.

Senator WYDEN. Because Senator Snowe asked you a very good question, and I listened very carefully to your answer. You said, we do not want to have anything that sends the wrong message to our agents. I just look at this and it sure does not look like rocket science. It is ongoing and it just says this is all about green, green,

green, as Senator Baucus said. I gather from your answer that you do not think that this sends the wrong message, and I think that is very unfortunate.

Mr. O'TOOLE. Senator, that is actually incorrect. I was talking——

Senator WYDEN. Well, tell us about the ad. Does the ad send the right message——

Mr. O'TOOLE. No. No, it does not.

Senator WYDEN. So the company does not feel that that——

Mr. O'TOOLE. No.

Senator WYDEN. Thank you.

Mr. O'TOOLE. We have a very stringent internal review process for anything dealing with the Medicare beneficiaries.

Senator WYDEN. So will the ad be taken out? This will not run in the future?

Mr. O'TOOLE. It was actually retracted as soon as we were made aware that it went out for distribution. It was an internal associate who did not follow an internal process. And no, I do not agree with the message of the ad, but certainly its content, as it relates to contracted agent compensation, I wanted to separate the two.

Senator WYDEN. All right.

Senator Snowe, anything else you want to add?

Senator SNOWE. No.

Senator WYDEN. All right.

We thank all of you. We like to give the witnesses the last word. Do any of you want to add anything?

Mr. MCRAITH. Thank you for your time, Senator Wyden and Senator Snowe.

Senator WYDEN. Mr. Harper, we thank you. We thank all of you. The committee is adjourned.

[Whereupon, at 12:15 p.m., the hearing was concluded.]

**SELLING TO SENIORS: THE NEED FOR
ACCOUNTABILITY AND OVERSIGHT OF
MARKETING BY MEDICARE PRIVATE PLANS
(PART II)**

WEDNESDAY, FEBRUARY 13, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Wyden, Stabenow, Salazar, Grassley, Hatch, Snowe, and Sununu.

**OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR
FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. The hearing will come to order.

The author D.H. Lawrence said, "Never trust the artist, trust the tale." In large part, the story of sales by private Medicare plans is a tale of trust. Seniors justifiably trust Medicare, but there are sales artists who are abusing that trust.

Last week, the Finance Committee held the first of two hearings on the subject. Last week we had several witnesses who had different points of view, who came from different parts of the country. But three separate witnesses testified that insurance sales agents are using abusive tactics to sell private Medicare plans. All three witnesses shared the same story. Private plans and their agents are pushing private Medicare plans using methods that are aggressive and too often abusive or fraudulent. CMS guidelines are just not enough to stop the abuses.

Sales agents gain easy entry into a beneficiary's home. Often they appear to represent Medicare. CMS may have prohibited door-to-door sales, but sales agents are skirting that prohibition. When the agents are in the beneficiaries homes, they ask the beneficiaries to call their neighbors on behalf of the agents. The agents tell the beneficiaries that their neighbors can get a same-day appointment. Beneficiaries may place the calls just to get the agents out of their homes.

Last week, one beneficiary, George Harper of Mayflower, AR, told the committee that a sales agent came to his house. Mr. Harper testified how the agent tried to sell him insurance that he did not want, he did not need. Mr. Harper told how an agent forged his signature to enroll him and his wife in a private Medicare plan.

The Harpers had a devil of a time getting out of the plan and getting fully reimbursed for their expenses. Those were expenses that they could not afford, expenses they should never have had to pay.

Sales agents canvass senior housing complexes. They offer free meals at restaurants to talk about “new Medicare benefits” to make it look and sound as though they represent Medicare, but they are really selling a private plan.

The committee heard how economic incentives are fueling an aggressive sales environment. The government pays private insurance companies generously. In Medicare Advantage, the government pays private insurers 13 percent more than the traditional program. Plans, in turn, offer big financial rewards to their sales agents. Humana, for example, is offering a \$10,000 bonus to agents who enroll 150 seniors into private Medicare plans by April 1.

The Illinois insurance director testified that the financial incentives to sell private Medicare plans, plus the absence of rigorous Federal oversight, invite abuses by companies and their agents. He likened the current marketplace for private Medicare plans to the early days of Medigap. Back then, lax Federal regulation allowed confusion and distress for seniors.

The committee also heard proposals to clean up marketing practices and strengthen oversight. Even Humana offered five recommendations. Among other things, Humana proposed more stringent Federal standards for marketing practices, new Federal requirements for sales commissions, and more Federal cooperation with State regulators on complaints.

I commend Humana for making these recommendations. I might say that in my State, my office gets many, many more complaints about Humana than any other single company, partly because Humana is a big company. So, I am impressed to learn that even Humana is asking CMS to do more than it is doing today.

Witnesses also proposed that the Federal Government allow States to expand their oversight. State’s insurance regulators are calling for a Medigap approach in which States are permitted to enforce national safeguards promulgated by HHS. Congress gave CMS exclusive authority to regulate insurers selling Medicare benefits. The idea was that a Federal program should be regulated by a Federal agency with one set of rules.

Today we will hear from CMS about the rules that they have set and how they are clamping down on bad sales practices. Mr. Weems, many Senators are skeptical that CMS has institutional knowledge, expertise, and willingness to do the job. Many doubt that CMS is taking a strong regulatory posture. Many question whether CMS can construct and enforce marketing rules that truly protect and assist seniors.

We need tough rules and they need to be enforced. We need more than just guidelines, otherwise private companies who care most about profits will find it too easy to take advantage of the elderly and disabled people just to make a buck.

Mr. Weems, today I hope that you will offer the committee solutions to the many problems that we heard last week. I hope you will move quickly to restore the trust of people like the Harpers in the Medicare program. Plainly, seniors should never trust these shady private Medicare sales artists, though we want to maintain

seniors' trust in Medicare. Mr. Weems, I trust that you will tell the tale of how we can do so.

I would now like to welcome our witness. We will hear from Mr. Kerry Weems, the Acting Administrator for the Centers for Medicare and Medicaid Services. Thank you, Mr. Weems, for taking the time to speak with us today. As a reminder, please limit your oral statement to 5 minutes, and your entire statement will be included in the record.

**STATEMENT OF KERRY N. WEEMS, ACTING ADMINISTRATOR,
CENTERS FOR MEDICARE AND MEDICAID SERVICES, BALTI-
MORE, MD**

Mr. WEEMS. Good morning.

The CHAIRMAN. Good morning.

Mr. WEEMS. I thank you for the opportunity to appear today. I am pleased to be here to discuss CMS's oversight efforts of marketing practices under the Medicare Advantage program. My focus today will be on relatively recent activities and the Agency's plan for further improvements for marketing oversight in the year ahead.

At the outset, I want to indicate my unequivocal commitment to protecting people with Medicare from marketing abuses and to giving beneficiaries the information they need to make informed choices about health care.

Since September of 2007 when I began my tenure as Acting Administrator, I have made it a top priority for CMS to be more proactive and more transparent in overseeing the Medicare Advantage program. We have made significant strides in strengthening our oversight.

Our activities fall into three major categories, as outlined in the chart before you: promoting transparency; strengthening our oversight tools; and taking enforcement action where warranted. I would like to discuss our efforts in each one of these categories.

In the interest of transparency, we implemented a 5-star rating system for Medicare Advantage plans last fall which expanded on the existing rating system. This web-based tool provided the public with a powerful new way to comparison-shop Medicare Advantage plans for the 2007 open enrollment period.

We have also made information available regarding compliance actions. The CMS website now contains information on more than 90 corrective action plans which outline the binding steps plans must follow to fix performance deficiencies. It also contains a list of all enforcement actions taken against Medicare Advantage and prescription drug plans since January of 2006. We believe that all these efforts toward increased transparency are shaping the Medicare Advantage plan behavior in ways that we had hoped, and helping beneficiaries to make informed decisions.

In addition to promoting transparency, we are taking steps to strengthen our regulatory framework and enforcement tools. For example, following the voluntary marketing suspension of 7 private fee-for-service plans last summer, CMS established rigorous audit protocols to review each plan's internal controls and processes. I personally reviewed each audit, and in several instances sent the

auditors back and required further proof of compliance before lifting a plan suspension.

Our experience with these 7 plans led to the development of a stringent new surveillance strategy for private fee-for-service organizations across the board. For example, we now require private fee-for-service plans to conduct outbound verification calls to confirm beneficiary enrollment and ensure enrollees understand fundamental plan rules.

The enrollment verification process is supported by new strategies to quality-check private fee-for-service call centers, enrollment materials they distribute, and their agent training and testing materials.

We have also greatly expanded our secret shopping initiative begun in the fall. Working with private contractors, CMS secretly audited plan marketing events to verify compliance with marketing guidelines. Contracted auditors and roughly 30 senior CMS officials, including myself, shopped 240 marketing events across 39 jurisdictions and 30 sponsored plans.

Our efforts identified 696 marketing violations. We took immediate action to address high-risk issues and to prevent further deficiencies. For example, one plan was placed on an immediate enrollment and marketing freeze which extended for the duration of open enrollment. Two other plans were placed on corrective action plans. Warning notices were issued to any private fee-for-service plan with at least one violation of CMS marketing rules.

Of course, with the benefit of recent reforms such as those included in the December 2007 compliance regulation, we will have even greater ability to go after bad actors and protect beneficiaries in the future.

Mr. Chairman, I understand the urgency of improvement in this area, so I would like to close by sharing a second chart with you. While the first chart depicts a significant increase in CMS oversight activities, the second chart begins to tell a story of significant decrease in marketing complaints, beginning in December when our compliance activities began.

I believe our increased oversight is paying off. We will continue to study indicators of plan compliance in the months ahead, and we are prepared to take further actions that may be required for further improvement. In conclusion, let me say that I am personally committed to taking whatever steps are necessary to ensure that people with Medicare are not misled or harmed by Medicare Advantage plans or their agents. We have made significant progress, and we are going to continue along this path. We are not done.

Thank you, Mr. Chairman, for the opportunity to speak this morning, and I look forward to answering any questions you may have.

The CHAIRMAN. All right. Thank you, Mr. Weems.

[The prepared statement of Mr. Weems appears in the appendix.]

The CHAIRMAN. I have a couple of questions. One, on your secret shoppers program. First of all, I commend you for undertaking generally that sort of an effort to try to determine abuses. I have a couple of questions, though. One is, if there are 696 violations, it sounds like not much corrective action is taken. You mentioned one plan out of 696 frozen, and you mentioned two placed on corrective

action plans. I have no idea what that is. Only 71 letters. That is roughly one-tenth of those where violations were found that got any kind of recognition of abuse, and that was just a warning letter. That sounds pretty soft to me. One out of 10 was just a warning letter.

Mr. WEEMS. Mr. Chairman, we were—

The CHAIRMAN. If a highway patrol comes along, does he just give 1 out of 10 tickets and the 9 he is just warning? Or does he say, all right, you are speeding, you were over the limit, so here is a ticket? I doubt that the ratio is 1 out of 10.

Mr. WEEMS. Mr. Chairman, we issued a warning letter for every violation that was found. Many plans had multiple violations, which would mean that there were letters which had multiple violations in them. The marketing and enrollment suspension that we undertook, it was very evident to us, and evident very quickly—our surveillance system was in place—that this particular plan, across the Nation, was not in compliance with our rules. We took action swiftly.

The CHAIRMAN. What did you do?

Mr. WEEMS. What did we do?

The CHAIRMAN. What was the nature of the action?

Mr. WEEMS. We had them suspend marketing and enrollment for the entire period of the enrollment.

The CHAIRMAN. That is one plan.

Mr. WEEMS. That is one plan.

The CHAIRMAN. Out of 696.

Mr. WEEMS. That is one plan which had multiple violations within that 696 number, sir.

The CHAIRMAN. That is a pretty low percentage, though.

Mr. WEEMS. This was an extremely severe set of violations.

The CHAIRMAN. And the others were just de minimis, negligible?

Mr. WEEMS. The others were brought to their attention and we asked them to correct them immediately. We can see the effects of the actions that we took. The number of violations that we saw diminished, the number of complaints that we received diminished.

The CHAIRMAN. They are going up.

Mr. WEEMS. We think our actions were effective.

The CHAIRMAN. But they are going up.

Mr. WEEMS. Mr. Chairman, I never want this committee to think that I am deceiving you. Our most recent data is before January. This is the kind of thing that you typically expect at the beginning of a plan year when a beneficiary begins to use their plan. They have made a change and they say, whoa, what is this change? Is this due to a marketing violation? We put those on the chart for you. I will give you this data every month. I expect the data to fall in February, I expect it to fall in March. The effect that we see in January—

The CHAIRMAN. It did not go down in prior years.

Mr. WEEMS. We did not have this in prior years, sir, and you did not have me.

The CHAIRMAN. This is the secret shopper program. What about all the door-to-door problems that we have?

Mr. WEEMS. Door-to-door problems are—

The CHAIRMAN. What enforcement action do you have to monitor door-to-door abusive sales practices?

Mr. WEEMS. If we find that a plan has engaged in door-to-door sales activity, we will respond appropriately with progressive enforcement, beginning with a warning letter and then moving to sanctions and civil monetary penalties as necessary.

The CHAIRMAN. I am just curious. How do you monitor door-to-door? Do you just wait for the complaints to walk in the door? Do you just wait for the complaints to come in or do you monitor the door-to-door activities? First of all, door-to-door——

Mr. WEEMS. Is a violation.

The CHAIRMAN. Is a violation.

Mr. WEEMS. It is.

The CHAIRMAN. But a lot of agents do go door-to-door. They get around it.

Mr. WEEMS. There have been reports of door-to-door.

The CHAIRMAN. They take the leads that are sold to them from the earlier cold calls, they take those leads, and they go to homes.

Mr. WEEMS. There have been incidences of that, and that is a violation of our rules.

The CHAIRMAN. What are you doing about those? How many instances of violations have you come up with?

Mr. WEEMS. I do not have the number of door-to-door readily available, but I certainly can provide it to this committee.

The CHAIRMAN. I guess what is kind of concerning, even Humana wants you to do more. Here is a private company that wants you to do more than you are doing.

Mr. WEEMS. And so do we, sir. We have further administrative actions that you will see from us that will deal with commissions, that will deal with beneficiary contact, and will deal with civil monetary penalties.

The CHAIRMAN. When will we see those?

Mr. WEEMS. I hope in the coming weeks, sir.

The CHAIRMAN. Why are these not in the nature of regulations as opposed to guidelines? Regulations have a lot more potency and are more powerful than guidelines.

Mr. WEEMS. Senator, these are administrative actions, and regulations may also be in the nature of administrative actions. I am not eliminating regulations as a possibility in that.

The CHAIRMAN. All right. I have more questions.

Senator Sununu? He is pointing to Senator Hatch, but you are next on the list, Senator.

Senator SUNUNU. Thank you, Mr. Chairman.

The CHAIRMAN. We might as well go by the rules here.

Senator SUNUNU. That is quite all right with me.

Mr. Weems, you mentioned corrective action plans, that you had issued a number of corrective action plans. Of course, you expect those to be followed. Are those legally binding? What enforcement powers or penalties can you impose if one of the plans is not following the corrective action plan that has been laid out? What is the range of penalties that you can impose?

Mr. WEEMS. We have a range of actions that we can take. A corrective action plan is a plan that a plan has agreed to. If they continue not to make progress on that plan we can, depending on the

severity of it, impose civil monetary penalties or kick them out of the program.

Senator SUNUNU. So there is no real limitation to your ability to take action if they are not acting in a way that is consistent with the corrective action plan? In other words, you do not need additional statutory power, additional regulatory power to enforce the plan?

Mr. WEEMS. We certainly do not need, in our view, additional statutory power. There may come a point when we need to clarify our regulatory authority in this area.

Senator SUNUNU. One of the suggestions that I have read about to address perceived shortcomings in the regulatory and enforcement process on these plans is to allow the States, I think, to regulate marketing practices in the way that I believe States are currently allowed to regulate the marketing of Medigap policies. The National Association of State Commissioners, Insurance Commissioners, I think has put out either a proposal or they have their own guidelines regarding the marketing practices of Medigap.

Could you perhaps, to the best of your ability, compare what is allowed at the State level for the marketing of Medigap with what you are trying to put into place or requiring in the marketing of these plans? How do the restrictions compare? What is allowed at the State level that might not be allowed with the marketing of these plans?

Mr. WEEMS. Medigap plans are uniform plans and, therefore, much easier for the States to regulate. For Medicare Advantage programs, the wide variety of State regulatory and enforcement schemes, we think, would make the Medicare Advantage program very, very difficult to administer. So, for instance, if a State required call center representatives to be licensed brokers or licensed agents, as some States do, that would effectively end the ability of plans to be able to have centralized call centers in the way that they do now. Plans would also be subject to a variety of State regimens of enforcement. Our first priority is protection of the beneficiaries. We think we have taken significant steps to do that. We think that we can regulate this product.

Senator SUNUNU. Senator Baucus spoke of a witness, I think, whom we had here who was approached on a door-to-door basis, the sales of one of these plans. You have indicated that under the guidelines you have issued that is not allowed, that that would be an activity subject to enforcement and penalties if it were identified.

Mr. WEEMS. Right.

Senator SUNUNU. Are Medigap plans allowed to be sold door-to-door under State regulations?

Mr. WEEMS. I do not believe they are. No.

Senator SUNUNU. They are not allowed to be sold door-to-door?

The CHAIRMAN. It depends on the State. It is up to the States. Some States allow it, some do not.

Senator SUNUNU. But some States do allow that.

The CHAIRMAN. Some disallow it.

Senator SUNUNU. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Yes, I will put a statement in the record because I was not here for the opening.

[The prepared statement of Senator Grassley appears in the appendix.]

Senator GRASSLEY. Thank you for coming.

Mr. WEEMS. Good morning.

Senator GRASSLEY. We appreciate it very much.

Last summer, CMS imposed a moratorium on marketing and enrollment of 7 of the Medicare Advantage private fee-for-service plans. In the past few months, CMS has suspended marketing and enrollment of several other plans. In one case it was for marketing violations. Suspension for marketing and enrollment is a major sanction. How severe do marketing violations have to be for CMS to suspend a plan's marketing and enrollment activities?

Mr. WEEMS. Let me reflect on my own experience in this area, Senator. The plan that underwent the enrollment and marketing suspension was actually a plan that I secret-shopped in Illinois. During that period, throughout the marketing program, the plan consistently failed to tell beneficiaries about the plan's limitation on access to physicians, even when probed. So they would say you could go to any physician. I probed, and I said, "Any physician?" They said, "Well, any physician who accepts Medicare." That is not correct.

They also told another person present at the marketing session that they represented Medicare. They do not represent Medicare, they represent a private company. After I shopped that particular incident, we went back and we looked. This particular company had this violation essentially all over the country. We were finding it everywhere in this particular company. This was a product either of poor training or deliberate corporate strategy. In either case, the plan was absolutely deficient in its responsibilities. We notified them, and we suspended marketing.

Senator GRASSLEY. Were the violations so blatant the Agency had to act or did the plan refuse to improve the practices after CMS alerted them?

Mr. WEEMS. We did not give them that option, Senator. We suspended marketing. Their actions were so egregious that we did not enter into a negotiation. We said we are suspending marketing until you complete retraining of your agents and can start marketing right.

Senator GRASSLEY. Let me refer to some testimony that we heard last week. These witnesses said that they themselves or beneficiaries have been subject to repeated unsolicited cold calls from Medicare Advantage or prescription drug plans. We also heard that often seniors will just agree to a meeting to get the agent to stop calling them. Given all these problems, why does CMS not just ban cold-calling altogether?

Mr. WEEMS. Thank you, Senator. As I told the chairman and members of the committee, CMS is considering further administrative actions, whether it is enforcement actions or whatever. One of those actions will include contact with beneficiaries, exactly how an agent can make contact with a beneficiary.

Senator GRASSLEY. So then I think the answer to the question is that you might take some action that would prohibit cold-calling?

Mr. WEEMS. We will take action in the range of approaches to beneficiaries. Cold-calling will be one of those areas that we look at. We are also looking at other things, such as approaching somebody in a parking lot.

Senator GRASSLEY. Yes.

The States license and regulate insurance agents/brokers, so CMS does not really have authority over agent and broker behavior except through the plans. Here I am using the words "agent" and "broker" interchangeably to mean the guys selling the product.

Two questions. When CMS gets complaints about agents, how are they communicated to the States? Do you hold the plans responsible for the behavior of their agents?

Mr. WEEMS. First of all, Senator, when an agent's behavior is brought to our notice, we share that information with the State. We have a memorandum of understanding with all but a few States that allows us to do that. Also, the States share information with us regarding behavior of their agents. And, yes, we do hold the plans responsible for the behavior of their agents.

Senator GRASSLEY. All right.

Mr. Chairman, I had a little time left, but I think that answers my questions.

The CHAIRMAN. All right. Thank you, Senator.

Senator Hatch, you are next.

Senator HATCH. Well, thank you, Mr. Chairman. It is nice to have you here, Mr. Weems. We really appreciate the tough job you have. If there is an impossible job in government, you have it, that is all I can say. It is very, very difficult.

At last week's hearing we had a SHIIP counselor from Salt Lake City who testified, and he said that, while there are still problems in Utah, they are not as prevalent as in other States. Now, he attributed that to the relationship that the SHIIP, the State Health Insurance Information Program, counselors and other State office holders have with representatives of the Medicare Advantage plans. In fact, he told us that the Utah SHIIP counselors met every month with a plan representative to discuss relevant concerns and issues within the State.

Now, is that something that CMS would be interested in encouraging in all 50 States? It seems to me that it would make a lot of sense. It works very well in Utah, and it would open up the lines of communication so that Medicare beneficiaries get the best information and are also given the immediate assistance with the problems that may exist rather than federalizing this and having one-size-fits-all answers to everything.

Mr. WEEMS. Senator, it does sound like a practice that we should promulgate and promote. It certainly sounds like a best practice to be shared across the many States. We have conferences among the plans. I would be anxious to get the leader of the Utah SHIIP there and discuss that with the plans.

Senator HATCH. You might want to do that, because they apparently have had a very workable situation that might be applied elsewhere.

What are your views regarding federalizing the regulations on marketing practices of Medicare Advantage plans? I ask that question because I am a little bit concerned about doing that because

there are States like my State of Utah that are doing a pretty darned good job. I am worried about the impact those regulations would have on my State, as well as others. Do you have any suggestions on how this should be addressed so seniors are not taken advantage of?

Mr. WEEMS. We are strengthening our own oversight and regulation of the plans. We think our relationship with the States is extraordinary helpful, especially the relationship where the plans have to meet the solvency test of the States, and also that agents have to be licensed by the States. But for marketing and marketing materials, we believe that we have the oversight capability to be able to carry that out and ensure that we have uniform information across the country.

Senator HATCH. Well, I want to work with you, and I want to help you any way I possibly can. It is a tough job. I applaud you for implementing the secret shopper program. Your testimony states that there were 240 marketing events at which a secret shopper was present. Only 59 had no marketing violations of those 240. That means that 75 percent of the events did have a marketing violation, and that is not a very good compliance record.

So my question would be, given that number of violations, why do you think that CMS acting alone can do a better job than it could in partnership with the States in making sure that the plans follow decent and honorable marketing rules?

Mr. WEEMS. One of the things that we noticed is the number of violations fell off as we began a more determined enforcement regimen. In fact, again, one of the secret shopper activities that I was in, this time in Woodbridge, VA, the agent was explaining the call-back procedures to verify the enrollment. The beneficiary asked and said, "Well, that seems to be an unnecessary complication." In a moment of irony, the agent said, "Well, we know CMS is watching."

Senator HATCH. I am not sure you want to make that point very strongly after reading 1984.

Mr. WEEMS. Well—

Senator HATCH. I am only kidding. Please forgive me. I just cannot help myself sometimes.

Mr. WEEMS. My point being that the sentinel effect and the situational awareness that we have created with the surveillance system that we have put into place gives us confidence that we are going to be able to spot marketing violations and act on them quickly.

Senator HATCH. Sure. Well, we appreciate you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

Welcome.

Mr. WEEMS. Good morning, Senator.

Senator STABENOW. Good morning.

First of all, just from an overall perspective when we look at what CMS is doing, it seems to me CMS is churning out regulation after regulation that cuts back on Medicaid and on Children's Health Insurance Programs, regulations that frankly are based on

policies that have been flat-out rejected by Congress. At the same time, we are seeing a program, Medicare Advantage, with virtually no regulation, a little bit of what you are talking about today.

But last week we heard from the Illinois State insurance commissioner. He called the private fee-for-service system a “wild west with seniors caught in the middle.” So it is concerning to me that, on the one hand, taxpayers are subsidizing private insurers. They are supposed to be more efficient, supposed to be less costly, and in fact are not. But we are not even requiring the private fee-for-service plans to report quality data.

At the same time, we are seeing more and more regulations that prevent a child with disabilities or a person with mental illness from getting any help through Medicaid. I mean, it just does not make any sense to me, unless we are talking about ideology versus just what makes good sense in government or the right kind of values in government.

So I wonder if you could speak a little bit more in terms of Medicare Advantage, in terms of what you are going to be able to do, and why. Why do we see this dichotomy of going after Medicaid and the access for Medicaid and Children’s Health Insurance, and yet under Medicare Advantage we have an insurance commissioner calling it the wild, wild west?

Mr. WEEMS. Well, thank you for the question, Senator. First of all, with respect to quality data, by statute we cannot collect the quality data from private fee-for-service plans. But looking at what you—

Senator STABENOW. Do you think it would be a good idea to do that?

Mr. WEEMS. Actually, yes. We supposed that in previous testimony.

Senator STABENOW. Thank you.

Mr. WEEMS. Looking at what you call the dichotomy, I guess I do not see it that way, and perhaps we can differ on that point. But on the Medicaid rules, those are targeting specific abuses that the GAO, our own Office of Inspector General, has documented. So you may say, well, what about similar abuses in Medicare Advantage? Just in the short time since marketing began this summer, we put into place a number of stringent measures that include compliance, that include surveillance, that include enforcement actions.

And, as we have said in testimony, we are not done yet. There is still more to do. You can expect future actions from us with respect to contact with beneficiaries, the way that a marketing agent can come into contact with beneficiaries, civil monetary penalties, and also the way that agents are paid commissions.

Senator STABENOW. Well, I appreciate very much that you have new guidelines that were issued in December, and so on. But do you have the staff resources to do what you are talking about? That is one of the things that my Budget Committee had hearings on that I am very concerned about right now—the ability to actually follow through with the resources that you have.

Mr. WEEMS. Well, you know, Senator—and I do not want anybody to mistake this for whining, this is just the pure budgetary realities of the world that we live in—our 2008 appropriation for

CMS, for the operations part, was below the President's budget. For operations, I believe the number was about \$170 million below the President's budget. For program integrity activities, which include oversight of Medicare Advantage, we requested an additional \$183 million and we got none of that. Much of that money—not all—was targeted toward audits of Medicare Advantage programs.

So the budget that we requested, I believe, is sufficient to be able to carry out these enforcement activities. Our 2009 budget is sufficient. We did not get our budget request in 2008. That leaves me and the senior management team at CMS with some hard choices to make about how we are going to spend those dollars.

Senator STABENOW. Well, hopefully we can work together so that the President will not veto our Health and Human Services budget again as he did last year, trying to increase that budget overall to be able to do important things.

Mr. WEEMS. Thank you.

Senator STABENOW. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator SNOWE?

Senator SNOWE. Thank you, Mr. Chairman.

Thank you, Mr. Weems, for being here. Last week, we had an interesting session in discussing the compliance and non-compliance of the Medicare Advantage program and the marketing tools. I asked Mr. O'Toole of Humana as to why they had so many unlicensed agents, and also the allegations of marketing abuses that they were also faced with as well. He cited the rapid growth in plan enrollment as a contributing factor to the firm's problem.

We have seen the growth of Medicare Advantage to the point that it is 1 in 5 beneficiaries who is now enrolled, and that growth is driven by the average subsidy. It has been more than 12 percent above the fee-for-service under the traditional Medicare program.

So I think the question that I have for you is, exactly what kind of oversight CMS is providing for compliance of the Medicare Advantage program, and also with respect to these marketing abuses.

Now, Director Orszag of CBO said last month, recently, back a few weeks ago, that your Agency is not helping in providing the information necessary for him to evaluate this program, that he is not getting the health data that he requires. In fact, he says he "continues to beg," and those are his words, "the data from insurance companies on private Medicare Advantage plans. It is almost like they are conducting a variety of experiments in disease management and various other things and they are doing so with public subsidies," referring, as it says in this article, to the 12-percent additional payments that are made above and beyond what we provide for traditional fee-for-service.

So obviously we have a problem here that needs to be corrected. I mean, States are in the forefront. My State has passed legislation banning cross-selling of products, cold calls, door-to-door. I think that is critically important, and I am going to ask you about that in a moment, whether or not we should have this as national legislation, in addition to a cooling-off period, which I think is also important.

But I would like to ask you specifically regarding non-compliance, how do you reconcile the rates of the non-compliance and the

lack of outcome data, the lack of data to evaluate these programs? In fact, CMS issued warning letters to 71 percent of the plans and notices of non-compliance to 63 percent, and required new business plans from 28 percent. So, clearly we have a ways to go here in effective oversight.

I would like to have you answer that question, and also specifically why CBO is not getting the data that it requires to conduct the oversight that is also essential, I mean, given the rate of subsidy the government is providing, \$50 billion over 5 years. That is a substantial subsidy by any measurement. So your Agency is accountable for evaluating that program and submitting the information so it can be independently verified.

Mr. WEEMS. Let me begin with Mr. Orszag's comments. Mr. Orszag was speaking about our disease management demonstrations, most of which are not required by statute. We do want to improve the way that we share information with him, but I think you will also find that Director Orszag amended his remarks in a later statement and that his remarks were confined to a very, very narrow piece of business, and he was not making a broad comment. As I said, he amended his comment.

Senator SNOWE. So are you saying that he does not have any problem with private fee-for-service and the reporting requirements?

Mr. WEEMS. I will let him speak for himself.

Senator SNOWE. Well, he said they had "a light reporting requirement." Those are his words.

Mr. WEEMS. He did. But he amended his comments.

Senator SNOWE. So you are saying now that he feels comfortable with the evaluation?

Mr. WEEMS. I think that he feels comfortable that he has an entrée into CMS to be able to get the data that he needs, according to the rules and agreements that we have set out. But again—

Senator SNOWE. When was that set up, just so we have some understanding?

Mr. WEEMS. Typically, even with other government agencies, CMS, just for the protection of our beneficiaries, will have Data Use Agreements so that we ensure that data are protected as we share them, even with other government entities such as GAO. So we have Data Use Agreements that govern the type of data that we make available.

The CHAIRMAN. Thank you, Senator.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I had high hopes for CMS when Secretary Leavitt came in. He came in to visit West Virginia. I took him to the place where I had been a Vista volunteer. He was very sympathetic. He brought his 16-year-old son with him. He visited a rural health center in a place where very few people can even get to in West Virginia, and I thought it made an impact. I was entirely wrong.

Had he been appearing this morning, I might have asked him why it was that he had not resigned 3 or 4 years ago rather than carry out what he has had to do at the administration's orders, because he has turned, to me, from somebody who works to help people to somebody who simply follows the will of those in the admin-

istration. I do not mean to lay that on you, but I do mean to lay that on him. It is one of the great disappointments of this administration, of which there are many, because I think he is such a good person, and I do not know what happened to him.

An example. The purpose of this question is to highlight the fact that the administration does not have the administrative authority to limit CHIP coverage to children at or below 250 percent of poverty. Now, I can point to a whole lot of recent regulations where your administration, you all, have gone well beyond the intent of Congress or the law.

However, I would like to focus one question on Children's Health Insurance, though. That is, the regulation, the really malevolent regulation, that you slipped in on August 17, you made it a CHIP directive. It was cynical because you know it was not possible. Ninety-five percent of all CHIP people at a certain level had to be enrolled.

You cannot do that, and you know it. Leavitt knows it. The President, I am sure, does not know it and would not be interested if it was told to him. But it has caused great distress. You have no authority to issue that directive. You have none, but it did not bother you. You just went right ahead. You just went right ahead and did it.

It should have been handled through the formal rulemaking process. You were not interested in that. It was like you started handing out Medicaid waivers just as fast as you possibly could. Unfortunately, you gave your first one to West Virginia. That was a terrible mistake by you, and a terrible mistake for our State. No proper public notice, no comment, no unilateral subregulatory guidance.

So it is very interesting. You are coming to Congress and you are seeking legislative permission to expand the malevolence of August 17th—I am going to ask you to defend yourself—to States wanting to cover children at levels higher than 200 percent of poverty, when you did not come to Congress the first time around. So do you believe that August 17th, the guidance then, has the force of law or that it is interpretive?

Mr. WEEMS. Senator, I have not had the opportunity to——

Senator ROCKEFELLER. Yes, you have.

Mr. WEEMS [continuing]. Speak to counsel on the——

Senator ROCKEFELLER. You know the answer to this question. Do not give me the counsel business. You are number-two up there.

Mr. WEEMS. Senator, we took this action believing we had the legal authority to do so.

Senator ROCKEFELLER. All right. So then there is a little case in New Jersey, *State of New Jersey v. U.S. Department of Health and Human Services*. It states that, "The language of the State Health Organization letter itself demonstrates that CMS does not intend the policy guidance to have the force of law." But still, you do it and you make it law because nobody stands up, because health care is not grabbing enough attention.

Why was this comprehensive policy change handled through a letter to the States, for heaven's sakes, when it is an impossibility for States to conform to? There may be one or two that can do that. We cannot even come close. So you cut the legs right out from un-

derneath us. I mean, that was the case before the President vetoed the CHIP bill twice. I really wonder why it is that you decided to slip that through in an administrative letter to the States and not come to us, honorably, with some kind of courage and integrity.

Mr. WEEMS. CMS takes many actions through State Medicaid directors' letters. This was one.

Senator ROCKEFELLER. That is an outstanding answer. It gives me a lot of comfort. I understand the way you are looking at me, because it is exactly the same way I feel looking at you. You consider us a harassment. You consider us unnecessary. You do something that takes away health insurance from thousands and thousands of children by setting up an impossible situation.

Can I ask whether or not Secretary Leavitt suggested to the President that he veto the Children's Health Insurance bill?

Mr. WEEMS. I never heard the Secretary communicate that to the President, but I am certain he has communications with the President outside of my earshot.

Senator ROCKEFELLER. When I read that he did—so my time is out and I feel a lot better for having said some fairly negative things to you, which I hope you will carry to the Secretary.

Mr. WEEMS. I will convey them to the Secretary, sir.

The CHAIRMAN. Mr. Weems, why not just ban in-house sales, period? That is just a huge problem. I mean, you have door-to-door. You have banned door-to-door directly. Why not just ban in-house? This fellow, Mr. Harper. A salesman visited him. Why? Because the salesman was at his brother's home and the salesman got the brother to call him, Mr. Harper, to skirt the door-to-door ban. Why not just ban in-home sales? These agents get in someone's home, and boy, that gets pretty abusive. That is high-pressure stuff.

A lot of times these seniors will sign anything to get the agent out of there, or do anything. They will make telephone calls. Sometimes the form will come down, sign here, Mr. Senior Citizen. Now, if you change your mind, you can tell us later. But once it is signed, it is pretty hard to get back out of it. That is the problem Mr. Harper faced. I do not think that is isolated. Why not just ban in-home sales?

Mr. WEEMS. Senator, that is certainly something that they are considering. A matter of personal interest to me, one of the things that I noticed while, again, I was on one of these secret shopping episodes, was at one point toward the end of the marketing episode I asked for an application. I said, "Can I have an application so I can fill it out and apply?" I was told, "No. We would like to come to your home to do it." To me, that is a clear indication of high-pressure marketing activity. I have seen it first-hand.

As I said, as we are deliberating with urgency—

The CHAIRMAN. When are you going to decide?

Mr. WEEMS. You will see something probably within the coming weeks, sir.

The CHAIRMAN. On this question?

Mr. WEEMS. On the question of contact with beneficiaries, yes.

The CHAIRMAN. I am talking about in-home sales.

Mr. WEEMS. We are considering a range of things.

The CHAIRMAN. I am sure you are, by definition. I am narrowing in on one.

Mr. WEEMS. I am not going to say to you absolutely, sir, that we will ban in-home marketing. It is one of the things that we are considering. If our actions do not meet your standards, I am sure you will want to talk to me about it.

The CHAIRMAN. One thing that is interesting to me is a signal that you are not doing enough. Here is the signal: we are not getting a lot of complaints from the Medicare Advantage plans saying, hey, get CMS off our backs. We do not get that at all. In fact, just the opposite. We hear Humana say, we want CMS to do more. I just do not hear, get them off my back, get them off my back, and all that kind of a thing. I do not know if anybody in this committee ever does. I have not heard any complaints. That, to me, is a signal that you are not doing enough.

Mr. WEEMS. As I said, we are considering more. You will see more from us in the future. I hope that the surveillance system that we have set up is a better sentinel of abuses than the calls that you might get.

The CHAIRMAN. An organization can have all kinds of flow charts and diagrams and all that stuff. All that is pretty irrelevant. What really counts is results.

Mr. WEEMS. Yes, sir.

The CHAIRMAN. I do not know about that. That is going up. It is not going down, it is going up.

Mr. WEEMS. Again, I am not going to try to deceive this committee by cutting that off in December.

The CHAIRMAN. Well, I appreciate that.

Mr. WEEMS. I am going to show you the data, and I am going to live by the data, sir.

The CHAIRMAN. And the data is going up. All I am saying is, by results, I mean I do not get a lot of complaints. I have not heard a single complaint, not one, from any plan saying that CMS is too aggressive on our marketing plans. I have not.

Mr. WEEMS. Again, Senator, I—

The CHAIRMAN. On the contrary.

Mr. WEEMS. I do not know what kind of measure—

The CHAIRMAN. I think that is a pretty good rough measure. Also, on the contrary, just to repeat myself, one major company says you are not doing enough, you should do more, you should crack down more on abusive practices.

Mr. WEEMS. They will likely get their wish.

The CHAIRMAN. Well, we will see.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Director Weems, first, let me apologize. It has just been, even by Senate standards, a crazy morning.

Mr. WEEMS. It is always good to see you, Senator.

Senator WYDEN. You as well.

Let me start by saying that I am prepared to say that I think efforts that you have taken—the secret shopper program, the regional offices effort, the memorandum of understanding—these kinds of steps have been useful. But we were told by the National Association of Insurance Commissioners and their representative last week that the problems are still ongoing, that the swamp has

not been drained in terms of the marketing abuses and the rogue agents and all of these kinds of problems.

So my question to you is, what is wrong with saying, as we do in our legislation, S. 1883, led by Chairman Kohl, that the Federal Government is going to address the concern that you have in terms of uniformity, that there is a strong Federal role here? We deal with the companies in a uniform way, marketing issues, ensure that CMS is a significant role in it.

What is wrong with saying that the States should not be able to supplement that, which is what S. 1883 does? So I think it would be helpful, first, on the record: does the administration support 1883, yes or no?

Mr. WEEMS. There are aspects of it that we support. I do not know that we have come up with a uniform statement of “yes, we support it” or “no, we do not.” We certainly support the spirit of 1883.

Senator WYDEN. So the door is open then to working with Chairman Kohl, myself, and others?

Mr. WEEMS. That door is always open, Senator.

Senator WYDEN. Well, I appreciate that.

So then let us kind of unpack it and have you tell us, first, what is wrong with the effort to have the States play this supplemental role? Because they really feel that a lot of seniors are getting hurt or are falling between the cracks with the current system because they cannot supplement what the Federal Government is doing in the consumer protection area in a timely way. In other words, they can take it from beginning to end and walk it all the way through the system. Conceptually, what is wrong with that?

Mr. WEEMS. Well, Senator, we would want to make sure that there was complete uniformity and that we were not having 50 separate enforcement regimens—50 separate, as you said before, regulatory regimens where the program might become literally ungovernable having to respond to that many regulatory regimens.

Senator WYDEN. So with a uniform approach, which is what I think Chairman Kohl has been seeking, certainly I support him as well, you could see supporting cutting the shackles off the States and giving them a supplemental role as well?

Mr. WEEMS. It is something we can talk about in the nature of, it has to be very, very uniform. We have these kinds of relationships with States under some very narrow circumstances. I will also say, Senator, that this kind of help is not going to come for free. We might consider giving CMS the resources that it asked for first before taking these steps. As I said previously, CMS’s operations budget was substantially less than what we had requested in the President’s budget. Right now in CMS, we have a hiring freeze on just to be able to make payroll for the year.

Senator WYDEN. Here is what Mr. McRaith said when he was speaking for the insurance commissioners. He said, “There needs to be a regulator that is able to respond to an individual complaint and go look at a company or respond to a pattern of complaints, as almost every State is receiving, look at a company and really scour that company and its business practices to understand and evaluate it so it complies with the national uniform standard.”

Is that something that you could find a way to support? We will have to work on the details. I think there is concern that you all will just rule out supporting 1883 altogether. But do you think there is validity in what Mr. McRaith and the insurance commissioners are saying there?

Mr. WEEMS. Well, certainly those are the kinds of things that we are trying to accomplish, and, Senator, I think it is something we can talk about.

Senator WYDEN. All right.

Mr. Chairman, I think my time has expired, and I will wait for another round.

The CHAIRMAN. All right. Thank you very much.

Senator WYDEN. Thank you.

The CHAIRMAN. Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

Mr. Weems, you were speaking about the rate of audits. Can you tell me exactly how much you are spending on audits? As I understand it, it has declined by half since 2001. So exactly what are you spending on audits, and what is the rate, comparatively speaking?

Mr. WEEMS. I can get that for you. Typically, I think this year we will—and it depends on which audit you are talking about. If it is the financial audits where we are required to do roughly a third—

Senator SNOWE. Correct. Right.

Mr. WEEMS. Those audits—

Senator SNOWE. Auditing the records.

Mr. WEEMS. Right. Again, within the operations budget that we have, we are hopeful that we will be able to do a third of the plans this year, but I am not in a position right now to be able to make that—

Senator SNOWE. And how much are you spending on audits?

Mr. WEEMS. I will have to get that for the record.

Senator SNOWE. I mean, how does that compare year to year? Is it true it has declined significantly?

Mr. WEEMS. We actually—

Senator SNOWE. Given the fact of the rate of subsidy here, it is all the more important, is it not, to make sure that these companies are audited in their records, given the dimensions of marketing abuses and practices that are totally unacceptable in the use of taxpayers' money?

Mr. WEEMS. In 2008, we had planned substantial increases in that area. I can get you the year-to-year time series.

Senator SNOWE. A substantial increase. But is that a net increase over time or does that just happen to be—

Mr. WEEMS. Yes.

Senator SNOWE. Well, you would not happen to know what that is?

Mr. WEEMS. Our plan for this year, using the program integrity funds, I believe was to dedicate another \$25 million to audit activities.

Senator SNOWE. Yes. That may well be. But the question is, what did we spend in the past, which was far more significant than it is today?

Mr. WEEMS. I will get that for you.

Senator SNOWE. Would you agree with that?

Mr. WEEMS. I—

Senator SNOWE. And given the rate of growth of the Medicare Advantage plans and the level of subsidy, all the more important to be engaged in aggressive oversight. That is a concern. It is troubling, the fact that those audits and the amount that is devoted to audits—you are talking about a \$50-billion subsidy over 5 years. If the rate of audits has declined by almost half, that is even more troubling since 2001.

Second, Glen Hackbarth, the chairman of the Medicare Payment Advisory Commission, mentioned that approximately half of these subsidies were retained by plans in the form of administration costs and profits. Would you not say that that is very high?

Mr. WEEMS. I would say that our actuaries review the plan bids for administrative matters and for profit and make a judgment as to whether those administrative costs are reasonable. They have agreed that, in the bids, they are.

Senator SNOWE. And you examine the commission structures?

Mr. WEEMS. We are going to take a look at commission structures.

Senator SNOWE. I see. It is not something you have done so far?

Mr. WEEMS. Well, certainly we have looked at it. The question is, are we—

Senator SNOWE. Well, I would think there would be. It is very disturbing that much of it is directed to commissions through very objectionable sales and practices. I mean, it is a recipe for disaster, so I think it is absolutely critical that that occurs within your agency.

Mr. WEEMS. As I have told the—

Senator SNOWE. And sends a very important message.

Mr. WEEMS. That is one of the items that you will see from us here soon.

Senator SNOWE. All right.

And, finally, on a cooling-off period, I happen to believe that a cooling-off period would be very important so people can return to their existing coverage if somehow they have been misled, the plans have been misrepresented, mischaracterized, given all that has happened. So would you support a cooling-off period so that they could return, a 60-day cooling-off period so they could return to their existing Medicare plan?

Mr. WEEMS. We have special enrollment periods now where we can act very quickly. If somebody feels like they have been deceived into a plan, we can disenroll them and re-enroll them prospectively into the next month by calling 1-800-MEDICARE.

Senator SNOWE. Well, we heard—

Mr. WEEMS. Although there is an election period where beneficiaries can change from like to like coverage or return to original Medicare.

Senator SNOWE. And we heard this last week in terms of even the appeals process and so forth. I just think, given the complexities of this program, a 110-page guide and all that is happening on the practices, I think it would be all the more important.

And speaking of enrollment periods, should we not synchronize these enrollment periods between Medicare Advantage and Part D?

I understand Medicare Advantage is in the first quarter of the year, and that is fine. But leaving the Part D program during the course of the holiday season, there are many enrollment periods, it is very confusing. Why not align them and synchronize them?

Mr. WEEMS. Well, we certainly perform education and outreach during the same time period. We are looking at aligning a number of our—

Senator SNOWE. Yes. The key is to be user-friendly. I think we understand what we are all talking about here. I do think it is critical that you realign these enrollment periods. There are so many of them. It is extremely confusing, let alone leaving the Part D during the holiday season, November and December. I think it is great to move the Medicare Advantage to the first quarter of the year. I think you ought to synchronize it in that regard. Thank you.

The CHAIRMAN. Thank you, Senator, very much.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. I might say, we have 13 minutes left on a vote.

Senator ROCKEFELLER. Oh. Well then, let me just say, how many children, Mr. Weems, who are currently enrolled in CHIP today will lose coverage because of the August 17th directive? And I do not want you to tell me “none” because of the grandfathering part, I want you to look out and say how many are going to lose coverage, do you think?

Mr. WEEMS. I do not have that number available to me, Senator.

Senator ROCKEFELLER. Would that not be something that would be of interest to CMS?

Mr. WEEMS. Senator, CHIP is not the only coverage option for children. Almost any proposal has crowd-out. Our policy of August 17th simply says we need to put the poorest children first. There are States leaving behind poor children because children who are wealthier are many times easier to find. It seems to be a noble goal to be able to say, let us find the poorest kids and let us put them on the rolls first before we reach to children of wealthier individuals.

Senator ROCKEFELLER. So in other words, if somebody is at 210 percent of poverty they can be ignored, but if they are at 200 percent of poverty they make it? Do you know what poverty is?

Mr. WEEMS. I do.

Senator ROCKEFELLER. Have you ever been to West Virginia?

Mr. WEEMS. I have.

Senator ROCKEFELLER. When, and what did you do there?

Mr. WEEMS. I have driven through it.

Senator ROCKEFELLER. On the way to the Greenbriar?

Mr. WEEMS. No, sir. I have never been to the Greenbriar. I grew up in southern New Mexico, sir.

Senator ROCKEFELLER. All right. Then you ought to be seeing things differently.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Weems, why not let State insurance commissioners develop guidelines for States to enforce the guidelines under which Medicare Advantage plans will be marketed and guidelines under which then the State insurance commissioners can then oversee the regulation, as in the case of Medigap? I do

not quite understand why the general approach that is taken in Medigap does not also apply to Medicare Advantage. But do not forget, Medicare Advantage is private companies. It is not government.

Mr. WEEMS. Yes.

The CHAIRMAN. It is not government at all. These are private companies.

Mr. WEEMS. They are.

The CHAIRMAN. Medigap is private companies, private insurances.

Mr. WEEMS. They are.

The CHAIRMAN. Not Medicare, it is private companies. We have this proliferation of Medigap plans that were being offered years ago, lots of marketing abuses. It was a mess. People were taken advantage of. It was just an outrage. I got very involved with this, as have other Senators, and it led to some Federal legislation. Senator Claude Pepper led a lot of it. As you know, it led to standardization of Medigap plans and States basically deciding how they are going to regulate enforcement, and so forth.

Why can the same approach not be taken here? I do not know that CMS is equipped, frankly. That is not a complaint. I just do not know that you are equipped to do the job in the right way. You are such a big agency, you cannot get out in all these cases the way the State insurance commissioners can to know what is going on and to do what is right. Why is that not just the right approach? The Medigap approach. Why is that not the right approach here?

Mr. WEEMS. Well, Senator, it is a good question, and I think one worthy of discussion here. I think you have hit on something very key in discussing Medigap policies. That is that one of the consequences of that effort was standardization. For Medicare Advantage programs, they offer a different and wide range of benefit packages. We believe that that is a good thing.

The CHAIRMAN. It is more complex, wider variety. Maybe that is part of the problem. You know, you can only do so much when you are insuring people for health insurance. You either get insured with basic coverage, maybe with basic drug coverage and so forth. I mean, when things get too complicated, little signals come up to me that somebody is trying to make a buck rather than trying to help serve people.

Mr. WEEMS. And again, Senator, I think it is a worthy conversation to have. In sitting and listening to the marketing of the plans and trying to be objective, listening to the variety of products that are offered, I think that you could see how different plans offering different benefits were going to be helpful to a different set of individuals.

The CHAIRMAN. Well, maybe you can have 12 plans, or 10. It just seems obvious to me that CMS is just not competent, not equipped, not qualified to really cover the problem nationwide, and probably for the reasons you are indicating. If there are so many different plans being offered and such variety being offered, that is all the more reason you cannot know about all of that. Let the States, through standards regulations developed by State insurance commissioners nationwide—it is not just Medigap. That is applied in other areas, too.

Mr. WEEMS. Yes. Standardization of benefits is not a result that we would be looking for. We have made strides in standardization of marketing material, standardization of contact with beneficiaries.

The CHAIRMAN. That is an interesting question. We have standardization of Medicare.

Mr. WEEMS. In fee-for-service——

The CHAIRMAN. We do in Medicare.

Mr. WEEMS. Well, that——

The CHAIRMAN. That is called Medicare. MMA is not Medicare.

Mr. WEEMS. Senator, there are variations in local coverage decisions. So what is covered in some areas is covered differently in others. It is not a 100-percent uniform——

The CHAIRMAN. It is pretty close. You have Part A, Part B. It is pretty close. It is pretty close.

Mr. WEEMS. There is variation in coverage, sir.

The CHAIRMAN. Pretty close, though. All right. I would just urge you to think very seriously about maybe doing this a little bit differently. It partly is to gain the confidence of people, of seniors who do have a lot of confidence and trust in Medicare, and it is maintaining that trust and confidence in Medicare. I might worry that seniors are going to lose that confidence in Medicare based on what you are doing, and we are then going to have a bigger problem on our hands.

Thank you.

Mr. WEEMS. I think we share the same interest here. As you consider legislation and as we consider further rulemaking, I would be interested in having a conversation. Thank you, sir.

Senator GRASSLEY. I hope you have a few more minutes here. Then, Mr. Chairman, I will adjourn the meeting if nobody else was——

The CHAIRMAN. Oh, no. I think Senator Wyden wanted to come back.

Senator GRASSLEY. Oh, yes.

Mr. WEEMS. I will have time for you, Senator.

Senator GRASSLEY. I guess you will have to have time for other members. All right.

First of all, I want to refer to a person who testified last week. We had Mr. Harper testifying that he was fraudulently enrolled in a Medicare Advantage plan. In an e-mail to my staff, the plan claims that because Mr. Harper disenrolled, he technically was never a member of the plan.

Two questions. If that is true, where does his money go? I guess, three questions. Why was it not refunded? Then as kind of a conclusion, if you have not looked into this, would you please get back to me on it?

Mr. WEEMS. Let me speak, in general, about this case. Senator, I am a little reluctant to speak in specific because this case has been referred to our Office of Inspector General.

Senator GRASSLEY. Oh. The IG? Yes.

Mr. WEEMS. Office of Inspector General. But let me speak in general.

Senator GRASSLEY. All right.

Mr. WEEMS. So if somebody believes that they have been fraudulently enrolled in a Medicare Advantage program or if they believe that they have been deceived into enrolling, they should call 1-800-MEDICARE. They call 1-800-MEDICARE. At that moment on that phone call, we can disenroll them from that plan and prospectively enroll them in another plan that will begin at the beginning of the next month. We can do that very quickly.

Now, if they have been in the plan for a bit and had incurred some expenses, with retroactivity, we want to make sure that we sit down with that beneficiary and, if they are changing plans, that they understand there may be some change in their financial obligation if we disenroll them from the plan that they were in. For instance, if they moved to a plan with different cost-sharing or different coverage. So, we want to go through that with them very deliberately.

So prospective we can do very quickly. Retrospective disenrollment and re-enrollment, we want to go through with the beneficiary very carefully so they understand the choices they confront in doing that.

Senator GRASSLEY. In regard to the IG investigating that specific case, even in writing I cannot get an answer from you?

Mr. WEEMS. I will see what we can do. We have just been asked to withhold further comment.

Senator GRASSLEY. All right.

Federal preemption of State law in the Medicare+Choice program was much less broad than it is now. Why is the very broad preemption of State law—especially with respect to marketing and sales—for Medicare Advantage and Part D plans important? From CMS's viewpoint, were the States inconsistent in their regulation of Medicare+Choice plans?

Mr. WEEMS. The Medicare Modernization Act brought growth opportunities for MA, as well as introduced Part D. Both C and D are administered now currently in a consistent manner. The significant growth in the number of enrollees in C and D would make it impractical to return to this previous regulatory approach. Having 50 States and territories set standards for MA organizations inconsistently would result in a program that could not be effectively administered.

For instance, if one State required customer service representatives to be licensed brokers if they provided just information on Part C or D, it would make it impossible for plans to have centralized call systems as they do now. Likewise, State review of marketing materials would be inconsistent with the time frames and the uniformity necessary to create a national program such as Medicare Advantage and Part D.

Senator GRASSLEY. Another question I have involves the appointment of agents. In the 2009 Medicare Private Plan Call Letter, it suggests that CMS will require the plans to file with the State Solicitor their appointed agents. Presumably CMS will keep the list for itself. How does requiring appointment of agents at the State or Federal level fit into CMS's own enforcement plan?

Mr. WEEMS. This is part of the data use sharing information that we have with States. We need to make sure that agents are prop-

erly licensed and properly appointed and that CMS and the States know who they are.

Senator GRASSLEY. All right.

I am going to turn to Senator Wyden. I am going to leave, Senator Wyden. I do not know what the plans are about other people coming back. I will let you make that decision. Maybe even Senator Baucus is coming back. I do not know for sure. I have to go.

Senator WYDEN. I thank my colleague, and I know we will be working together on this and the whole health care agenda.

Let me turn now, if I could, to the commission structure again, because I heard you talk to Senator Snowe, Director Weems, and I do not get the sense that this is a big priority, reform in this area. I want to see if maybe we can change your mind.

Here is what Mr. McRaith said. This is, again, talking about an ongoing problem, not something that has been corrected: "Commission structure is important. Commissions that reward agents for volume of submitted applications, that is a serious problem." Last week, Chairman Baucus held up a chart that had been used by Humana until there was an effort to blow the whistle, and I really commend Senator Baucus and Senator Grassley for highlighting this, talking essentially about how there would be a paradise of bonuses, \$10,000 bonuses.

That was ongoing. It did not talk about something in the past, it talked about now. That would have been running, I believe the date was, through April of 2008. Does not a whole lot more need to be done to fix this problem of incentivizing commissions in a way that damages older people? I mean, one of the reasons I feel so strongly about this is that I think these practices are giving the private market a bad name. Our Healthy Americans Act, with 12 Senators, is built around a private market. We are not going to have a lot of confidence in America if these practices do not get corrected.

So I want to give you another chance on the commission issue to see if you will amp up what is being done to control these abuses, and abuses that, according to Mr. McRaith, are going on now, not a thing of the past?

Mr. WEEMS. Senator, I agree with you. I agree that this is not theoretical. As I have said in testimony today, we are under way with further administrative actions that go directly to commissions. You can expect to see that from us here in the coming weeks.

Senator WYDEN. Well, send a wake-up call. What kinds of things, without giving up proprietary information, are you trying to go after? I assume you want to deal with this outrageous ad of Humana that was taken off the market. But what kinds of commission practices are you most concerned about?

Mr. WEEMS. I am most concerned about churning. That, I really consider an objectionable kind of practice. Beneficiaries should be in the coverage that is best for them, not best for their agent. They should choose it and, if it is good for them from year to year, that is what they should stay in and they should not be churned. I find that practice objectionable.

Senator WYDEN. So what kinds of limitations would you be looking at in terms of churning? Just, again, I recognize we are not putting out a rule here or writing a piece of legislation. But for pur-

poses of this morning and sending a message that you as the Director are concerned about it, what kind of limitations would you see as appropriate in the churning area?

Mr. WEEMS. There are certain industry standards right now about churning that I think we are going to take a hard look at and see if those should be codified.

Senator WYDEN. So you would see beefing up some of the restrictions in the industry rules and putting teeth in the enforcement?

Mr. WEEMS. Yes.

Senator WYDEN. And I hope that you will also take a look at even beefing up the rules in addition to the enforcement. Are you open to that?

Mr. WEEMS. We are open to that discussion. Yes, sir.

Senator WYDEN. All right.

Let me come back to one of the other questions that we touched on, and that is making sure we deal with this quickly, that we not have the back and forth that has gone on for months and months over the CHIP legislation, and something is vetoed, and the like. The States are ready to go now. They are equipped now. They are ready to use their resources now to help consumers who are still getting exploited now. So that is not a question of Federal resources.

Again, what can be done quickly to take the shackles off the States so that they can do what they see is the essence of their work and we do not have more people hurt as the Congress just chews and chews and chews on this forever?

Mr. WEEMS. I think that, immediately, CMS can strengthen its relationship with States so that, if there are things that the State agents or State commissioners receive in terms of complaints, they can get to us very quickly and then we can act very quickly. That is an immediate action that we can take. It is certainly considered in the memorandum of understanding that we have. We have some instances of that. I think that relationship still needs to be strengthened more.

Senator WYDEN. I think, again, that is constructive. As I touched on, I mean, I have looked at your programs, the secret shopper. I think they are useful. This is not a referendum on somebody saying that they are lousy. I think that they are useful. But it is not enough, and it is not enough on the basis of what the seniors are saying, it is not enough from the standpoint of what the Area Agencies on Aging are saying. It is just not getting it done.

I think the memorandum of understanding fits very much into this category. I think it is useful but it does not carry the force of law, the force of immediacy, the force of urgency, the force of consumer protection that these senior groups and the insurance commissioners feel is necessary.

So when do you believe you could get back to us on the administration's position on S. 1883?

Mr. WEEMS. A couple of weeks. Is that satisfactory?

Senator WYDEN. Yes. That will be constructive. What I would like, for the direction of Chairman Baucus, Chairman Kohl, myself, the people who are involved, what parts of the legislation you can support and what parts of the legislation you cannot support.

Mr. WEEMS. All right. We will do that.

Senator WYDEN. Let us talk for a minute about Medigap because, as you know, I have had a lot of interest in this over the years. I want to approach it in a different kind of way because, I think, a lot of the Medigap discussion, particularly as it relates to Part D, kind of misses the point. They are two different products and we are trying to acknowledge that in 1883. They are just different. The Medicare supplement is different than a program that is run by the Federal Government.

But the real value of Medigap is that now you can walk into any senior citizen center in the United States anyway—because I have done this—and people can walk you through the Medigap choices. They can take you through the 10 or so standardized packages, and older people and their families can figure out what makes sense for them and their particular needs. That is not true for Part D. People cannot sort this out. I get calls from somebody who is in their 30s or 40s who is a lawyer, an accountant, who says, “Ron, I am working with my mom’s Part D. I cannot figure this out. Could you please help me?”

Do you not think there is a long way to go in terms of simplifying this process and that the Medigap model—recognizing that it is a different product, number one, recognizing that what we are talking about in our legislation is the Federal Government through CMS playing this important role, uniformity on marketing, uniformity on jurisdiction over the companies—still has a lot to recommend it to us because people can sort the information out quickly, and they have not been able to do that in Part D?

Mr. WEEMS. Senator, with respect, I think our experiences are different. By that, I am not in any way discounting your experiences. I spent a lot of time this year on Part D, going around the country, talking to people, listening in on counseling sessions. CMS has devoted a lot of resources to counseling to make sure that people get on the plan that they need. It has just been my view that that has been, for the most part, easy, seamless.

With respect to the Medigap model, I think one of the things that we would not want to do is to reduce the number of choices that are available. Choice is a good thing. I believe our seniors are capable of choosing plans that are right for them. In fact, the data from independent polling firms show great satisfaction with the Part D benefit and the way it is administered. Eighty-seven percent. It is pretty rare for a government program.

Senator WYDEN. So people have not been confused with this large array of choices. Is that what you are saying?

Mr. WEEMS. My experience has been that people get the help that they need so that they can make good and informed choices in choosing a plan that is right for them, and that CMS has devoted considerable resources to making sure that that happens.

Senator WYDEN. Respectfully, the seniors, the witnesses who have been here, the advocates to Area Agencies on Aging and the National Association of Insurance Commissioners, disagree with you. I hope you will take a look at this. I am asking you to take a look at it, recognizing that it is a different product, it is a different system. But people can sort through their choices on something that, back when we started this, the abuses were flagrant, arguably more flagrant than what we are seeing today, and it has

worked. It has worked for seniors and their advocates, and it has worked for responsible companies.

Now, you mentioned that CMS can provide seniors who have been misled into signing up for a Medicare Advantage plan—that they can change the plan in a special enrollment period. On average, how long does it take for CMS to provide a special enrollment period for a beneficiary who calls 1-800-MEDICARE?

Mr. WEEMS. There are two types of enrollments and disenrollments, and I want to make sure that we properly distinguish between them. A beneficiary who calls 1-800-MEDICARE and says I want to change plans, we can, on that call, disenroll them and enroll them in a plan and their coverage will begin in that plan at the beginning of the next month with one phone call.

Now, if there is a retrospective disenrollment and then re-enrollment, we want to make sure that we do not handle that on that phone call. Instead, that goes to a case worker who can tell a beneficiary, you were enrolled in this plan, you may have received these services. The plan you are going into may have a different cost-sharing or different coverage structure.

We want to work with them to make sure that they understand that their financial liabilities might change—they might change in either direction—and that the premiums are different. That takes a little longer to work through because it is something we want to make sure we get exactly right for the beneficiary. We handle those on a case-by-case basis.

Senator WYDEN. Let us talk about disenrollment when you have an individual who has been the victim of fraud. For example, in Oregon we have heard of cases where straightening this out has taken 6 months or longer. There is a case in Wisconsin where it took 8 months to sort out. Is this not an area where there needs to be significant improvement?

Mr. WEEMS. Well, those were older cases where the enrollment and disenrollment may have been handled by a contractor. CMS handles those now. We are much more nimble in recent months. Again, Senator, on enrollment and disenrollment where it is prospectively, we can do that very quickly and we can handle it in that one phone call. Where the beneficiary may have used that plan, we want to sit with them and go through very carefully how their costs may have changed or any monies that they may owe, or be owed to them.

Senator WYDEN. One of the reasons that I feel so strongly about getting the States in this supplemental role is, when you say we are going to sit with people—the Federal Government is not as close to this as the States are and the Area Agencies on Aging, so I hope you will incorporate them. I mean, it is even part of the problem with the secret shopper. I have already told you, I think the secret shopper is a good program, useful. But it does not get the people in their houses, where so often a lot of the most outrageous conduct takes place.

Mr. Weems, we will wait your written report on S. 1883. I hope, in sending you off, you can see how strongly Senators feel about this, and particularly reflect on the views of Mr. McRaith and the commissioners, and the seniors. They are saying that they think a number of these steps that the Agency has taken have been useful,

and they largely share my view. But they believe that the problems are ongoing. As we speak today, this week, we still have older people falling between the cracks, taken advantage of.

It is giving the private sector a bad name, and it is time to put all the tools that are available out there to deal with this, which is what the point of S. 1883 is all about, to try to find that space where the Federal Government can benefit from the States engaging in a complementary effort, not supplanting the Federal Government, but allowing the States to complement the efforts so we have a beefed-up role in the consumer protection area.

I would like to give you the last word. Is there anything you would like to add?

Mr. WEEMS. Just, thank you for the opportunity to appear. I admire your passion, and I hope you know I share it.

Senator WYDEN. Well, we thank you and look forward to working with you.

With that, the Finance Committee is adjourned.

[Whereupon, at 11:39 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

SUBMITTED BY SENATOR BAUCUS

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50 accreted applications	Agent receives an additional \$1,000 bonus	*Total bonus - \$2,000
75 accreted applications	Agent receives an additional \$1,000 bonus	*Total bonus - \$3,000
100 accreted applications	Agent receives an additional \$1,500 bonus	*Total bonus - \$4,500
125 accreted applications	Agent receives an additional \$2,500 bonus	*Total bonus - \$7,000
150 accreted applications	Agent receives an additional \$3,000 bonus	*Total bonus - \$10,000
150 Medicare Advantage applications accreted by 4/1/2008	Agent will receive a total cumulative \$10,000 BONUS	

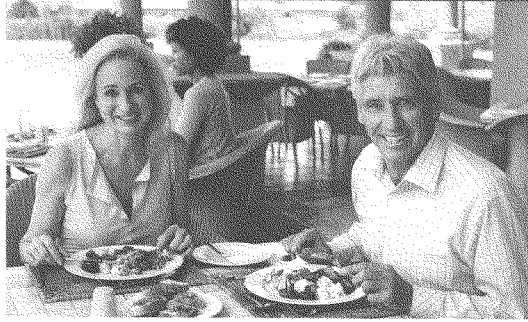
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United States Senate
Committee on Finance



Sen. Chuck Grassley · Iowa
Ranking Member

Opening Statement of Charles E. Grassley
Hearing, "Selling to Seniors: The Need for Accountability and Oversight of Marketing and Sales
by Medicare Private Plans (Part 1)"
Thursday, Feb. 7, 2008

I appreciate all of you being here today to help us understand how Medicare private plans are being sold. In Iowa this past December, some of my constituents found that they had been sold a Medicare Advantage plan that their doctors did not take. It was a private fee-for-service plan, so there was no list of preferred doctors.

I have heard from some people that the salesman told them all the doctors took the plan. That's not right and the agent shouldn't have said that. The agent may not have intended to mislead my constituents. But they ended up in a plan that did not work for them. It made me wonder about the agent's training and incentives.

In a case in New York, an agent sold a plan outside its service area. Maybe he strayed over a county line without noticing. But it was a big problem for the people who bought the plan. Both the family and Medicare ended up very confused some months later when it was entirely unclear how they were covered – whether they were covered by the plan they shouldn't have enrolled in or original Medicare. Despite the ordeal caused by the agent, he was never disciplined.

I am hearing that seniors who are perfectly happy with their health coverage are getting a hard sell to change plans each year. I am hearing stories about agents visiting the homes of elderly people sick with flu and insisting on enrolling them in a private Medicare plan. I am hearing that health plans are buying beneficiaries lunches and dinners as part of the sales pitch. Some people feel obliged to enroll as a result. And I am hearing that seniors who asked for Medigap coverage have ended up in a Medicare Advantage plan. They are stunned to find out -- usually about the time they receive bills for cost-sharing they thought Medigap covered.

Now some of this may be the result of Medicare beneficiaries not examining their choices carefully. And these are anecdotes that implicate only a few of the many agents and plans working with Medicare beneficiaries on their plan options. Nonetheless, it appears that some Medicare beneficiaries were subject to abusive sales practices just months ago.

There were a number of shocking stories in 2006 about Medicare Advantage and Part D plans' sales activities. While I am a proponent of Medicare choices, it was clear this was an area that needed close scrutiny. As a result of these startup problems in 2006, CMS clarified its policies. It has continued to tighten up sales requirements for plans. And anecdotal evidence suggests that the worst of the abuses may have ended. And I commend CMS for taking those decisive steps.

But there are some areas that CMS did not address. Commissions, for example, continue to give agents the wrong incentives. I have here an ad that was posted on Craigslist, on the Internet, a few days ago. It's an ad for agents to "sign up" seniors to the Medicare Advantage program. Let me quote it:

"I am part of a National Agent Team whose mission is to sign up 'eligible' seniors to the Medicare Advantage program. Notice that I didn't say, 'sell,' I said 'sign-up.'"

"That's because the beauty of this opportunity is that it doesn't cost the recipient anything additional . . . All they do is receive additional benefits to their existing Medicare program. It's really NOT a sale! It's a 'presentation'. They sign up and you get the commission. . . it's at least \$200 . . . and up! The visit can take as little as 45 minutes . . . so you do the math!"

"This is NOT a joke or a game. There are agents making a great living right now!"

The ad gives a link to express interest in selling MA plans. Mr. Chairman, I would ask consent to insert a copy of this ad into the record. This ad tells me that something is wrong with how the agents, and perhaps the plans, are looking at Medicare Advantage. We know that many seniors need personal counseling to help them pick a plan. They rely on their children and counselors, but also on their insurance agents. They rely on the agents to help them pick the plan that is best for them. I have no doubt that many of the agents are doing just that. I have had calls from agents who refused to sell certain products that they considered sub-standard.

But that ad makes it clear that not everyone out there is acting with the beneficiary's best interests in mind. I've heard from insurance agents that some plans' commission structures were providing excessive incentives to urge seniors to switch plans each year. Some plans pay a commission on each signed application an agent submits. One of today's witnesses never signed a form, but ended up enrolled.

The plans themselves have told me they wish someone would intervene to regulate commissions. When one plan is paying half or a third the commission of another, it seems to me the agent will recommend the other plan.

Another problem is that some agents tell beneficiaries that they are from Medicare. Or they say that they need to meet with the beneficiary to explain Medicare's new benefits. This is a violation of the federal regulations. But it continues to happen.

Door-to-door sales are barred in Medicare. Cold calling is not. And an agent may visit if a beneficiary has indicated interest in meeting with an agent. You can see how a senior might agree to a meeting just to get an agent to stop calling.

CMS has tried to get a handle on these abusive sales activities. Last summer, it suspended marketing by seven private fee-for-service plans until they instituted key reforms, such as improved agent and broker training. As recently as December, CMS suspended sales and enrollment by an MA plan with overly aggressive tactics.

The states agree that they have authority over the actions of insurance agents. Yet, they complain that they lack the authority to hold the Medicare Advantage plans accountable when there is a pattern of abusive sales practices. They also say that CMS lacks the experience and the staff to oversee plan sales activities.

So a key question is whether the current CMS guidance and enforcement actions are adequate to protect beneficiaries from abusive sales tactics.

While we will not hear from CMS Administrator Kerry Weems until next week, today's witnesses should shed some light on private plan marketing and sales in Medicare. I look forward to hearing from them.

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Reply to: job-561279591@craigslist.org
Date: 2008-02-03, 2:15AM EST

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All they do is receive additional benefits to their existing Medicare program. It's really NOT a sale! It's a "presentation". They sign up and you get the commission. The commission varies from state to state, but it's at least \$200... and up! The visit can take as little as 45 minutes... so you do the math!

There is NO COLD CALLING. Qualified appointments are set up for you in advance. They are supplied to you in the zip codes and hours you request. The "closing" ratio is very good, again, because it doesn't cost them a dime extra!

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United States Senate
Committee on Finance



Sen. Chuck Grassley · Iowa
Ranking Member

Statement of Sen. Charles Grassley
Hearing, "Selling to Seniors: The Need for Accountability and Oversight of
Marketing and Sales by Medicare Private Plans (Part 2)
Wednesday, February 13, 2008

Good morning. Last week we heard testimony from a range of witnesses about continuing problems with marketing and sales of Medicare Advantage plans. Mr. Weems, I appreciate your joining us this morning. I hope you can shed light on CMS's role in setting and enforcing standards for marketing and sales activities of Medicare Advantage and prescription drug plans.

At last week's hearing, we heard some shocking stories about sales of Medicare Advantage. Our beneficiary witness, Mr. Harper, told us that he had never signed up for Medicare Advantage. And yet an agent had enrolled him in a plan anyway. It took him months to resolve the problem. And he never got back the money the plan took out of his Social Security check.

In an e-mail to my staff, the plan claims that because Mr. Harper disenrolled, he technically was never a member of the plan. If that's true, where did his money go? Why wasn't it refunded?

Last week, we also heard about insurance agents telling seniors they were from Medicare. We heard that the agents said that private fee-for-service plans were the same as Medigap.

And we heard that cold calling often led to seniors agreeing to meet with an agent just to stop the daily phone calls. Some of these are already against the rules. But they are still happening.

Some witnesses suggested that the problem was with insurance agents ignoring their training and not following the rules. Some thought the states would do a better job with enforcement. They also argued that state authority needed to be strengthened. They pointed out that the states oversee enforcement of Medigap insurance. They said that works well.

Medigap insurance is not part of a federal entitlement program. It is paid for with no federal dollars. I have a problem with states having too much oversight of a federal program.

But the agents are regulated by the states. So it is essential that the states can truly hold the agents accountable. And it concerns me that CMS has allowed some obvious problems to continue.

For example, CMS has allowed agents representing Medicare Advantage and Part D plans to cold-call beneficiaries unless they are on the national do-not-call list.

By cold-calling, I mean calling a beneficiary without that person expressing interest in the product ahead of time.

This strikes me as a glaring example of a practice with great potential for abuse. We have heard that agents sometimes repeatedly call the same senior, until she gives in and invites the agent to come to her home.

In some areas, CMS has stronger standards than many states do. In Medigap, many states allow door-to-door sales. CMS does not allow door-to-door sales for Medicare Advantage and prescription drug plans.

At the same time, over the past eight months CMS has strengthened its enforcement activities. Last July, it placed a moratorium on the marketing, sales and enrollment of seven private fee-for-service plans until they improved their practices.

In December, it suspended sales and enrollment for two plans, one due to overly aggressive sales tactics. The call letter for plan year 2009 includes several ideas to improve sales and marketing practices of MA plans.

One of them is to require plans to inform states as to which agents are selling on behalf of that plan in the state. Another is to bar an agent from selling a Medigap plan at the same time as a Medicare Advantage plan.

I hope that the CMS rules can curtail egregious sales tactics. But I am unclear how CMS is working with the states to ensure that plans themselves crack down on bad agents.

So I welcome CMS Administrator Weems to the Finance Committee. I look forward to what he has to tell us about CMS's efforts to make sure that the marketing and sales of Medicare Advantage and Part D plans are consistent with CMS rules.

I also look forward to understanding how CMS views its efforts to coordinate with states and where Mr. Weems thinks CMS needs more help.

“Selling to Seniors: The
Need for Accountability
and Oversight of
Marketing by Medicare
Private Plans”

Statement of
George Harper

Medicare Beneficiary
Mayflower, Arkansas

Before the
Committee on Finance
U.S. Senate

I appreciate you all letting me take the time out to tell you about this and letting me have a voice to say what I want to say about it.

Last July, I was busy taking care of my wife. She was real sick at the time. She had to go to the hospital 2 or 3 times a week to get IV antibiotics. I was sort of depressed about that.

I got a call from my brother. He was talking to a Medicare guy and thought I should talk to him said he wanted to come by and explain to me that there was some extra help through Medicare that I didn't know about.

I told him I didn't have time to talk with him that day. He kept asking, I got tired of him and I didn't want to argue with him on the phone, so I finally just said "ok, come on by."

He came by the same day. He knew more about what my business was than I did. He didn't ask really ask me any questions, he pretty much was telling me what I had. I was uncomfortable and leery because he knew so much about me.

I am cautious when people tell me things about me, instead of asking me about me. It kind of throws me off. My wife was

disabled in 1990. We've had to keep up with her Medicaid, hospitals, and stuff so I read everything and ask questions before I sign anything.

I was trying to be nice so I sat and listened to him, but I told him I was satisfied and didn't want to change. He said these were free benefits that seniors are entitled to like prescription drugs, eye glasses, dental, and stuff like that. I told him again that I was satisfied with what I had and I didn't want to change anything.

He would not leave. He talked, he'd scribble a little every now, and then he'd talk. He left a blank form for me and said, "Well, there is no cost to you. If you decide you need the extra help all you have to do is fill this out and send it in." That was on Saturday.

The next day, Sunday, another gentleman named Lynn Kelly came by my house talking about the same program. I said, "I'm going to tell you just like I told the guy yesterday that I don't need anything else." Mr. Kelly said, "Was it Bill Perkins? If so you need to call Monday morning because you are signed up for this program." I said, "Man, I haven't signed anything." He said "you might not have signed, but you are in this program."

Monday morning I called Mr. Perkins and he swore that I wasn't signed up for anything. He said, "I filled out a form to make sure my company knew that I was by to see you. All I have to do is call the office and in about 5 minutes they'll get this straightened out and I'll call you." He didn't call me. I kept calling for him, but they said he was out every time I called.

My wife and I endured extra charges for this plan. In August, Care Improvement Plus took \$64 out of my social security check and \$64 out of my wife's. The program I didn't sign up for, didn't want, and was supposed to be free, cost us \$128 a month.

I started calling Social Security and Care Improvement Plus about my check. I never could get it into my head how can they tap into Social Security so easily when it is supposed to be so sacred and private. I don't know how they could do it so easy and so fast when it is so hard to get out of their program.

Finally, I got with the lady that was supposed to be running things down there at Care Improvement Plus and she said she had papers I signed. I told her I didn't sign any papers and she should get

ready for a lawsuit. She said, "Sue us, we don't care. You signed the papers."

She mailed me a copy of the papers. I did not fill out the papers she mailed me. It is not my signature on the papers and the Medicare number he put on there is not my number, the last number is wrong. He had my Medicaid number on there too. I never did tell him about Medicaid, we was only discussing Medicare A & B. How he got that Medicaid number, I don't know. I never showed him my cards or anything.

Care Improvement Plus wanted \$100 more a month for our prescriptions. Before this plan, I paid \$56 for me and \$13 for my wife at the start of each year and then we pay \$1-\$5.60 per prescription.

We had numerous hospital bills during this time. My wife went and stayed in the hospital in August. The people down there are real nice but I had to answer so many questions about this company. They asked why did I change my plan and when did I change my plan. I tried to explain to them that I had not changed my Medicare or Medicaid. I had to go through all that for a whole week.

I do not know why he would sit in my house, lie to me and do me like that. It mad me really angry. I'm not the smartest person in the world but I'm not dumb.

According to Medicare everything is resolved but Care Improvement Plus is still sending me statements for hospital stays. I had eye surgery in August. I got an Explanation of Benefits a few weeks ago that said \$720.00 of my eye surgery will not be covered. Our money coming in is our Social Security checks and \$720 is more than half our monthly check amount.

These people were operating under false pretenses that they represent Medicare. I know of one other person that is going through this same thing with these same people. We just want to be heard and live accordingly. Don't bury us before we die. It seems like the system is working against us, in a sense, more than it is working to help us.



**Selling to Seniors: The Need for
Accountability and Oversight of Marketing
and Sales by Medicare Private Plans**

February 7, 2008

**Statement of
Peter C. Hebertson**

**Director of Outreach
Salt Lake County Aging Services**

**Before the
Committee on Finance
U.S. Senate**

Chairman Baucus, Ranking Member Grassley, distinguished Committee members, I am Peter Hebertson, Director of the Outreach Information and Referral Programs of Salt Lake County Aging Services, the local Area Agency on Aging. I appreciate the opportunity to be here with you this morning to discuss our experience with Medicare advantage plans and their marketing practices.

Introduction

We became interested in health insurance issues for older adults in the 1970's. So, we were very excited when the Omnibus Budget Reconciliation Act (OBRA) of 1990 was enacted and provided for the State Health Insurance Information Program (SHIIP). We have served as a provider of a SHIIP program in Utah for seventeen (17) years.

The role of the SHIIP program in Salt Lake County is to help people with Medicare understand and make informed decisions about their Medicare benefits. We accomplish this mission by providing various services. These services include outreach and education, Medicare prescription drug plan screenings, Medicare casework, assistance with problem resolution and Medicare fraud prevention. Salt Lake County Aging Services SHIIP program also leads the Salt Lake County Access to Benefits Coalition (Attachment A).

Part of our SHIP program's strategy has been to develop and maintain working relationships with Medicare beneficiaries, Medicare private insurance companies and other stakeholders. This positioning has enabled our program and staff members to be in a place to identify and resolve Medicare marketing related issues in our community. Following are some of the challenges that our seniors and staff members experience as they attempt to access and understand their Medicare benefits.

Private Medicare Plan Marketing Problems in Salt Lake County

Utah has been fortunate in comparison to other states when it comes to systematic violations by those companies and individuals marketing the Medicare Advantage Plans. Salt Lake County Aging Services has worked diligently to develop relationships with our Medicare Advantage Plan providers and to report problems and potential violations to them. Frequently, the companies have acted to stop the abusive sales practices with no more action needed on our part. This has been possible because we have been conscientious in establishing and maintaining cooperative relationships. These relationships have been in existence since 2004 and were a strategy to protect people with Medicare and provide accountability for the Medicare Advantage Plans.

All Salt Lake County's Medicare Advantage Plans are encouraged to participate in the Salt Lake County Access to Benefits Coalition. This coalition meets monthly to discuss

issues and problems directly related to all aspects of Medicare. Despite these genuine efforts and successes, Salt Lake County's seniors experience numerous aggressive marketing and sales tactics.

Many of the marketing problems that we experience are not illegal but they add to the confusion of all older adults. It is our experience that confused people often make poor choices.

One of the first issues or common complaints is the huge quantities of marketing materials seniors receive through the mail. We have had seniors come to our office with a stack of mail between 3-4 inches thick asking what they can throw away.

We have had reports of seniors who threw away critical documents because they thought they were marketing materials, or responded to marketing materials because they thought they were official letters. Seniors tell us that they can't differentiate the material from private plans from an official Medicare or Social Security document. This occurs despite the requirement for all marketing material to be approved by Centers for Medicare and Medicaid Services (CMS).

Another common concern reported to our SHIP program is aggressive telemarketing phone calls. Even people who are on the "Do Not Call Registry" are marketed by the

private Medicare companies. Many seniors reported that even when they told the marketer "no," they continued to receive follow-up calls.

We also receive complaints from seniors who attended free dinner seminars hosted by Medicare Advantage companies. Seniors have reported to us that they felt pressured into signing applications. Many report they did not understand what was being presented or what they were signing up for. We have also had several seniors who attended multiple dinners and signed up for multiple plans.

Independent agents continue to be one of the major complaints we receive. One of the issues is that the agent does not fully understand the plan they are selling or how that plan interacts with existing coverage. When this occurs the SHIP staff can spend three to four hours helping to correct the problem. We also have received reports from individuals about aggressive agents who would not leave the home without an application being signed. They tell the senior that they will hold the application and not submit it without authorization and submit the application anyway. Another complaint is the agent will state to the senior that they are a representative from Medicare. The misrepresentation is used to create a false sense of trust.

Salt Lake County Aging Services SHIP program has found our local Medicare Advantage Providers very responsive to complaints about independent agents. We

have had local Medicare Advantage Plans discontinue their agents' ability to sell because of some of the above tactics. However, we would be naïve to think that the Salt Lake County Aging Services SHIIP program hears but a small number of the issues that exist.

Below we have listed two specific examples of the types of complaints and issues that have been reported to our SHIIP program.

Example #1

One of Salt Lake County Aging Services certified State Health Insurance Information Program (SHIIP) counselors was attending her regularly assigned Senior Center. When she entered the building, she was informed that there was a Medicare presentation being held. The SHIIP counselor was approached by one of the presenters. The presenter introduced herself as being a representative for Medicare. The counselor corrected the presenter by saying, "You mean you are an insurance agent who is selling Medicare Advantage Plans and not from Medicare", and the presenter agreed.

During the presentation the presenter made several references that would lead the senior attendees also to believe that she was a representative from Medicare. Again, the SHIIP counselor had to clarify with the presenter that she

was an independent insurance agent selling a Medicare Advantage Private Fee-For-Service Plan and not from Medicare. This misrepresentation is a common marketing tactic used by independent agents to build false trust with the seniors.

Another area of concern during the presentation was when the agent/presenter was comparing the Medicare Private Fee-For-Service (PFFS) plan she was selling with traditional Medicare. All of the comparison information was based on Medicare Part A and B only and did not take into account the possibility of the individual purchasing a Medicare Supplement Plan. This comparison gave the impression of huge savings to the beneficiary who switched to the Medicare PFFS plan. During no part of the presentation did the agent/presenter discuss the possibility of purchasing a supplementary plan to offset the gaps of Medicare Part A and Part B.

When the SHIIP counselor asked the agent/presenter about basic plan details, the agent/presenter was unable to provide accurate answers. Here is an example: The counselor questioned whether or not a physician's visit co-payment would count towards the annual out-of-pocket maximum. The agent/presenter responded, "Nothing counts towards the annual out-of-pocket maximum", instead of indicating physician co-payments would count toward the out-of-pocket maximum. Immediately after the presentation the SHIIP counselor

contacted her supervisor. The SHIP program relayed the information to the Utah State Division of Aging and Adult Services. The SHIP program also filed an official complaint with the Utah Department of Insurance.

Example #2

A husband and wife, both in their late 80's who live in Salt Lake County, were enrolled in a Medicare PFFS Advantage Plan. They received a telephone call from another Medicare PFFS Advantage Plan wanting to set up an appointment to meet. Initially the couple declined, but the plan persisted in making numerous phone calls until the couple consented to a home visit. The agent was extremely aggressive and the couple felt pressured to sign up for the new plan.

A few days later the couple knew they had made a bad decision and contacted the new plan requesting that the application be cancelled. The new plan refused to do so and stated the issue must be handled by CMS, forcing the couple to call 1-800-Medicare. During this particular time the wait times at 1-800-Medicare were 25-35 minutes.

1-800-Medicare referred the couple to Salt Lake County Aging Services SHIP program. By the time the SHIP counselor received the call, this elderly couple was extremely distressed and frustrated. The SHIP counselor filed a complaint

with CMS and helped the elderly couple switch back to their original Medicare Advantage Plan. Despite these changes, the problematic Medicare Advantage Plan has continued to call and badger this couple.

Conclusions

Salt Lake County Aging Services SHIP Program staff has spent a considerable amount of time thinking about and discussing possible solutions to marketing abuses of the Medicare Advantage Plans with our Access to Benefits Coalition members.

We understand and support the many different Medicare Advantage options available to seniors. We have had great success helping people find cost effective plans when all plans are impartially explained to the individual and the decision is based on their current health care and financial needs.

A significant problem remains in how the Medicare private companies market and pay commissions to agents.

CMS currently approves all Medicare Advantage Plan marketing materials. More oversight of the quantity of materials and tag lines that might lead individuals into thinking the information is official Medicare correspondence would be helpful.

In conversations with the local Medicare private insurance companies, five major companies have expressed that one of the key problems is how agents are reimbursed their commission.

They have reported that as long as different companies pay different commission rates to agents, those agents may lack the incentive to sell plan enrollment based on what is best for the senior.

Policy Implications

We value the diversity of options available in the Medicare Advantage Plans. However if an individual is not informed about options, they will not be able to take full advantage of the benefits that Congress have provided.

We need a system that rewards agents and brokers for selling a plan that best meets the health and financial needs of the senior, rather than rewarding agents and brokers for selling a specific company's plan. This could address many of the aggressive marketing strategies that currently frustrate and confuse seniors and may cause poor choice in access to health care and increased cost.

Salt Lake County Aging Services SHIP program will continue to strive to ensure that individuals with Medicare understand all their available options. We will continue to do this through direct conversations with seniors, relationships with private Medicare Advantage Plans, CMS and other stakeholders.

Thank you for this opportunity to share our experiences with you. Sharing ground level information to you from the seniors who are experiencing these issues will hopefully be able to help the committee enhance the Medicare services and the individual's opportunity to take the best advantage of this important program. Salt Lake County Aging Services stands willing to serve as a resource to the Senate Finance Committee in the future. Please do not hesitate to contact us if we can be of assistance.

**SALT LAKE COUNTY AGING SERVICES
ACCES TO BENEFITS COALITION**

AARP - UTAH CHAPTER
CATHOLIC COMMUNITY SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
CONSTITUENT SERVICES, OFFICE OF CONGRESSMAN MATHESON
HEALTH INSIGHT
HUMANA
MOLINA
MULTIETHNIC HOUSING
REGENE BLUE CROSS BLUE SHIELD OF UTAH
RX AMERICA
SALT LAKE COMMUNITY ACTION PROGRAM
SALT LAKE COUNTY AGING SERVICES
SIERRA LIFE AND HEALTH INSURANCE
SMITH'S FOOD AND DRUG
STATE OF UTAH DIVISION OF AGING AND ADULT SERVICES
STATE OF UTAH DIVISION OF HEALTH CARE FINANCING
STATE OF UTAH OFFICE OF ETHNIC AFFAIRS
STATE OF UTAH REHABILITATION SERVICES
STATE OF UTAH SERVICES FOR PEOPLE WITH DISABILITIES
UNITED HEALTH CARE
UNITED STATES SOCIAL SECURITY ADMINISTRATION
UNIVERSITY OF UTAH, COLLEGE OF SOCIAL WORK
UNIVERSITY OF UTAH, HEALTH SCIENCES CENTER, PHARMACY
UTAH FOOD BANK 211 SERVICES
UTAH LEGAL SERVICES, SENIOR MEDICARE PATROL
UTAH NON-PROFIT HOUSING
UTAH STATE DEPARTMENT OF HEALTH
UTAH STATE DEPARTMENT OF INSURANCE
VALLEY MENTAL HEALTH

**Testimony of Michael McRaith
Director of the Illinois Division of Insurance**

Before the United States Senate Finance Committee

**Selling to Seniors: The Need for Accountability and Oversight
of Marketing and Sales by Medicare Private Plans**

February 7, 2008

Good morning Chairman Baucus, Ranking Member Grassley, and members of the United States Senate Finance Committee. My name is Michael McRaith and I am Director of the Illinois Division of Insurance.

Thank you for holding this important hearing today and for inviting me to testify about Illinois' experience and views on the need for accountability and oversight of marketing and sales by Medicare private plans. As a member of the NAIC Senior Issues Task Force and chairman of the NAIC Health Innovations Working Group, I also intend to share some of the views of the National Association of Insurance Commissioners (NAIC).

State insurance regulators are well-versed in the marketing and sales practices used by companies that offer Medicare private plans (*i.e.*, Medicare Advantage and Medicare Part D Prescription Drug Plans). This testimony will summarize problems with the Medicare private plan marketplace, describe the benefits of state-based consumer protection, and endorse the grant of additional state authority found in the Accountability and Transparency in Medicare Marketing Act of 2007.

Problems in the Marketplace

The problems occurring in the marketing and sales of Medicare private plans have been well publicized. Countless media reports have described the overly-aggressive, inappropriate, and sometimes deceptive practices used to market, sell, and enroll seniors into Medicare private plans. Federal and state legislators across the United States, perhaps including your offices, have received innumerable complaints from Medicare-eligible constituents about these problems.

During several Congressional hearings on these topics during 2007, state insurance regulators reported that their respective departments and State Health Insurance Assistance Programs (SHIPs) received a consistent pattern of complaints, most of which related to the marketing and sale of Medicare private plans. While the media often focused on Medicare Advantage private-fee-for-service plans, state insurance regulators did and do recognize that many complaints also involve other types of Medicare Advantage and Prescription Drug Plans.

Regulators receive frequent reports of a variety of problems, including: marketing and sales practices that pressure beneficiaries to enroll into inappropriate or unsuitable plans; marketing and sales practices leading beneficiaries to enroll into Medicare Advantage plans without fully understanding that enrollment would lead to the loss of traditional Medicare and Medigap plans; beneficiaries being misled about a Medicare Advantage plan's provider network or provider reimbursement policies; mishandling of enrollment applications; beneficiaries being misled or not informed about a plan's cost-sharing; tying (*i.e.*, cross-selling) tactics where agents use Medicare Part D as a pre-text to develop a relationship with a senior and then sell the senior an unrelated and often unsuitable product (*e.g.*, a Medicare Advantage plan or life insurance policy); and, finally, outright common law fraud.

As a result of the frequent and severe misconduct and resulting bad publicity, CMS has recently announced a number of new requirements for Medicare Advantage Private Fee-for-Service plans. State insurance regulators generally support the new CMS requirements, including the

call-back system, the secret shopper program, and the requirement that plans administer agent training. The NAIC has informally surveyed the states to assess whether the CMS changes noticeably improved the quality or quantity of consumer complaints. The survey results received thus far are mixed: some states report clear improvement for consumers during the past year, while other states, such as Illinois, report neither a clear improvement nor a clear worsening of the situation.

For insurance commissioners, these marketplace problems are startlingly reminiscent of the early days of Medigap. Just like Medicare private plans today, federal Medigap regulation in the late 1980's created confusion and financial distress for seniors. Prudently, Congress developed and passed important legislation in 1990 that gave the NAIC authority to develop national, state-enforced standards for Medigap plans. This model for cooperative federal-state oversight can be adapted to create in the Medicare private plan marketplace greater protection and clarity for Medicare beneficiaries, while preserving viable options.

The Oversight Role of State Regulators

The program to provide Medicare beneficiaries the option of private plan coverage, once referred to as Medicare+Choice, operated successfully for almost 10 years with state oversight. The Medicare Modernization Act (MMA) not only created the new "Medicare Advantage" plan, but stripped state regulatory oversight of insurance company activities. Not surprisingly, reported marketing and sales abuses began to proliferate shortly thereafter.

The Medicare Advantage program provides an important option for seniors in Illinois. However, as currently structured, the Medicare Advantage program provides insufficient oversight and thereby invites abuses by companies and agents, both of which receive great financial rewards for steering seniors to private, limited-network products that often do not meet a senior's basic needs. For instance, many seniors have been enrolled in Medicare Advantage plans without being told or without understanding that the private plan's provider network does not include that senior's long-known primary care physician.

Greater state authority is needed to both properly oversee the marketing activities of Medicare private plans and to quickly assist seniors who have been harmed. For reasons described below, state insurance regulators urge passage of the Accountability and Transparency in Medicare Marketing Act of 2007 (S. 1883), pending legislation that would supplement federal oversight with a limited grant of authority to states to monitor insurance company marketing abuses. Uniformity of state laws is guaranteed – the grant of authority is explicitly tied to national standards developed by a diverse working group.

The top priority of insurance regulators is consumer protection. Insurance regulators not only license private insurance companies, but also possess broad authority to act against a state-licensed entity on behalf of consumers.

Every day insurance regulators receive and respond to consumer inquiries or complaints for non-Medicare private health plans. When the Illinois Division of Insurance receives a consumer complaint, professional staff immediately reports the complaint to the company. State law

requires that the company then review the complaint and provide a specific written response, which may include corrective action. If necessary, state law requires the company to provide additional information. We evaluate all information and determine whether the company violated Illinois' insurance consumer protection laws. Every complaint receives this thorough attention.

If the Division finds a violation of state law, or if the Division receives more than one complaint about a company, then the Division initiates an investigation under general regulatory authority granted to the Director of Insurance. State insurance regulators can issue a subpoena, examine witnesses, and conduct a hearing. If the investigation reveals that a company has violated the Insurance Code, then several remedies are available: order the company to take corrective action; impose a fine on the company; and/or issue a cease and desist order to immediately stop the company from harming consumers. Ultimately, I can also revoke or place limits on a company's certificate of authority. State regulators also conduct regular and cyclical market conduct examinations that comprehensively evaluate a company's compliance with consumer protection laws.

State regulators, familiar with local companies, agents, and providers, are engaged and vigilant in ensuring proper behavior of all marketplace participants. Necessary state laws authorize regulators to investigate, fine, penalize, and even shut down companies that employ practices harmful to the public interest. State regulators not only foster competitive insurance markets but also actively demand consumer protection.

The Problem of Preemption

A principal reason for the proliferation of problems in the Medicare private plan marketplace is the absence of rigorous oversight to protect and assist consumers. State insurance regulators, including my Illinois department, have uncovered practices that would appear to violate state consumer protection laws. Unfortunately, we are precluded from taking action because, with the exception of licensing and solvency, the MMA specifically preempts states from regulating Medicare Advantage and Prescription Drug Plans.

The Illinois Division of Insurance regularly receives complaints and inquiries from seniors who were sold unsuitable Medicare private plans, but is without authority to call the company and clarify or correct the problem. The only recourse for the senior is to call Medicare, wait for a live person to answer the phone (a process that can take 20 to 30 minutes), report the violation to CMS, and sometimes wait weeks or months for CMS to respond. Seniors deserve better.

State regulators continue to exercise appropriate authority over licensed agents. Nevertheless, the method by which state regulators tackle widespread marketing and sales abuses is by addressing the financial incentives that drive the behavior – the marketing plans and agent compensation practices developed by the companies. Since regulators lack authority over the companies, reaction is often limited to case-by-case investigations of abuses and prosecutions of agents.

Despite the jurisdictional limitations, the Illinois Division of Insurance noted a pattern of complaints against persons selling Humana Medicare Advantage and Prescription Drug plans. In

response to this pattern, the Division examined Humana and its relationships with sellers. Upon finding that Humana engaged and received Medicare Advantage and Prescription Drug plan applications from at least 67 unlicensed sellers, the Division, on January 11, 2008, entered an order against Humana requiring appropriate corrective action and imposing a \$500,000 fine.

While the Division has taken action against Humana for using unlicensed sellers, we can not hold Medicare private plans responsible for the acts of their licensed agents, unlike other types of private health insurance. State insurance regulators require additional authority over the marketing and sales strategies of the plans in order to protect vulnerable seniors from unscrupulous agents.

Additionally, the current regulatory bifurcation (*i.e.*, CMS has exclusive regulatory jurisdiction over the companies and states have jurisdiction over agents) creates a wide regulatory gap that invites exploitation by both companies and agents. When state regulators attempt to protect consumers, the companies cite preemption and advise regulators that CMS limits jurisdiction. This gap harms consumers.

In Illinois, as with other states, seniors have reported abusive sales practices resulting from the cross-branding or tying of private insurance products. While in other commercial transactions the practices of cross-branding and tying may be appropriate, such practices can be wholly improper when directed at seniors frequently overwhelmed by the level of detail associated with products like Medicare Part D coverage. For example, under current CMS guidelines an agent selling a Medicare Part D plan to a senior may also sell that senior an annuity, a life insurance policy, or a Medicare Advantage plan. Without access to a discerning family member or SHIP volunteer, a senior on a fixed income can easily be steered into purchasing the wrong product(s).

Seniors are also harmed by company behavior not directly connected with plan marketing. For example, a company may encourage agent abuses by paying volume-based bonuses to agents, *e.g.*, the agent receives additional compensation by increasing the volume of his or her submitted applications. Also, evidence demonstrates that the short 45-day enrollment period may drive companies to work with agents of a quality that the company would not normally allow.

Improved State Oversight and Enhanced Consumer Protection

With nearly fifteen percent (15%) of a state population enrolled in Medicare – a number likely to increase in the near future – federal preemption of state consumer protection laws generates significant challenges for too many of our residents. The lack of an effective federal safeguard against abusive sales and marketing practices heightens the need for improved oversight.

The problems identified in this brief summary can be resolved with measured reforms that do not interfere with the fundamental objectives of the MMA. Fortunately, the federal and state experience with Medigap reform provides an instructive precedent.

In the late 1980's, Senator Ron Wyden and others on this Committee collaborated with the NAIC and led the effort to address problems in the Medigap marketplace. This pro-consumer

collaboration culminated in 1990 with the passage of landmark legislation that established the current regime of Medigap insurance regulation.

The 1990 Medigap legislation established joint federal-state regulation, with state regulation tied to state adoption of NAIC-developed model regulations. After adopting the standards, states were authorized to enforce the rules. Given that the Medigap problems of the late 1980's strongly resemble the company and agent abuses in today's marketplace for Medicare private plans, the Medigap solution provides an appropriate template for reform.

As proposed by Senators Kohl, Wyden and Dorgan, the "Accountability and Transparency in Medicare Marketing Act of 2007" (S. 1883) would encourage the NAIC to develop a set of standardized marketing requirements for Medicare Advantage and Prescription Drug Plans. Under this bill, the NAIC would develop these standards in consultation with a balanced working group comprised of state insurance regulators, CMS, industry representatives, consumer groups, and other experts. The Secretary of Health and Human Services would promulgate these national standards and, thereafter, states would be permitted to enforce the rules.

The S. 1883 federal-state partnership approach ensures that Medicare Advantage and Prescription Drug Plans would not be subject to state-specific rules but, rather, would allow state regulators to protect and assist seniors. States would not interfere in the contracting process and would not have approval authority over company marketing materials. States would, though, have the legal capacity to require accountability if a company's marketing practices, or the practices of a company agent, failed to satisfy the essential consumer protections developed by the S. 1883 working group.

Summary

Expansion of state oversight authority over Medicare Advantage and Prescription Drug Plans will allow insurance regulators to better protect seniors from agents engaged in unscrupulous or abusive sales practices. With measured delegation of responsibility, state insurance regulators cannot only continue to foster competitive insurance markets but also ensure that fewer seniors are mistakenly sold unnecessary Medicare Advantage or Prescription Drug Plans.

The Illinois Division of Insurance, like all NAIC members, works every day to protect consumers, especially those seniors who are among the most vulnerable members of our communities. State insurance regulators have long-standing institutional knowledge, expertise, and resources upon which to construct appropriate marketplace safeguards.

Grateful for the opportunity to participate in this important discussion, the Illinois Division of Insurance and the NAIC remain committed to working with the United States Senate, CMS, and other essential policymakers to draft and implement those practices that serve the best interests of the growing Medicare-eligible population. We remain certain that consumer-focused collaboration will benefit all interested parties.

**Testimony by
Patrick O'Toole, Vice President-Medicare Sales
Humana Inc.**

February 7, 2008

Senate Finance Committee

Mr. Chairman, Committee members, I appreciate the opportunity to testify about the oversight of Medicare Advantage plans marketing activities. I am Patrick O'Toole, Vice President, Medicare Sales for Humana Inc. Humana, headquartered in Louisville, Kentucky, contracts with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare beneficiaries affordable health plan coverage through a variety of products. We currently offer three stand-alone prescription drug plans (PDP) in 50 states, 2 plans in Puerto Rico and one in the District of Columbia; private-fee-for-service plans (PFFS) in 50 states; regional preferred provider plans (RPPO) in 23 states, local preferred provider organizations in 17 states and Puerto Rico; and health maintenance organization plans (HMO) in 8 states and Puerto Rico. We sell Medigap policies in 40 states. In addition, Humana offers private health plan options through the Department of Defense's TRICARE program; network services through a contract with the Veterans Administration's Healthcare Effectiveness through Resource Optimization program (HERO) and plans to government employees through the Federal Employees Health Benefits Program. We offer a Medicaid plan in Florida and a reforma plan in Puerto Rico. Finally, we offer health insurance and specialty product coverage and related services to employer groups, other government-sponsored plans and individuals. In total, we provide medical insurance or administrative services to over 11.5 million members.

I would like to begin my testimony where it ends: A set of recommendations for strengthening Medicare Advantage (MA) marketing practices and oversight. For over 20 years, Humana has served Medicare private plan beneficiaries. We have worked with both federal and state regulators, state health insurance assistance programs, the National Association of Insurance Commissioners (NAIC) and many consumer advocacy groups in marketing MA products. We understand well the public trust the government has placed in us and the vulnerability and special needs of the population we serve. Thus, we offer the following recommendations to improve the MA program through stronger federal standard-setting and oversight and improved cooperation with state regulators:

1. The Secretary of Health and Human Services (HHS) should establish a requirement that MA plans be required to adhere to state department of insurance agent appointment rules. Humana's policy from the outset has been to license and appoint its agents.
2. The Secretary of HHS should establish a requirement that limits the total commission compensation paid to agents to a fixed percentage of premium. This will ensure agents fully inform beneficiaries of the products and associated plan rules and will reduce the opportunity for high-pressure sales. Further, such requirements should provide for level commission payments year-over-year—for renewal sales as well as for replacement sales.
3. The Secretary of HHS should establish a requirement in conjunction with state regulators for a registry of agents (with civil immunity to companies reporting data) where companies can share and access information related to verified beneficiary allegations of sales practice violations and

- questionable sales tactics. This would prevent agents from moving from company to company, possibly avoiding enforcement actions.
4. CMS should continue to work with state regulators to enhance data exchange and enforcement actions especially in the areas that affect market conduct.
 5. We support the adoption of more stringent federal standards in areas relating to cold calling, cross-selling of non-health related products, consumer disclosures, agent training and certification, and other marketing practice-related areas, including co-branding, the standardization of certain benefit terms, clarity in plan type and more easily understood plan/benefit comparisons.

I will expand upon these recommendations following an overview of the MA program, Humana's marketing program oversight and improvements, regulatory agency actions and corrective action and remedies and industry initiatives.

Overview of Medicare Advantage

The MA program provides valuable opportunities for seniors and Americans with disabilities to benefit from the integrated systems of care, chronic care initiatives, and other innovations that Humana and other health insurance plans have developed to improve patient care and enhance the overall quality of life for our members. Approximately 9 million Medicare beneficiaries – accounting for nearly 21 percent of all beneficiaries nationwide – currently are enrolled in MA plans and are receiving comprehensive, quality, affordable coverage with benefits and innovative services that go beyond the coverage offered by the Medicare FFS program.

MA plans are now providing beneficiaries across the country with choices that offer additional benefits and comprehensive care. According to CMS, MA plans will provide enrollees with, on average, savings of \$90 per month or almost \$1,100 per year in 2008 – through improved benefits and lower out-of-pocket costs – compared to what they would pay in the original Medicare program.¹ This translates into aggregate savings of over \$9 billion annually.

These additional benefits are especially important for beneficiaries with the greatest health care needs. A recent study for the Kaiser Family Foundation demonstrated that beneficiaries who are among the top five percent in total incurred Medicare costs could have been expected to save as much as \$4,000 in out-of-pocket costs in 2006 – up to 50 percent – in an MA plan when compared to the cost-sharing they would pay in the FFS program.² MA plans are also important to low-income and minority Medicare beneficiaries, especially those who fall just short of qualifying for

¹ Presentation by CMS before The National Medicare Education Program Partnership Alliance, October 24, 2007.

² "The Value of Extra Benefits Offered By Medicare Advantage Plans in 2006." Prepared by Mr. Mark Merlis for the Henry J Kaiser Family Foundation (January 2008).

Medicaid, cannot afford Medicare Supplement insurance or afford the high out-of-pocket costs they would incur under the original Medicare program. In February 2007, America's Health Insurance Plans (AHIP) published a study³ showing that MA plans are the most popular option for beneficiaries with annual incomes between \$10,000 and \$20,000.

The approach to care provided by MA plans is distinctly different than that offered in the fee-for-service program. The average Medicare beneficiary is likely to have two or more chronic illnesses – 23 percent of Medicare beneficiaries have five or more chronic conditions – and these beneficiaries account for two-thirds of Medicare spending.⁴ Recognizing that many Medicare beneficiaries suffer from multiple chronic conditions – such as diabetes, heart disease, cancer, asthma, and depression – Medicare Advantage plans meet a critical need by offering care coordination and management for diseases that commonly afflict these individuals.

To address the need for better coordination and early intervention, health insurance plans have played a leadership role in developing strategies and programs to encourage prevention and evidence-based care to improve patient care for persons with chronic conditions. Plans are focused not only on ensuring that patients with chronic conditions live longer – but also helping them live healthier lives, with fewer symptoms, so they can fully participate in the activities they enjoy.

This focus on care coordination is evident across the different models of plans – coordinated care plans like HMOs and PPOs, and private fee-for-service (PFFS) plans that organizations participating in the Medicare Advantage program are offering beneficiaries. In Humana's congestive heart failure chronic care management program, between February and August 2007, our members raised their prescription drug compliance rate to 88%. We've reduced hospital admissions in our PFFS plans by 6%, emergency room visits by 21% and 30-day readmission rates are running 11.9% compared to the Original Medicare FFS rate of 17.6% due to clinical interventions such as case management and chronic care management.

The effectiveness of these initiatives was highlighted in a June 2007 report⁵ by the California Association of Physician Groups (CAPG), which stated: "It is the experience of more than 150 physician groups in California and the 59,000 physicians who are part of these groups that they are able to provide better health care to their patients who are in Medicare Advantage plans than those in traditional Medicare." While discussing the specialized services that are needed for patients with chronic conditions, the report stated

³ Low-Income and Minority Medicare Beneficiaries in Medicare Advantage Plans, AHIP, February 2007

⁴ Testimony by Gerard Anderson, Ph.D., Bloomberg School of Public Health, before Senate Special Committee on Aging, May 9, 2007.

⁵ The Experience of California Physicians in the Medicare Advantage and Traditional Medicare Programs, Executive Summary, California Association of Physician Groups, June 2007

that, “these care management services are possible only in the context of the MA program and are virtually non-existent in traditional Medicare.”

Actions to Ensure Humana MA Marketing Compliance

Humana currently employs about 2,300 career field and telesales agents and we hold exclusive contracts with three leading, national insurance managing general agencies: State Farm, USAA and Thrivent. In addition, we contract with several regional and local managing general agencies. We require our agents to be licensed, appointed and certified to sell our Medicare products. In 2007, our employed or career sales agents accounted for about 75% of Humana’s agent-assisted MA sales. (We believe we have one of the largest employed Medicare sales forces.) Over the past two years, Humana has significantly reduced the number of delegated agents and contracted managing general agencies. In 2007, we reduced the number of delegated agents selling our products by 43% and reduced the number of contracted general agencies by 29%.

Humana requires all agents marketing our MA products to meet all state, federal and company statutes, regulations and contractual requirements. Humana requires a background check on all agents, and we check the licensure status of agents against the National Insurance Producer Registry (NIPR). Since 2007, we validate the licensure status of each agent on a monthly basis, checking for license expiration. Agents deemed to have an expired license are prevented from access to any Humana electronic enrollment system.

All Humana MA agents participate in a training program and pass a certification test. Last summer, we enhanced our recertification training program to include curriculum developed by AHIP (for PFFS plans) and approved by CMS. That same curriculum will be incorporated into our new-hire training programs and pre-work materials for all employed and contracted agents. Our program features online learning, classroom training and field training/evaluation. The program varies somewhat for employed and contracted agents. On-line or classroom training includes the following subjects:

- Humana orientation (Employed agents)
- Humana history & background (Employed agents)
- Ethical sales practices and compliance [including the signing of the Sales & Marketing Code of Ethics, with a prohibition of door-to-door marketing, (*Exhibit #1*), HIPAA policies, etc.]
- Original Medicare (utilizing the CMS booklet: “Medicare & You”)
- Medicare Advantage products
- Medicare Part D
- Humana’s enrollment process (proper completion of forms)
- Humana sales system, sales materials, use of suitability and needs assessment
- MA & PDP presentations (these presentations have been updated to address issues identified through trends in beneficiary complaints and regulator and consumer advocate concerns—issues that cause

beneficiary confusion, e.g. an MA product is not a Medicare Supplement policy; ensuring that the beneficiary's provider accepts the MA product)

- Seminar selling and small group sales presentation role-playing for employed agents (delegated agents are generally prohibited from conducting these types of presentations—if a situation arises where one is needed, an employed agent must be present)

At the end of the session, all agents must successfully pass a certification test in order to be authorized to sell Humana's MA plans. Annually thereafter, agents must successfully pass a recertification test to demonstrate ongoing knowledge and competence related to the sale of MA plans. Employed or career agents follow their classroom training with field training to ensure that their sales presentation skills meet company compliance standards. After initial training, field career agents are evaluated every six months. Contracted agents are also evaluated in the field according to agent oversight procedures. Local sales managers provide ongoing training as needed on various topics based on local market issues, trends, new policies, procedures or regulatory requirements. Training may take the form of conference calls, face-to-face meetings, etc.

We note that Humana's sales practice standards prohibit such practices as door-to-door marketing, cold-calling, high-pressure sales tactics, failure to fully and fairly disclose plan rules and benefits to beneficiaries, inappropriate enrollment in a plan that does not meet beneficiary needs, falsified application forms, any form of gift or financial inducement, enrolling beneficiaries not competent to make an enrollment decision, any misrepresentation of plan benefits or rules or who they represent and any form of health screening to name a few. Violation of this or any other marketing practice standard constitutes grounds for termination. In 2006, Humana terminated approximately 98 agents and in 2007, terminated approximately 44 more agents for violations of sales practice code of conduct violations. While Humana sales management monitors these issues on an ongoing basis, if we are informed by any external source of such an incident, we investigate the issue and take action.

Humana improved the tools used by sales management to monitor agent sales practices. Policies for sales management agent oversight includes procedures related to agent oversight (including training/testing, licensing validation check/policy, cancellation & short term disenrollment monitoring, sales allegation investigation process, progressive discipline process and field evaluations); use of PFFS disclaimers and disclosures; process for communicating and updating agents and marketing materials an agent provides to a beneficiary. New monitoring reports focus on short and long-term disenrollment rates, cancellation rates, complaints and sales allegation investigations, and where warranted, field evaluations, etc. Local sales management is responsible for monitoring the actions of both employed and contracted agents. When trends or issues arise, sales management has a variety of disciplinary tools they can use—from coaching and counseling, regular monitoring of field presentations to termination and reporting to relevant state agencies. Further, Humana's long-held policy dictates that agents are not

paid commission for members who disenroll within the first 90 days of membership. This “chargeback” process continues to be a critical safeguard for ensuring proper selling techniques.

Over the past two years, Humana strengthened its oversight and monitoring programs to ensure regulatory and contractual compliance and strengthened contracted agency compliance requirements. We also reached out to state Departments of Insurance, Medicaid agencies, state health insurance assistance programs, beneficiary groups and Congressional offices in all 50 states to educate them on our plan offerings and to respond to specific constituent issues—some 150 visits and contacts in the fall of 2007. We offered each a special toll-free number, staffed by experienced customer care representatives, to resolve critical constituent issues as well as other contacts. A few of our monitoring enhancements this past year included:

- Established a special Medicare sales allegation/complaint investigation unit outside of Sales (in our Compliance Department) and re-engineered our sales allegation investigation process.
- Added a post-sale, outbound enrollment verification process for all PFFS enrollments and for all HMO and PPO enrollments when an inbound verification does not occur.
- Instituted secret shopping initiatives.

With regard to the identification and investigation of sales-related complaints, these complaints are now investigated by a special compliance unit outside of the sales area and follow a specific policy and procedure (*Exhibit #2*) related to prohibited marketing and sales activities. Determinations are reported to local sales management and based on the investigation determination, corrective action is taken. Corrective action ranges from coaching and counseling to additional agent training to agent termination, and where applicable, reporting to the relevant state Department of Insurance.

During 2007, we received and investigated approximately 1,595 MA sales allegations. That represented 0.59% of our total agent-assisted MA sales in 2007. Of those allegations, approximately 258 were “founded” and corrective action was taken (depending on the offense, disciplinary action included counseling, training and/or termination). During 2007, we terminated 44 agents and reported the relevant agents to state Departments of Insurance according to specific requirements in their reporting laws.

With regard to enrollment verification, since 1991, Humana has had an inbound enrollment verification system (outside of sales) for face-to-face enrollments. This verification system was established as a final check at enrollment to ensure that the beneficiary (or his/her authorized representative) understood he/she was enrolling in an MA plan and understood the basic rules of the plan. If we are unable to verify a sale at enrollment, we mail a letter to the beneficiary once the enrollment has been processed. This system has been enhanced on a regular basis to include lessons learned from

customer service calls, regulator and consumer advocate input and our experience over time with this process.

During the fall of 2007, we instituted an outbound enrollment verification process in compliance with CMS standards for PFFS enrollees. Outbound verification calls are made by live customer care representatives (outside of sales) to confirm the beneficiary's intent to enroll and understanding of plan rules. We make three attempts to reach the beneficiary. If we are unable to reach the beneficiary, we mail the beneficiary a letter. Less than 0.45% of outbound verification calls have resulted in plan cancellation. As a final safeguard against inappropriate sales, Humana's commission chargeback process applies. As stated, we take back any commissions for any sales where the member disenrolls or cancels within the first 90 days of enrollment.

Finally, with regard to secret shopping of sales presentations, Humana provides CMS on the 20th of the preceding month, a list of all MA seminars being conducted by agents. CMS' vendor then selects seminars to secret shop. While the feedback Humana has received from CMS on these seminars is not specific, we do coach and counsel agents as a result of any feedback we receive. We also use Humana compliance directors as secret shoppers in a similar way.

In line with our ongoing discussions with beneficiary advocates, by the end of the first quarter, we will launch a pilot secret shopper program with the National Council on Aging. These advocates will shop our seminars and call center presentations and provide critical feedback.

Regulatory Agency Oversight

The MA program is subject to regulation and oversight by CMS with state regulatory oversight for issues related to licensure and solvency. As required by law, Humana has undergone regular and special reviews by both federal and state regulators. When issues are identified that were not already identified by Humana and corrected, Humana has taken necessary corrective action. These actions have improved program operations.

Last summer, Humana was one of seven plans identified by CMS that voluntarily agreed to cease MA PFFS sales and improve sales and marketing efforts, including additional consumer and provider disclosures, outbound enrollment verification and other activities. In addition, we provide CMS with a biweekly report of sales complaints and continue to have biweekly calls that span a variety of issues including sales and marketing. CMS has increased their oversight of MA plans through secret shopping and other enrollment-related activities.

Two state Departments of Insurance, Oklahoma and Illinois, issued final examination reports related to agent licensure issues covering 2005-2006. Each state fined Humana \$500,000. CMS fined Humana \$75,000 for this issue as well. The licensure issues initially identified by Oklahoma were system-wide data system issues

and have been remedied across all states. We have undertaken a review of all applications submitted nationwide to Humana to remedy the issues raised. Specifically:

- **Oklahoma:** During the 2005-2006 examination period, the state reviewed approximately 950 agents. Humana was cited for 61 agents (6.4%) who accounted for 123 enrollments, representing less than 1% of the approximate 24,639 agent-assisted sales. One delegated agent accounted for 17 of the 123 enrollments and is no longer contracted with Humana. All agents were licensed in the state in which they sold the policy, but they did not hold an Oklahoma license, the state in which the member resided (border state issue). None of the members associated with these sales filed a complaint with Humana.
- **Illinois:** The State of Illinois, in its 2005-2006 examination period found 84 agents out of a total 2,237 agents sold Medicare products without the proper Illinois license, the majority of whom held a license in another state. The 84 agents accounted for 357 enrollments, representing less than 1% of the approximately 54,000 enrollments examined by the State. Of the 84 agents, one agent accounted for 50% or 179 of the 357 enrollments involved. That agent was a delegated agent and no longer sells Humana products. The State also identified an issue related to reporting terminated agents to the Department. No members were adversely affected by these licensure issues.

Humana developed permanent system enhancements to strengthen our agent license and certification monitoring processes, including the following actions:

- All electronic enrollment tools control agent access to Medicare applications based on their license and appointment status. If an agent is not licensed and appointed in the state of beneficiary residence, the agent cannot access an electronic application.
- When agents upload completed applications to the Humana system, the system checks the agent's license and appointment status and downloads only the applications for states and products for which the agent is eligible to sell.
- For agents using the agent portal on the Humana website, the secure logon process validates the agent when logging into the portal, allowing only contracted agents in and allowing access to only applications for which the system indicates they are eligible to sell.
- Delegated agents may also contact one of our Call Centers and have a telesales agent facilitate the completion of the application by phone. The telesales agent keys in the delegated agent's information to validate their licensure and appointment status.
- When Humana receives paper applications, they are processed and then screened electronically for licensure/appointment status on the back-end. All members affected by a non-compliant enrollment are re-contacted by a

licensed and certified Humana agent and provided a compliant sales presentation.

- Agents submitting non-compliant applications are contacted by local Humana sales management.
- Agents with non-compliant applications are not compensated for those applications.
- Humana also established a company-wide policy and process which includes an internal review board that is responsible for monitoring agent terminations and ensuring consistency in the termination and reporting process.

Industry Steps to Strengthen Beneficiary Protections

In May 2007, the AHIP Board of Directors adopted a set of industry principles for protecting beneficiaries as they consider enrolling in Medicare Advantage and Part D programs and ensuring that brokers, agents and plan marketing staff meet new qualifications and requirements. These initiatives build upon the extensive rules CMS already has established for marketing and enrollment activities by plan sponsors.

The AHIP Board statement includes safeguards and protections that AHIP members support in the following areas:

- Qualifications for Brokers, Agents, and Plan Marketing Staff: Clearly communicating, and consistently applying the qualifications that brokers and agents and plan marketing staff must meet to market Medicare Advantage and Part D plans. This means using multiple strategies including:
 - Performing background checks, including verification of required state licensure;
 - Checking applicable databases for documentation of prior serious misconduct;
 - Obtaining documentation substantiating that threshold test scores have been achieved on core competency training and ensuring that continuing education credits are available for licensed brokers, agents, and plan marketing staff. We have urged CMS to establish standards for training that require that specific topics must be addressed in detail including:
 - Medicare fee-for-service eligibility and benefits;
 - Medicare health plan and Part D plan types and structure, including the key differences between HMOs, PPOs, PFFS plans, SNPs, and Cost plans; and
 - Permissible, prohibited, and required marketing practices, including non-discrimination rules and the prohibitions against door-to-door marketing.

- Requiring brokers and agents and plan marketing staff to obtain threshold test scores on plan-specific training that provides detailed information about the plan types and benefits offered by the plan sponsor.
- **Annual Recertification and Targeted Retraining:** Establishing requirements for annual recertification for brokers and agents and plan marketing staff, such as achieving threshold scores on annual recertification tests and repeating core competency training, as needed. This also includes addressing topics requiring special attention that may arise throughout the year through strategies such as targeted retraining and provide updated information on an ongoing basis through a variety of mechanisms including e-mails, web sites, or other means.

Threshold scores for annual training serve the goal of ensuring that brokers and agents and plan marketing staff regularly demonstrate their knowledge or expertise so they can fully and clearly inform beneficiaries about the details of their coverage options. Moreover, the targeted retraining ensures that brokers and agents and plan marketing staff will promptly receive in-depth information on specific issues that arise during the year.

- **Enrollment Safeguards:** Including steps in a plan's marketing and enrollment processes to verify beneficiaries' intent to enroll and understanding of the plans they are electing. Strategies for verification include:
 - adding to the plan's enrollment application attestations by the beneficiary or his/her legal representative or guardian and the broker, agent, or plan marketing staff that address the beneficiary's understanding of the plan structure and benefits; and
 - conducting oversight such as post-enrollment outbound calls from the plan sponsor to the beneficiary or his/her legal representative for face-to-face enrollments or systematic monitoring of recorded telephonic enrollments.
- **Monitoring Compliance:** Establishing processes for tracking and analyzing individual broker and agent and plan marketing staff performance in such areas as beneficiary satisfaction, rapid disenrollments, and complaints. This ongoing process of evaluation allows plan sponsors to promptly identify conduct that merits urgent investigation, such as provision of incorrect, misleading, or inaccurate information; unauthorized contact or home visit; fraudulent enrollment submission; or intimidation.
- **Investigating and Responding to Complaints:** Establishing processes for rapidly investigating complaints and taking immediate and decisive action when complaints are verified, including re-qualification, suspension, or termination. AHIP has strongly urged CMS to work with the NAIC to develop a uniform process and criteria for plan sponsors to report serious misconduct by licensed brokers, agents, and plan marketing staff in a timely fashion to state agencies

overseeing broker and agent licensure. AHIP is pleased that CMS is establishing a reporting mechanism.

- **Compensation:** Compensation arrangements must comply with CMS Medicare Marketing Guidelines, including withholding or withdrawing payment for rapid disenrollments. AHIP has strongly supported compensation requirements in the CMS Medicare marketing guidelines which are designed to reward brokers and agents when beneficiaries are satisfied with their choices and penalize brokers and agents who use marketing tactics that result in beneficiaries signing up for a product that they do not fully understand – and then disenrolling a short time later after learning more about the plan.
- **Provider Outreach:** Making available to physicians, hospitals and other providers detailed information about plan structure, benefits, rules and payment terms of the plans they offer. Outreach activities should include strategies to educate providers prior to market entry and ongoing efforts to build and maintain relationships to serve plan members.

To build upon the industry-wide initiatives outlined in its Board statement, AHIP recently announced a new online training program for brokers, agents, and plan marketing staff that is designed to strengthen their ability to provide Medicare beneficiaries the information they need to make the decisions that are best for them. AHIP launched this education program in partnership with the Association of Health Insurance Advisors (AHIA) and the National Association of Health Underwriters (NAHU). The program is available through AHIP's Center for Insurance Education and Professional Development at www.MedicareOnlineTraining.com, and is designed to give brokers, agents, and plan marketing staff an understanding of:

- the basics of Medicare fee-for-service eligibility and benefits;
- the different types of Medicare Advantage and Part D prescription drug plans, eligibility, and coverage; and
- marketing and enrollment requirements under the Medicare Advantage and Part D programs, including requirements for PFFS plans.

The course is designed to provide rigorous training on the rules for the individual Medicare market so that brokers and agents will be able to achieve a certification that they can provide to all Medicare Advantage and Part D plan sponsors with which they contract. The training would complement each plan sponsor's plan-specific training for brokers, agents, and plan marketing staff. The training content has been updated to reflect the increasingly stringent requirements established by CMS, including requirements for PFFS plans.

Additionally, AHIP has been engaged in discussions with the National Association of Insurance Commissioners (NAIC) to explore ways to strengthen the Medicare Advantage and Part D marketing standards to help ensure that there are adequate consumer safeguards by adoption of additional federal requirements and increased CMS and State Insurance Department collaboration.

Recommendations/Conclusions

Allow me to reiterate the recommendations I discussed at the beginning of my testimony:

1. The Secretary of Health and Human Services (HHS) should establish a requirement that MA plans are required to adhere to state department of insurance agent appointment rules. Humana's policy from the outset has been to appoint its agents.
2. The Secretary of HHS should establish a requirement that limits the total commission compensation paid to agents to a fixed percentage of premium. This will ensure agents fully inform beneficiaries of the products and plan rules and will reduce the opportunity for high-pressure sales. Further, such requirements should provide for level commission payments year-over-year—for renewal sales as well as for replacement sales.
3. The Secretary of HHS should establish a requirement in conjunction with state regulators for a registry of agents (with civil immunity to companies reporting data) where companies can share and access information related to verified beneficiary allegations of sales practice violations and questionable sales tactics. This would prevent agents from moving from company to company, possibly avoiding enforcement actions.
4. CMS should continue to work with state regulators to enhance data exchange and enforcement actions especially in the areas that affect market conduct.
5. We support more stringent federal standards in areas relating to cold calling, cross-selling of non-health related products, consumer disclosures, agent training and certification, and other marketing practice-related areas, including co-branding, the standardization of certain benefit terms, clarity in plan type and more easily understood plan/benefit comparisons.

There has been much discussion about federal and state oversight of the MA program. Under the Medicare Modernization Act, CMS has jurisdiction over the MA program with the exception of issues related to licensure and solvency which fall within state jurisdiction. Over the last two years, CMS and most states have entered into a Memorandum of Understanding (MOU) to facilitate cooperation and data sharing (including data on enforcement actions) between CMS and state regulators regarding the conduct of MA plans and PDPs. Through our work in the NAIC Senior Issues Task

Force-Private Plans Work Group, we believe there are additional actions that CMS can take to improve sales practices and program integrity and to encourage greater involvement of states as mentioned in my recommendations.

Unlike Medigap products, the MA program is part of a federal entitlement program and is not a supplemental insurance product. And, unlike the Medigap market where beneficiaries pay the entire premium for an insurance product, in MA the federal government contracts with plans and pays the majority of MA costs. This public/private partnership under which MA plans contract with CMS to provide Medicare benefits and with Medicare beneficiaries to provide Medicare coverage is very different from the Medigap market where insurers only have a contract with beneficiaries.

There has been much discussion about the standardization of materials in the MA program. Today's MA materials have a high degree of standardization in language and in communication templates required by CMS. One of the most important member communications, the Summary of Benefits, contains standardized language. CMS is moving to standardize the Annual Notice of Change (ANOC) and the Evidence of Coverage. These practices promote increased beneficiary understanding of MA plan components. Further, along with our industry, Humana continues to work with beneficiary groups to improve and simplify the Summary of Benefits and other materials.

Although we support the current regulatory structure, state regulators have valuable insights on marketing to beneficiaries from their experience overseeing Medigap, long-term care and other senior insurance products. Increasing consultation and strengthening of collaboration through the CMS-NAIC MOU can improve sales and marketing oversight without creating regulatory conflicts and inefficiencies. CMS-NAIC interactions have already contributed to changes in marketing rules. We believe this ongoing dialogue can strengthen marketing rules and substantially improve enforcement while retaining CMS enforcement of sales and marketing rules that are essential to ensure every senior, no matter where they live, is uniformly protected.

Finally, looking forward, we believe it is important for policymakers to preserve the competition, choice, and innovation that have played such a crucial role in delivering savings and value to our nation's Medicare beneficiaries. Reforms that limit the ability of MA plans to respond to consumer preferences and changes in medical science would stifle market innovation and undermine the success we have achieved in delivering high quality, affordable coverage to Medicare beneficiaries.

Thank you.

Exhibit 1

PROPRIETARY INFORMATION – PROPERTY OF HUMANA MARKETPOINT

**Sales & Marketing Code OF Ethics****Medicare Advantage and Prescription Drug Plans**

As a leader in Medicare Advantage (MA) and Prescription Drug (PDP) plans, Humana is committed to providing appropriate guidance to its valued customers. Our company's continued success depends upon the integrity of all persons representing us.

Each sales agent will subscribe to the following Code of Ethics, applicable to the sale of Humana's MA and PDP plans. In addition, agents agree to comply with Humana's Principles of Business Ethics, all Centers for Medicare and Medicaid Services (CMS) and state Department of Insurance (DOI) regulations, as well as Humana MarketPOINT policies as an expression of personal commitment to honest and ethical sales and marketing practices.

Your signature below acknowledges that commitment and that any violation of this Code may subject you to termination and/or possible legal action as specified by CMS and/or State regulations.

READ & INITIAL EACH ITEM

- _____ 1. Agents will conduct themselves with professionalism and integrity and with respect for the rights and reasonable requests of prospective customers at all times.
- _____ 2. Agents will disclose their name, agency name, and the purpose of their visit. They will make no claim other than to explain the appropriate Humana MA and/or PDP plan, its benefits, limitations, the offering company and how to enroll/apply. Misrepresentation of the purpose of the visit or of any kind is strictly prohibited.
- _____ 3. Agents agree to use of the appropriate CMS approved Humana Sales Presentation in its entirety when presenting a Humana MA and/or PDP plan to ensure full disclosure of all plan benefits, limitations, and cost sharing. Agents commit to presenting all required CMS disclaimers during the sales presentation.
- _____ 4. Agents will base their presentation of the Humana MA and/or PDP plan on the merit of the respective plan and will not disparage competitors or their plans.
- _____ 5. Agents will make only approved claims as authorized by Humana and CMS and shall use no forms of pressure, scare tactics, coercion, deception, sympathy, appeal, or other unethical sales tactics in their presentation.
- _____ 6. Agents will always give clear, thorough and accurate information regarding Humana MA and PDP plans. They are prohibited from making false, misleading, half-true, or exaggerated statements.
- _____ 7. Agents are prohibited from conducting door-to-door solicitation for MA and/or PDP products, per CMS guidelines.
- _____ 8. Agents understand that only a competent enrollee or their appropriate legal designee, as stipulated by CMS, can sign an enrollment application: Agents will not sign the enrollee's name, with or without their permission, on the enrollment application or knowingly accept a signature other than the enrollee's on an application for any product, except in the case of an authorized POA. They will not knowingly accept a signed incomplete application. Agents are responsible to ensure that all information on an application is complete and accurate and will not alter, remove, replace or misrepresent any information obtained from the prospect.
- _____ 9. Agents will conduct a Suitability assessment with all clients to determine what Humana plan, if any, is appropriate for the client and will sell or replace a product only when it is clearly in the policyholder's best interest, without regard for the agent's compensation.

PROPRIETARY INFORMATION – PROPERTY OF HUMANA MARKETPOINT

- _____ 10. Only licensed agents who present the benefits of the plan and confirm their intent to enroll may sign the application as the selling agent of record.
- _____ 11. Agents are responsible for all applicable insurance licenses required to sell MA and PDP plans in all states in which they market. Agents must have a valid resident or non-resident license issued from the state where the Medicare beneficiary permanently resides in order to market or sell an MA and/or PDP plan
- _____ 12. Agents will use only Humana and CMS approved marketing materials. They will not modify or alter approved materials for their use in marketing/sales of MA and/or PDP plans.
- _____ 13. Agents may not send e-mails to Medicare beneficiaries unless the person has agreed to receive emails and they have provided his/her email address personally. Agents can not rent or acquire an email address through any type of directory.
- _____ 14. Agents may not offer or accept gifts from providers and/or territorial contacts; arrange to share or split their MA/PDP incentives; accept additional financial incentives; or otherwise allow themselves to be influenced or coerced in any way in the conduct of their business. Agents will not involve themselves in facilitating the execution of Healthcare Power-of-attorney documentation, disenrollment from another plan, medical referrals (as applicable) or any other activity that could be viewed as unethically influencing an enrollment.
- _____ 15. Agents may neither give nor offer a gift or payment of any kind to a prospective MA and/or PDP member as an inducement to enroll in a Humana plan. An offer of a rebate in any form is strictly prohibited. CMS permits the use of gifts of a nominal value, defined as having a value of \$15 retail or less and that can not be readily converted to cash.
- _____ 16. Agents will assure, to the best of their ability, that the prospective enrollee is of sound mind and capable of thoroughly understanding the plan. If, at any time, they doubt the enrollee's mental ability to comprehend, they will discontinue the enrollment until such time as they can meet with someone with appropriate legal authority to enroll the Medicare eligible prospect.
- _____ 17. Agents may indicate that the Humana MA/PDP plans meet criteria specified by government agencies. They will never imply that their visit is in any way connected with the government or approved by a particular government agency or official, or portray themselves as a representative of Medicare or any other government agency
- _____ 18. Agents understand that the Humana operates its Medicare programs and offers its MA and/or PDP plans and services to all enrollees and applicants for enrollment without regard race, color, religion or national origin in compliance with Title VI of the Civil Rights of 1964. In addition, all agents must observe the company's policy of non-discrimination on the basis of race, creed, color, sex, age, national origin and health status, except as provided by the Federal Register and/or CMS guidelines.
- _____ 19. In the event an allegation of misconduct is lodged against an agent, the Agent will provide a detailed written response to the complaint within 5 business days of notification of the complaint.

Acknowledgement

I, _____, have read this Code of Ethics and commit to abide by it. I understand that violation of any part of this code may subject me to termination and/or possible legal action as specified by CMS and/or State regulations.

Agent Name - PRINT

Agent Signature

Agency Name

Date

Delegated Agent

Exhibit 2

PROPRIETARY INFORMATION – PROPERTY OF HUMANA MARKETPOINT

**SALES & MARKETING CODE OF ETHICS****Medicare Advantage and Prescription Drug Plans**

As a leader in Medicare Advantage (MA) and Prescription Drug (PDP) plans, Humana is committed to providing appropriate guidance to its valued customers. Our company's continued success depends upon the integrity of all persons representing us.

Each sales agent will subscribe to the following Code of Ethics, applicable to the sale of Humana's MA and PDP plans. In addition, agents agree to comply with Humana's Principles of Business Ethics, all Centers for Medicare and Medicaid Services (CMS) and state Department of Insurance (DOI) regulations, as well as Humana MarketPOINT policies as an expression of personal commitment to honest and ethical sales and marketing practices.

Your signature below acknowledges that commitment and that any violation of this Code may subject you to termination and/or possible legal action as specified by CMS and/or State regulations.

READ & INITIAL EACH ITEM

- _____ 1. Agents will conduct themselves with professionalism and integrity and with respect for the rights and reasonable requests of prospective Humana customers at all times.
- _____ 2. Agents will disclose their name, company name, and the purpose of their visit. They will make no claim other than to explain the appropriate MA and/or PDP plan, its benefits, limitations, the offering company and how to enroll/apply. Misrepresentation of the purpose of the agent's visit is strictly prohibited.
- _____ 3. Agents agree to use the CMS approved Humana Sales Presentation in its entirety when presenting a Humana MA and/or PDP plan to ensure full disclosure of all plan benefits, limitations, and cost sharing to all prospective enrollees and will present all required CMS disclaimers during the sales presentation.
- _____ 4. Agents will base their presentations on the merit and quality of the respective plans and will not disparage competitors or their plans.
- _____ 5. Agents will make only approved claims as authorized by Humana and CMS and shall use no form of pressure, scare tactics, coercion, deception, sympathy, appeal, or other unethical sales tactics in their presentation.
- _____ 6. Agents will always give clear, thorough and accurate information regarding Humana MA and PDP plans. They are prohibited from making false, misleading, half-true, or exaggerated statements.
- _____ 7. Agents are prohibited from conducting door-to-door solicitation for MA and/or PDP products, per CMS guidelines.
- _____ 8. Agents will not sign the enrollee's name, with or without permission, on the enrollment application or knowingly accept a signature other than the enrollee's on an application for any product, except in the case of an authorized POA. They will not knowingly accept a signed incomplete application. Agents are responsible to ensure that all information on an application is complete, accurate, and will not alter, remove, replace or misrepresent any information obtained from the prospect.
- _____ 9. Agents will conduct a Suitability assessment with all clients to determine what Humana plan, if any, is appropriate for the client and will sell or replace a product only when it is clearly in the policyholder's best interest, without regard for the agent's compensation.

PROPRIETARY INFORMATION – PROPERTY OF HUMANA MARKETPOINT

- _____ 10. Only licensed agents who present the benefits of the plan and confirm their intent to enroll may sign the application as the selling agent of record.
- _____ 11. Agents are responsible for all applicable insurance licenses required to sell MA and PDP plans in all states in which they market. Agents must have a valid resident or non-resident license issued from the state where the Medicare beneficiary permanently resides in order to market or sell an MA and/or PDP plan.
- _____ 12. Agents will use only Humana and CMS approved marketing materials. They will not modify or alter approved materials for their use in marketing/sales of MA and/or PDP plans.
- _____ 13. Agents may not send e-mails to Medicare beneficiaries unless the person has agreed to receive emails and they have provided his/her email address personally. Agents can not rent or acquire an email address through any type of directory.
- _____ 14. Agents may not offer or accept gifts providers and/or territorial contacts; arrange to share or split their MA/PDP incentives; accept additional financial incentives; or otherwise allow themselves to be influenced or coerced in any way in the conduct of their business. Agents will not involve themselves in facilitating the execution of Healthcare Power-of-attorney documentation, disenrollment from another plan, medical referrals (as applicable) or any other activity that could be viewed as unethically influencing an enrollment.
- _____ 15. Agents may neither give nor offer a gift or payment of any kind to a prospective MA and/or PDP member as an inducement to enroll in a Humana plan. An offer of a rebate in any form is strictly prohibited. CMS permits the use of gifts of a nominal value, defined as having a value of \$15 retail or less and that can not be readily converted to cash.
- _____ 16. Agents will assure, to the best of their ability, that the prospective enrollee is of sound mind and capable of thoroughly understanding the plan. If, at any time, they doubt the enrollee's mental ability to comprehend, they will discontinue the enrollment until such time as they can meet with someone with appropriate legal authority to enroll the Medicare eligible prospect.
- _____ 17. Agents may indicate that the Humana MA/PDP plans meet criteria specified by government agencies. They will never imply that their visit is in any way connected with the government or approved by a particular government agency or official, or portray themselves as a representative of Medicare or any other government agency.
- _____ 18. Agents understand that the company operates its Medicare programs and offers its MA and/or PDP plans and services to all enrollees and applicants for enrollment without regard race, color, religion or national origin in compliance with Title VI of the Civil Rights Act of 1964. In addition, all agents must observe the company's policy of non-discrimination on the basis of race, creed, color, sex, age, national origin and health status, except as provided by the Federal Register and/or CMS guidelines.
- _____ 19. In the event an allegation of misconduct is lodged against an agent, the Agent will provide a detailed written response to the complaint within 5 business days of notification of the complaint.

Acknowledgement


I, _____, have read this Code of Ethics and commit to abide by it. I understand that violation of any part of this code or the Humana Principles of Business Ethics may subject me to termination and/or possible legal action as specified by CMS and/or State regulations.

Humana MarketPOINT Associate Signature


Sales Director Signature

Market

Date


 HUMANA.		Policy and Procedure Regulatory Compliance – Sales Allegation	
Original Issue Date: 11-15-2007		Policy Number: Process Overview	Page 1 of 5
Subject: Sales Allegation Investigations (Section A)			
Original Approved By: K. St. Germain		Original Approval Date: 5-15-2007	
Revision Approved By: K. St. Germain		Revision Approval Date: 1-15-2008	
Change Summary:			
<p>Policy Purpose:</p> <p>The Centers for Medicare and Medicaid Services (CMS), have defined certain practices that are prohibited in the sales and marketing of a Medicare Advantage and PDP plan. (Humana and state departments of insurance have also defined certain practices deemed unacceptable in the sales and marketing of a Medicare Advantage and PDP plan. This policy and procedure does not apply to the sale of Medicare Supplement Insurance Plans (Med Supp).</p>			
<p>Scope:</p> <p>Medicare Advantage (MAPD) and Prescription Drug Plans (PDP)</p>			
<p>Procedure:</p>			
<p>1. Definitions:</p>			
<ul style="list-style-type: none"> ▪ Section A Violation – Allegation of inappropriate or unethical activity on the part of a sales agent related to the sale or marketing of a Humana MA, MA-PD, and/or PDP plan. Section A violations can be willful or negligent violations of the rules and guidelines as presented by CMS, state departments of insurance regulations, Humana policies, CMS Marketing Guidelines, Agent and Delegated Agent training programs, Humana Policy and Procedures, including Code of Conduct and Ethics Training. Section A allegations will most often be a result of a beneficiary complaint, lodged with a Humana associate, CMS, SHIPs counselor or departments of insurance, or other agencies. <p>Examples of Section A violations include, but are not limited to the following:</p> <ol style="list-style-type: none"> 1. Dishonesty or theft, including but not limited to forgery. 2. Use of threats, coercion, intimidation, deception, scare tactics or any other forms of high pressure or unethical sales practice when dealing with a prospective customer or member. 3. Failure to conduct a comprehensive presentation and/or presenting only limited information of plan benefits, features, limitations or exclusions. 4. Failure to make mandated CMS disclosures during the sales presentation and/or at the time of enrollment. 5. The sale of a product to a person who is obviously unable to understand the product. 6. Omission or falsification of significant information on any company form or application for enrollment or coverage. 7. Providing legal advice regarding the appropriate legal authority to enroll in an MA plan. 8. Failure to properly disclose and explain all applicable limiting provisions (i.e., required use of network providers and limitations on changing plans). 9. Failure to properly present the MA, MA-PD, and/or PDP plan. 10. Use, without intent to misrepresent, of unapproved marketing material. <ul style="list-style-type: none"> ▪ Section A Findings <ol style="list-style-type: none"> 1. Founded – evidence clearly supports allegation as true. 2. Unfounded – evidence does not support the allegation as true. 3. Inconclusive – evidence does not support either founded or unfounded 			

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 HUMANA.		Policy and Procedure: Regulatory Compliance – Sales Allegation	
Original Issue Date: 10-15-2006		Policy Number: 2006 - 1	Page 2 of 5
Subject: Sales Allegations		Revision Approval Date: 1-15-2008	

2. Process:	
Humana Operations Department	A. Encounters a situation that allegedly involves inappropriate action on the part of a career or delegated sales agent. <ol style="list-style-type: none"> 1. Completes the "Section A Investigation Request" form. 2. Forwards the completed form along with any supporting documentation to the Section A Unit Correspondence_mail box (SectionA@humana.com).
Sales Allegation Unit	B. Receives the allegation and logs the Section A request on the Sales Compliance Data Base. <ol style="list-style-type: none"> 1. Determines if the request meets the definition of a Section A, is a duplicate allegation submission, or if the investigation should proceed. <ol style="list-style-type: none"> a. Dismissals. <ol style="list-style-type: none"> 1. Dismiss case and update database. 2. Return allegation to initiator with an explanation. b. Proceed with investigation. 2. Creates file in Q Drive and updates tracking sheet. 3. Pulls application and determines channel. <ol style="list-style-type: none"> a. Determine whether an agent was involved in the sale. If an agent was not involved: <ol style="list-style-type: none"> 1. Dismiss case and update database. 2. Return document to initiator with explanation. b. Pull written complaint or recording of call to determine exact nature of the allegation
Compliance Analyst	C. Make direct contact with the beneficiary to make a personal assessment and to obtain the allegation and any additional details as appropriate. There are to be 3 attempts made in a period of 5 days. <p>D. Request verification recording(s) or letter.</p> <p>E. Obtain member history (CI, CCP, ICS, etc.)</p> <p>F. Determine agent status via Solar and log agent allegation in Solar.</p> <ol style="list-style-type: none"> 1. Request agent statement as long as the agent is still active. 2. Proceed with the investigation if the agent is no longer employed or contracted with Humana. 3. The agent statement is due within 5 business days. 4. Request a copy of the telephonic signature if applicable. <p>G. Review allegation and supporting documentation. Supporting documentation may include, but is not limited to, the following:</p> <ol style="list-style-type: none"> 1. Enrollment application

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 HUMANA.	Policy and Procedure: Regulatory Compliance – Sales Allegation	
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Subject: Sales Allegations		Revision Approval Date 1-15-2008

2. Written disenrollment request
3. Digital recording of the enrollment verification
4. Verification control number
5. Copies of premium payment checks
6. Applicable enrollment system screen printouts
7. Member correspondence
8. Statement from other involved parties
9. Power-of-attorney (POA) or Legal Guardianship (LG) documentation, if applicable
10. Sales agent statement (request clarification from the agent if necessary)
11. Witness Translator Form, if applicable
12. Review Sales Agent Compliance Data Base for any previous Section A activities pertinent to current investigation
13. ANOC/ANOR mailing dates, if applicable

H. If, at any time during the investigation process, the Compliance Analyst determines that the allegation does not meet the definition of a Section A violation, the initiator should be notified of the decision in writing. The Section A investigation form should not be completed and the case will be dismissed (refer to Section B).

I. Complete the "Medicare Sales Allegation of Misconduct Investigation and Determination" form with details of investigation, a determination, and all supporting documentation related to the case.


1. Based on the evidence gathered, makes a determination as defined:
 - a. **Founded** – evidence clearly supports allegation.
 - b. **Unfounded** – evidence does not support the allegation.
 - c. **Inconclusive** – evidence does not support either founded or unfounded

J. Completed form and supporting documents should be sent applicable Risk Advisor for corrective action, as necessary.

K. Distribute copies of investigation and any recommendations to the following:


1. Sales Director/Manager of Sales Administration. (MSA) for the market in which the agent sells
2. Risk Advisor in Sales Administration
3. Risk Manager (for state involved)
4. Secure folder on the Q drive
5. Send a written response to the initiator indicating whether the complaint was founded, unfounded, or inconclusive. (If the resolution of the case is required by a third party, such as CMS or departments of insurance. No other information should be included.)
6. Close the case and update the case file on the Sales Allegation Data Base with the final determination.


References:
Section A CMS Response Form.



SECTION A CMS RESPONSE FORM.doc

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 HUMANA.	Policy and Procedure: Regulatory Compliance – Sales Allegation	
Original Issue Date: 10-15-2006	Policy Number: 2006 - 1	Page 4 of 5
Subject: Sales Allegations		Revision Approval Date 1-15-2008
<p>Refer to all documents covered under this procedure. Suggested format: Document number, title</p>		
<small>UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use</small>		

 HUMANA.	Policy and Procedure: Regulatory Compliance – Sales Allegation	
Original Issue Date: 10-15-2006	Policy Number: 2006 - 1	Page 5 of 5
Subject: Sales Allegations		Revision Approval Date: 1-15-2008
<p>Insert workflow or process map, if applicable.</p>		
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**Testimony of
Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Before the
Senate Finance Committee
On
“Selling to Seniors: The Need for Accountability and
Oversight of Marketing by Medicare Private Plans, Part 2”
February 13, 2008**

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) oversight of marketing practices under the Medicare Advantage (MA) program. As you know, last year CMS testified a number of times on MA marketing and oversight before various committees, and clearly this Committee was very active on these issues as well. My focus today will therefore be on relatively recent activities and the Agency's plan for further improvements to marketing oversight in the year ahead.

At the outset, I want to indicate my unequivocal commitment to protecting people with Medicare from potential marketing abuses and to ensuring that beneficiaries have the information they need to make informed choices about their health care. Since September 2007, when I began my tenure as Acting Administrator, I have made it a top priority for CMS to be more proactive and transparent than ever before in overseeing the MA program, and we have made significant strides in strengthening program oversight.

Greater transparency allows beneficiaries, you in the Congress, and all interested parties to have a clearer awareness of our ongoing oversight activities, the nature of any plan violations, and the actions we take to remedy them. In November 2007, for example, we implemented a star-rating system for MA plans that expanded on the existing rating system for prescription drug plans. This Web-based tool provided the public with a powerful new way to comparison shop MA plans during the 2007 open enrollment period. In the past week, we refined our approach to posting Corrective Action Plans (CAPs) on the CMS Web site, making the information on CAPs more accessible and understandable for beneficiaries and others.¹ CMS has posted summary

¹ <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/CAP/>.

enforcement action information to the Web as well, such as information on intermediate sanctions and civil monetary penalties (CMPs) levied against plans.² We believe that all of these efforts toward increased transparency are shaping MA plan behavior in the ways that we had hoped. For example, in a recent meeting with a sanctioned MA plan, the plan's senior officials cited the public posting of CMPs as a significant concern due to its impact on how existing and potential enrollees, view the plan. In other words, plans are taking CMS oversight very seriously.

We have strengthened our oversight and enforcement tools through a variety of measures aimed at holding MA plans -- and, because of the relative "newness" and rapid growth of this option, private-fee-for-service (PFFS) plans in particular -- responsible for their marketing practices and the conduct of their agents and brokers. In December 2007 we published a Final Rule clarifying and modifying compliance requirements for MA and prescription drug plans.³ For example, under the new Final Rule, we are streamlining the process of imposing intermediate sanctions and civil monetary penalties (CMPs), by eliminating the informal reconsideration process that had significantly delayed CMS action and our ability to make compliance actions public in the past, among other actions. We also have made clear in the Final Rule that appealing plans bear the burden of proof when challenging an adverse contract determination.

Beyond the compliance regulation, CMS is in the process of considering additional administrative actions in a variety of areas related to the marketing of MA plans including: (1) further steps to limit the ability of plans to pressure beneficiaries into certain products (in addition to the special enrollment period for beneficiaries who have been pressured or deceived into enrolling in a plan); (2) improvements to information sharing with States regarding brokers and agents; and (3) requirements tailored to the marketing of special needs plans (SNPs) and better coordination of such plans with State Medicaid agencies. We have also stepped up our routine communication with our Office of Inspector General and the Department of Justice to ensure coordination on matters that ultimately may require law enforcement oversight or investigation.

² http://www.cms.hhs.gov/MCRAAdvPArDENrolData/Downloads/Enforcement_Actions_Web.pdf.

³ CMS-4124-FC, 72 Fed. Reg. 68700, Dec. 5, 2007.

CMS currently oversees the MA program through a variety of measures such as marketing reviews, audits, and other compliance activities funded with the Program Management (PM) accounts of the CMS budget and with Medicare Integrity Program (MIP) funds. Our 2009 Budget requests \$3.3 billion for our traditional PM accounts, and \$ 198 million for the discretionary Health Care Fraud and Abuse Control (HCFAC) account. The President's FY 2009 Budget request seeks \$198 million in added discretionary funding for the HCFAC account, to include approximately \$19 million for both the HHS Inspector General and Department of Justice, respectively, in part for expanding MA as well as Medicare prescription drug plan oversight and enforcement activities. We respectfully request the committee's support for this additional oversight and enforcement funding in FY 2009. I intend to continue using all of the enforcement tools at my disposal, along with continued transparency, to protect beneficiaries from harmful marketing practices and other program violations to the best of our ability for the remainder of my tenure as Acting Administrator.

Background

Currently, MA enrollment is at an all-time high, with one-in-five Medicare beneficiaries enrolled in a MA plan. MA plans are available in every State across the country and, in large part due to improvements enacted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), MA plans are now serving a significant number of beneficiaries in rural areas. In 2008, MA plans are offering an average of approximately \$1100 in additional annual value to enrollees in terms of cost savings and added benefits. Some examples of extra benefits available through MA plans are coordination of care, special needs services, predictability in out-of-pocket costs, reduced cost-sharing for Medicare covered services, as well as vision and dental benefits.

One significant reason why MA plans are more widely available is that regional preferred provider organizations (RPOs) and PFFS plans have located in areas that were not previously served by any private plan. PFFS plans are a particularly important option in rural areas. In 2008, over 600,000 beneficiaries from rural areas are enrolled PFFS plans.

Due to its relative newness, specific features of the PFFS product were unfamiliar to many beneficiaries and providers last year, and therefore, as more beneficiaries enrolled, CMS became aware of increasing beneficiary and provider confusion about the product. We also became aware of some marketing practices that were, at best, less than complete and accurate, and in some cases, deliberately deceptive.

CMS responded in the 2008 Call Letter for MA plans, outlining several new requirements relating to the marketing of PFFS products. For example, we stated that door-to-door solicitation by agents and brokers would not be permitted. We also required that employees, brokers and independent agents first secure a beneficiary's permission (1) before providing assistance in the beneficiary's residence; (2) prior to conducting any sales presentations; and (3) before accepting an enrollment form in-person. When we released the Call Letter, we indicated that we would provide additional sub-regulatory guidance delineating all of our specific requirements for the PFFS product, and we did so on May 25, 2007. We developed the May guidance after a thorough review of information from various oversight sources including our Complaints Tracking Module (CTM) and a "secret shopping" program that relied on unannounced, anonymous auditor visits to scheduled MA marketing events to assess compliance. As a result of this heightened scrutiny, CMS identified several organizations with which we had issues and concerns ranging from relatively minor to significantly concerning.

On June 15, 2007, CMS announced that seven MA plans voluntarily agreed to suspend all marketing activities for their PFFS plans effective June 22, 2007. CMS initiated a rigorous review of each of the seven MA sponsoring organizations to determine whether they had appropriate written procedures in place to prevent marketing abuses, as well as protocols for identifying and handling abuses if they occurred.

We based our review on seven key elements: marketing material compliance; sales agent training and licensure; provider outreach and education; enrollment verification; reporting of

sales events; coordination with States; and review of outstanding Corrective Action Plans (CAPs) (if applicable).⁴ CMS required all submissions to be documented in writing.

Once CMS completed the written material reviews, we conducted on-site audits using teams of experts in all areas of compliance. Auditors reviewed sample files and met with line and management staff to verify that the appropriate management and systems controls were in place. CMS developed readiness checklists to ensure that each plan was evaluated fairly and consistently.

After auditors thoroughly reviewed each plan's internal controls and processes and were satisfied that the plans complied with appropriate marketing practices and established rules, CMS lifted the suspensions.⁵ I personally reviewed each audit, and in several instances required a plan to provide further proof of compliance before lifting their suspension. We also warned each plan that it would continue to be subject to careful scrutiny from CMS.

Strategies for Further Improvement to Sales and Marketing Oversight

Because the MA program has brought quality health care, meaningful choice, and in some cases, lower-cost sharing to millions of people with Medicare, it has been very popular. Regardless of its popularity, protecting people with Medicare from deceptive or harmful practices is among our highest priorities at CMS. We responded to sales and marketing issues among PFFS plans in 2007 by quickly strengthening and expanding our oversight. We are now moving to implement some of these requirements for all MA plans through the 2009 Call Letter,⁶ and will consider further improvements through future guidance.

PFFS Oversight

In September 2007, CMS implemented a stringent, unprecedented PFFS market surveillance plan to strengthen oversight of PFFS organizations across-the-board. The current results of

⁴ At the time of the voluntary suspensions, 4 organizations had outstanding CAPs in place with CMS. Blue Cross Blue Shield of Tennessee, Coventry Health Care Inc., and Universal American Financial Corp. did not.

⁵ The voluntary suspensions were lifted as follows: Universal American Financial Corp. on 8/7/07; Coventry Health Care Inc. and Wellcare Health Plans Inc. on 8/16/07; Blue Cross Blue Shield of Tennessee, Humana Inc., Sterling Life Insurance Co., and United Health Group on 9/24/07.

⁶ See <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>.

several of those activities are described below. CMS expects to provide all PFFS plans with feedback on the overall results of this current round of monitoring activities in April.

All MA organizations offering PFFS plans are now required to conduct outbound education and verification calls to ensure beneficiaries requesting enrollment understand the plan rules. These verification calls are made to the beneficiary after the sale has occurred. To evaluate plan compliance, CMS targeted a sample of recent PFFS enrollees to evaluate their marketing and enrollment experiences and their understanding of what their plan offered.

In the Fall 2007, calls were made exclusively to beneficiaries who enrolled in one of the seven PFFS plans that voluntarily suspended enrollment earlier in the year. As many as 95 percent of beneficiaries contacted remember receiving letters and/or phone calls from their plans after enrolling, explaining how their PFFS plans operate. This finding confirms that plans are meeting the new call-back requirement established in 2007 for such calls. Beginning this month, calls will be made to a sample of beneficiaries who enrolled in any PFFS plan.

The new PFFS surveillance plan also incorporates strategies to quality-check PFFS plan call centers and the enrollment materials they distribute to beneficiaries. We assessed the ability of call centers and agents to respond to two simple questions about the PFFS product with complete and accurate information. We also reviewed enrollment packets for required disclaimers. Our findings led to warning letters where appropriate. Further action will be taken as necessary. The draft 2009 Call Letter also specifies new strategies to address underlying issues.

A third important element of the new PFFS surveillance plan involved advance review of PFFS organizations' agent training and testing materials. Agents themselves must understand the plans they are marketing and provide beneficiaries with accurate information. To achieve this, agents require comprehensive training.

CMS requires MA sponsoring organization to train agents and brokers on Medicare rules, regulations and compliance-related information on products they intend to sell.

The success of this training is verified by a required minimum score of 80 percent on a written test. These requirements apply to both employed and contracted agents and brokers.

CMS is in the process of obtaining baseline information on training practices from all PFFS plans to identify trends, determine best practices, and articulate areas for improvement. The draft 2009 Call Letter also addresses trends identified in our preliminary findings. We will distribute best practices for all MA sponsoring organization when we complete our final analysis of PFFS plan training programs. CMS will also use this opportunity to issue warning letters to plans that need to improve their agent/broker training and testing practices to conform to industry standards.

Review of Marketing Materials

Our review of plans' 2008 marketing materials uncovered too many cases where information was inaccurate or incomplete. We are very concerned by this lack of quality control, and have included some proposed remedies in the draft 2009 Call Letter. For example, we have proposed a quality control checklist to ensure that plans have included all necessary information and have undertaken a thorough quality control review prior to submission of materials to CMS for review. This quality control checklist would cover both content and format. By requiring plans to attest to the accuracy and completeness of their marketing submissions based on the checklist, we will improve plan accountability and our enforcement options in this area.

Standardization of Information in Plan Materials.

In the draft Call Letter, we propose that in calendar year (CY) 2009, we will require plans to use a template for the *Annual Notice of Change* and *Evidence of Coverage* (ANOC/EOC) that includes standard as well as plan specific language. This approach is consistent with way the Federal Employees Health Benefits (FEHB) Program standardized enrollee informational materials several years ago. In addition, because standardization will help expedite the CMS review process, MA sponsoring organizations will be able to send a combined ANOC/EOC to beneficiaries earlier so they have comprehensive plan information prior to the annual election period. We believe that using templates with standard language where appropriate will reduce

the number of errors in these documents and will enable beneficiaries to make comparisons across consistent materials.

“Secret Shopping”

CMS launched a secret shopping initiative for verifying plan compliance with marketing guidelines in early 2007, working through private contractors. The Spring 2007 initiative shopped a total of 42 marketing events in 12 states. It proved so informative in identifying problem areas that we expanded the initiative significantly in Fall 2007. We required plans to supply CMS with a list of all scheduled marketing events for the 2007 open enrollment period. Contracted auditors and roughly thirty senior CMS officials, including myself, shopped 240 marketing events across thirty-nine jurisdictions and sponsored by thirty different plans. Although attending PFFS events was CMS’ first priority, we also shopped at RPPO, health maintenance organization (HMO), SNP and prescription drug plan events. We found fifty-nine events with no deficiencies.

Auditors identified 696 violations that occurred during the marketing events. These violations were categorized as either high risk or not. Examples of high risk violations include:

- Failure to clearly communicate provider participation or network restrictions;
- Failure to include the required disclaimers in marketing materials; or
- Misrepresentation of a plan in any way (*e.g.*, regarding premiums, deductibles, co-pays, provider network).

CMS took swift action to address high risk issues and help prevent further deficiencies. For example, one PFFS plan was placed on an enrollment and marketing freeze for the duration of open enrollment. Two other plans were placed on CAPs. Warning notices were issued to any PFFS plan with at least one violation of the CMS marketing guidelines.

Our contractor’s analysis of data from the Spring and Fall 2007 secret shopping initiatives reveals that CMS interventions against deficient behavior were successful. The average number of violations per event fell from Spring 2007 to the end of December 2007. Our secret shopping efforts also have helped generate stronger attention to compliance on the part of a number of MA sponsoring organizations. We are aware that many organizations now incorporate secret shopping strategies in their own compliance plans.

Continued Collaboration with States

Though CMS has worked hard to develop a solid federal regulatory framework for MA plans, and we continue to work closely with states, strengthened relationships and information sharing with state regulators are critical to ensuring that private plan sponsors and their agents and brokers act within the rules that govern this program.

One of the most important developments in this partnership in the past year has been the co-signature of Compliance and Enforcement Memoranda of Understanding (MOU) between CMS and states. To date, forty-seven jurisdictions have signed the MOU, and we have seen positive results from the information sharing that the MOU has made possible. For example, under the MOU, CMS assisted the State of Kentucky in addressing concerns about a PFFS plan that had access to care issues. CMS also is able to share name-specific agent/broker complaints immediately with state Departments of Insurance.

State Insurance Commissioners have told us we need to exchange information more effectively to improve oversight of agent and broker conduct. We are in the process of collecting information from plans about the brokers and agents who market their products and we will make that information available to all states that are parties to the MOU. CMS also participates regularly in an ongoing workgroup of the National Association of Insurance Commissioners (NAIC) focused on improving the oversight of MA plans and their marketing brokers and agents. We also are considering future administrative action to improve information sharing with state regarding agent and broker appointments.

Conclusion

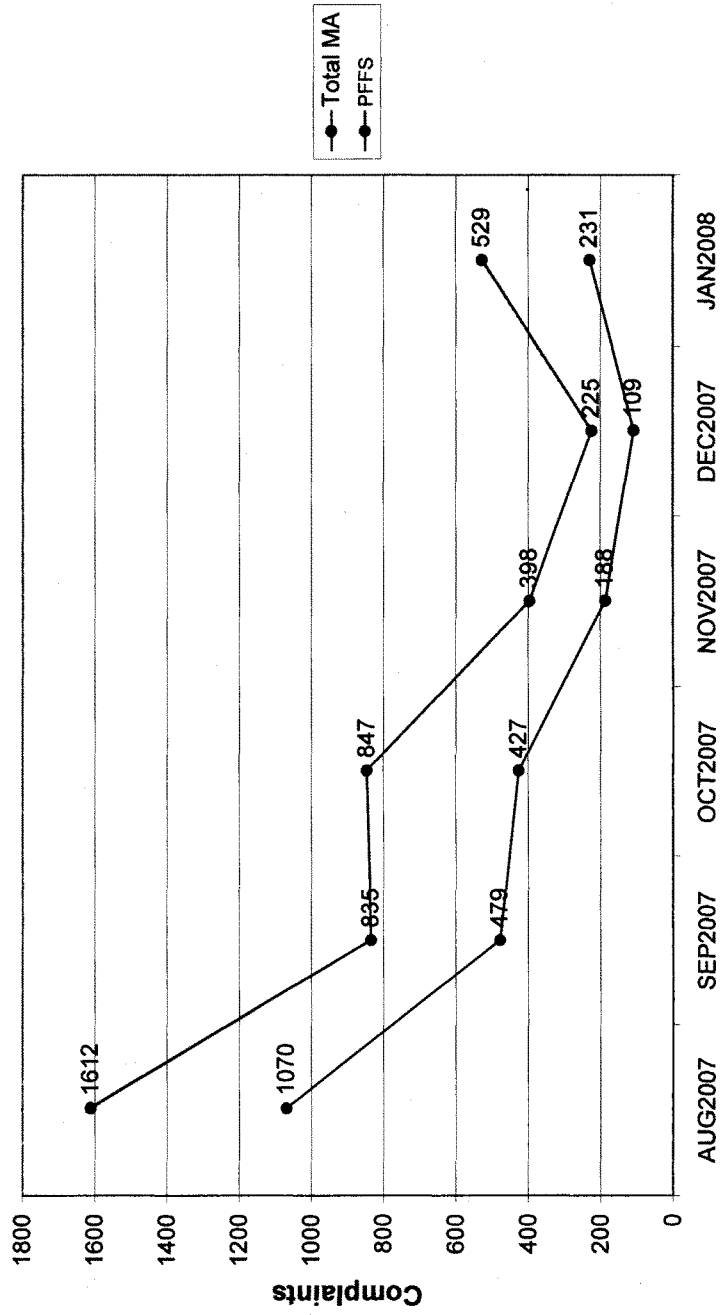
CMS is committed to taking the necessary steps to ensure that people with Medicare are not misled or harmed by MA plans or their agents. CMS has made significant progress in overseeing the marketing practices of MA sponsoring organizations through more proactive and transparent oversight strategies bolstered by stronger enforcement tools. We know our work is not over and we must remain vigilant and proactive. Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.

Recent CMS Oversight Initiatives

Initiative	August '07	September '07	October '07	November '07	December '07	January '08	February '08
Improved CAP postings						08 Draft Call Letter	
Continued PFFS monitoring & 37 warning letters (call centers)							
National PFFS conference							
Compliance Regulation							
SNP Quality Measures Released for Comment							
MA Plan star rating launched							
CAPs posted to Web							
Secret Shopping > 200 events; 71 warning letters; 2 Corrective Action Plans (CAPs)							
Civil Monetary Penalties vs. 2 MAOs							
Enforcement actions posted to Web							
Broker/Agent added to CTM							
New PFFS surveillance plan							
CMS places 100 enrollment verification calls to PFFS enrollees							
CMS audits 7 PFFS plans under voluntary marketing suspension							

Key
 Transparency
 Oversight
 Enforcement

Medicare Advantage Marketing Complaints August 2007 - January 2008



COMMUNICATIONS



MGMA Center for Research
American College of Medical Practice Executives
Medical Group Management Association

February 20, 2008

Chairman Baucus
Committee On Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Feb 13, 2008 Medicare Advantage Accountability and Oversight

Dear Senator Baucus:

As the Senate Finance Committee continues to examine the operations of the Medicare Advantage program and its impact on Medicare beneficiaries and participating providers, the Medical Group Management Association (MGMA) wishes to suggest a series of important adjustments to the current law governing this program. Based on consistent feedback from our members nationwide, we believe that the following changes are imperative in order to allow medical groups to continue to provide quality care to Medicare Advantage beneficiaries.

MGMA, founded in 1926, is the nation's principal voice for medical group practice. MGMA's more than 21,500 members manage and lead 13,500 organizations, in which more than 270,000 physicians practice. MGMA's core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them.

Standardization of Medicare Advantage patient identification cards

Variations in the Medicare Advantage program subject medical practices to excessive administrative confusion that both impairs efficient patient care and adds to the cost of treating Medicare beneficiaries. In recent research, MGMA members expressed concern regarding the inability to identify Medicare Advantage patients. Over 56 percent of respondents said they could not accurately identify Medicare Advantage patients, with 90 percent of respondents indicating that patient insurance cards provided ineffective insurance coverage identification. MGMA members overwhelmingly believe (91 percent) that a majority of Medicare Advantage patients do not understand their coverage. Members also strongly believe (89 percent) that Medicare Advantage enrollees do not understand that they are no longer traditional Medicare patients. This contributes to widespread patient confusion, leading to the research findings that over 90 percent of MGMA practice respondents had some of their Medicare Advantage patients switch out of a Medicare Advantage plan and back to traditional Medicare over the last year.

Standardized patient identification cards for Medicare Advantage enrollees would allow medical providers to more easily identify the specific type of beneficiary health coverage (e.g., traditional Medicare; Medicare Advantage health maintenance organizations; Medicare Advantage private fee-for-service plans; etc.). Identification card standardization already exists for traditional Medicare patients, and should be extended to Medicare Advantage. By standardizing Medicare Advantage patient identification cards, providers can correctly deliver the appropriate medical services entitled to their patients, and patients can better understand their Medicare Advantage plan and the additional benefits that plan may offer. **Therefore, MGMA recommends that all**

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Medicare Advantage products be mandated to adhere to a governmental standard for patient identification cards. The card should bear a CMS-approved Medicare Advantage logo, the Medicare Rx logo (if Part D coverage applies) and clearly state the Medicare Advantage plan sponsor, type of Medicare Advantage product, coinsurance amounts (if any) and claim submission address and phone number. Additionally, the card should prominently state “Providers: Do not bill Medicare. Submit claims directly to [name of plan].” MGMA encourages Congress use the Workgroup for Electronic Data Interchange endorsed American National Standard (INCITS 284:1997) for all Medicare patient identification cards.

Elimination of the Medicare Advantage “Deeming Provision”

MGMA members also report widespread confusion caused by Medicare Advantage private fee-for-service plans. These plans are not required to have a provider network but may “deem” providers to be in-network by virtue of treating the plan’s patient to be in-network. In effect, the section requires that non-participating providers seeing a Medicare Advantage private fee-for-service patient are treated as though they have a contract with the sponsoring plan. No other insurance product enables plans to create networks without contracts with providers. Medicare Advantage plans should be held to the same contracting standards as the rest of the industry. The deeming provision section of the Medicare regulation is found at 42 CFR 422.216(f).

While the Medicare regulations stipulate that a provider is only deemed if they knew or were “given a reasonable opportunity to obtain information” that they are treating a Medicare Advantage private fee-for-service patient, plans do not pro-actively ask providers whether they knew that the patient was indeed enrolled in a private fee-for-service plan. The regulations state that a provider is deemed if the provider knew or should have known that the individual was enrolled in the plan and understood the terms and conditions of payment. The regulations state that this information must be provided in a manner that is designed to “effect informed agreement,” such as a patient identification card. Sixty-five percent of respondents to our research noted that they have been deemed in-network by one or more Medicare Advantage plans. This requirement underscores the importance of the standardized Medicare Advantage patient identification card. **MGMA recommends that the deeming provision be eliminated in its entirety.**

Fair contracting for Medicare Advantage providers

Many private insurance companies include provisions in their provider contracts that require providers to accept all of the plan-sponsored products. Thus, a medical practice may be forced to participate in a Medicare Advantage plan by virtue of an unrelated contract signed previously by the practice. “All products” clauses in provider-private payer contracts result in a practice being classified as a network participant with a Medicare Advantage sponsor without the practice’s affirmative acceptance of a Medicare Advantage plan. The elimination of the “all products” clauses in Medicare Advantage plans would increase transparency of the Medicare Advantage program and improve patient and provider relations. Many fair contracting practices have already been agreed to by several Medicare Advantage plan sponsors in the Multi-District Litigation settlements and mandated by several states. All products clauses typically require a provider to submit to the same terms that would have applied had he or she originally signed a separate contract to provide services for a specific insurance plan. According to MGMA members that participated in our Medicare Advantage research, 41 percent of respondents were considered part of Medicare Advantage networks through the “all products” clauses. Thus, “all products” clauses are a significant component of Medicare Advantage provider network creation. Several named payers in the Multi-District Litigation settlements are restricted from requiring physicians to participate in products without affirmative agreement for each product. Notably, Aetna, CIGNA, Anthem/Wellpoint and HealthNet are required to specifically exclude “all products” clauses from their contracts. Several states have passed similar prohibitions including Alaska, District of Columbia, Colorado, Kentucky, Maryland, Minnesota, Nevada and Virginia. Therefore, MGMA recommends that Congress mandate fair contracting practices. **Specifically, MGMA recommends that Congress prohibit the establishment of Medicare Advantage networks through private contract all products clauses and require affirmative acceptance of plan sponsor and products for Medicare Advantage networks.**

Medicare Advantage prompt payment of providers

Plans participating in Medicare Advantage should be compliant with CMS' payment policies regarding contracts and timely payments made to providers. Medicare regulations already require prompt payment for non-network providers seeing Medicare Advantage private fee-for-service patients, but these logical provisions are not extended to network providers. The Medicare statute requires Part B contractors to issue payment for 95 percent of all clean claims within 30 days after the date on which the claim is received.

MGMA recommends that Congress apply the Medicare Part B timely processing requirement, found at 42 USC 1395u(c), for all claims submitted by providers to Medicare Advantage plans as part of the plan's contracting requirements to the Medicare program.

We applaud the committee's recent examination of Medicare Advantage programs and believe our recommendations will further strengthen the Medicare Advantage program. Once enacted, these recommendations will greatly enhance the ability of medical providers to offer quality services to beneficiaries enrolled in the Medicare Advantage program. If you should have any questions, please contact Robert Bennett in the Government Affairs Department at 202.293.3450 ext 1378.

Sincerely,



William F. Jesse, MD, FACMPE
President and CEO

**NCPSSM National Committee to Preserve
Social Security and Medicare**

*Barbara B. Kennelly
President & CEO*

**Testimony for the Record
Barbara B. Kennelly, President and CEO
National Committee to Preserve Social Security and Medicare**

**United States Senate
Committee on Finance**

**Hearing on “Selling to Seniors: The Need for Accountability
and Oversight of Marketing and Sales by Medicare Private Plans”**

February 7, 2008

Mr. Chairman and Members of the Committee:

I am Barbara Kennelly, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare, and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization devoted to preserving and promoting the financial security and health of maturing Americans.

Mr. Chairman, earlier this week the President released his Fiscal Year 2009 Budget which proposes severe cuts to Medicare, totaling \$178 billion over the next five years, \$556 billion over the next 10 years, and more than \$10 trillion over the next 75 years. These massive cuts are funded by increasing beneficiary cost-sharing and slashing reimbursement rates to providers who serve beneficiaries in traditional Medicare. We are concerned that cuts of this magnitude will undermine the strength of traditional Medicare and negatively impact the health outcomes of beneficiaries by limiting their access to care.

While the President’s budget places traditional Medicare on the chopping block, it continues to fund substantial subsidies to private Medicare Advantage plans. These private health plans were first allowed to participate in Medicare because policymakers believed they could provide better services at a lower cost than traditional Medicare. In fact, because it was anticipated private plans would be so efficient, the government initially paid them five percent less for each beneficiary they enrolled than it would have cost to cover that same beneficiary in traditional Medicare.

Medicare now pays private plans significantly *more* than it would cost to cover the same beneficiaries through traditional fee-for-service Medicare. Today the government pays an average of 13 percent more to cover a beneficiary enrolled in a private Medicare Advantage plan than it would cost to cover *that same beneficiary* under traditional Medicare. In simple dollar terms, Medicare pays about \$1,000 more a year to cover a beneficiary in a private plan than it would cost to provide care to that same beneficiary under traditional Medicare.

All beneficiaries, whether they enroll in a private plan or not, subsidize payments to private companies by paying higher Part B premiums. Today, these premiums are almost \$50 per year higher per couple than they would be absent the subsidies to private plans. This number will continue to grow exponentially in future years. These increases are in addition to the record-setting increases in Part B premiums beneficiaries have already experienced – and which are expected to continue – as a result of overall increases in the cost of health care.

In addition to adding costs for individual beneficiaries, subsidies to Medicare Advantage plans result in higher costs to the federal government. Medicare's actuaries estimate that eliminating these subsidies would add two years of solvency to Medicare's hospital insurance trust fund. According to the Congressional Budget Office (CBO), paying private plans at the same rate as traditional Medicare would save \$54 billion over the next five years and \$149 billion over the next ten years.

For all of these reasons, I support the Medicare Payment Advisory Commission's (MedPAC) recommendation that payment policy should be built on a foundation of financial neutrality between payments in the traditional fee-for-service program and payments to private plans. We should be using taxpayer dollars to promote quality in Medicare, instead of bestowing unwarranted subsidies on inefficient private plans that serve a fraction of Medicare beneficiaries.

Today's hearing focuses on the marketing abuses that exist in the Medicare Advantage program. Medicare Advantage subsidies are driving unscrupulous agents and private plans to use aggressive sales tactics and misrepresentations to sell their products to beneficiaries. A recent survey of state insurance departments found that 39 of 43 states have received complaints about misrepresentations and inappropriate marketing practices of Medicare Advantage plans. In most cases, these practices led to Medicare beneficiaries enrolling in a private plan without adequate understanding of the plan or their ability to stay in traditional Medicare. The inflated payments to private plans allow them to offer exceedingly large commissions to agents who enroll beneficiaries into Medicare Advantage plans, regardless of whether the plan meets their needs. To receive their commissions, some insurance agents have engaged in fraudulent activities including: forging signatures on enrollment documents; mass enrollments and door-to-door sales at senior centers, nursing homes, or assisted living facilities; and enrolling beneficiaries with dementia into inappropriate plans.

Mr. Chairman, one of our National Committee members has witnessed countless examples of marketing abuse in the Medicare Advantage program. Marion Seymour is a senior citizen living in Syracuse, New York. Ms. Seymour is a licensed insurance agent who has sold life and health insurance policies for nearly fifty years. On a personal level, Ms. Seymour receives numerous telephone calls on a weekly basis from insurance agents selling Medicare Advantage plans. Oftentimes, the insurance agents will identify themselves as “working for Medicare” or “contracting with Medicare due to government backlogs”. According to Ms. Seymour, some of the agents are very reluctant to identify the name of the insurance company providing the policy. Many of the agents she spoke with could not answer basic questions about the benefit package of the Medicare Advantage plan. She has found some of these agents will promote coverage for prescription glasses or gym memberships, but cannot answer questions about coverage for chemotherapy. In addition to the telephone calls, Ms. Seymour also receives weekly direct mailings containing invitations to informational get-togethers. She attended a get-together at one of the area’s finest restaurants where the Medicare Advantage plan paid for dinner for every attendee.

Since Ms. Seymour is a licensed insurance agent, she continually gets offers from many different companies to sell Medicare Advantage plans. Ms. Seymour does not accept these offers because she believes the plans provide inferior benefits and she is opposed to the subsidized payments they receive. Based on her calculations, Ms. Seymour believes she could make at least three times her current commission selling Medicare Advantage products instead of the supplemental policies she sells to Medicare beneficiaries. She has been offered commissions ranging from \$250 to \$600 up front per sale of a Medicare Advantage plan.

As a supplemental insurance agent, Ms. Seymour encounters many seniors who enrolled in a Medicare Advantage plan under the belief that they were enrolling in a supplemental policy to traditional Medicare. In some instances, the beneficiaries called the insurance company to be placed in a supplemental policy only later to find out they were enrolled in a Medicare Advantage plan. In other instances, the agents misrepresented the Medicare Advantage plan as a supplement to traditional Medicare. Ms. Seymour is aware of adult children enrolling their parents in a Medicare Advantage plan because the agent misrepresented the plan as a supplement to traditional Medicare. Some of Ms. Seymour’s most heart-breaking examples of marketing abuse have occurred when Medicare Advantage agents went to senior housing facilities and adult day care facilities to enroll vulnerable beneficiaries who did not understand the ramifications of their actions.

Unfortunately, the kind of fraudulent marketing practices that Ms. Seymour is witnessing in New York are occurring throughout our country. I do not believe that Congress will be able to eliminate marketing abuse in the Medicare Advantage program until it removes the excessive subsidies these plans receive. As long as private plans are overpaid, they will be tempted to use that money to offer agents exceedingly large commissions and to engage in unethical and illegal sales tactics. However, until private plans operate on a level playing field with traditional Medicare, I encourage Congress to increase the

oversight and regulation of these plans. I support Sen. Kohl's legislation—the *Accountability and Transparency in Medicare Marketing Act of 2007* (S. 1883)—which would request the National Association of Insurance Commissioners to develop standardized marketing requirements for Medicare Advantage organizations and prescription drug plans.

Mr. Chairman, thank you for holding this hearing today. As you know, the vast majority of Medicare beneficiaries remain in the traditional program. In a time of budgetary challenges, we cannot continue to reward private plans with taxpayer and beneficiary-funded subsidies. I look forward to working with you and other members of this committee to restrain unwarranted spending in the Medicare Advantage program and to ensure that traditional Medicare is preserved for generations to come.

MARION E. SEYMOUR
Life & Health Insurance
Experience Integrity

**United States Senate
Committee on Finance**

**Hearing on "Selling to Seniors: The Need for Accountability
and Oversight of Marketing and Sales by Medicare Private Plans"**

February 7, 2008

Mr. Chairman and Members of the Committee:

I am Marion E. Seymour, residing at the address below for nearly 34 years. Since 1982 my chief source of income has been from sales of all lines of life and health insurance. During the past ten years providing seniors with Medicare supplements (Medigap) protection has become somewhat of a specialty as I have seen the tremendous and growing need for honest and qualified representation in the senior health insurance market.

As a result of this exposure I have become painfully aware that many high-pressure sales people are taking almost criminal advantage of uninformed and unsuspecting seniors at a time in their lives when they are most vulnerable to financial ripoffs.

For many years America's seniors had very good coverage with Medicare Parts A and B. Add to that a Medicare supplement from a reliable insurance company and our older population could come through catastrophic illnesses (cancer, heart surgeries, etc.) without disastrous financial consequences.

Then came the Medicare Advantage plans. After assisting many of the victims of misleading advertising and marketing to regain their original Medicare coverage I have been forced to the following conclusions regarding what was probably a well-meant program when it started.

First, the amazingly high commissions being offered are motivation for the high pressure and often dishonest sales practices used by greedy sales people. I have seen offers of commissions of anywhere from \$250. to over \$600. Indeed, this week I received a solicitation to sell a Cigna plan from an agency with which I have been associated for several years. They were offering a commission of \$665. up front per application. Ten sales a week would give an annual income to an unscrupulous agent of around \$300,000 per year.

Second, the marketing methods employed can result in seniors making a poor decision. There is an unbelievable television advertising campaign in the Syracuse area. These are not just 10- to 30-second spots but really high-pressure sales not mentioning any of the negatives and often adding the comment that, "Most doctors participate". Many doctors and hospitals do not participate and the co-pays can be punishing, even disastrous, for middle-income retirees. Pharmaceutical manufacturers in advertisements state side effects and often recommend to "talk to your doctor" about this product. Why not force insurance companies to do the same?

Seniors are subjected to the expensive television ads; very expensive full-page ads in our daily papers; direct mailings done in color on expensive, glossy paper and invitations to "informational breakfasts and other meals in good local restaurants where the inquirer is told to order whatever they like - the sales people pick up the bill. The interminable telemarketers and these Medicare Advantage marketing methods become an assault to which many seniors finally fall victim because they are worn down. My sister and I share our home and we frequently receive these telemarketing calls, sometimes four or five in a week from the same company. I learned very quickly that either these callers know nothing about their product or they deliberately misrepresent themselves and their plans. As I write this, I have just received a phone call from a young lady who called herself Taisha. She said there would be a "Medicare specialist" in our area and wanted to know if I would be home at 10:00 tomorrow morning. When I asked what company she represented she hung up. (Please go to Page 7 for conclusion to this call.)

In support of the above statements, one agent who called told me that he wanted to enroll me in a plan which was "JUST EXACTLY LIKE WHAT I HAD WITH MEDICARE A and B AND IT WOULD COST ME NOTHING". Several others have wanted to come to our home and explain "THE NEW BENEFITS WHICH MEDICARE HAS ADDED". Some carefully give the impression that they are indeed calling from Medicare itself. One telemarketer (from Well-care) said that Medicare had contracted with them to handle the Medicare benefits because the program had gotten so large that Medicare can no longer handle it alone. These methods either are rankly dishonest or are so questionable that they should be forbidden to be employed..

Third, the obscene commission structures and the large subsidies to insurance companies drive marketing abuses in the sales of Medicare Advantage plans.

It is my understanding that these so-called Medicare Advantage plans are funded by the \$96.40 per month deducted from a senior's Social Security payment for Medicare Part B being turned over to the insurance company selling the plan PLUS an amount equal to the average cost per senior per month Medicare is now paying direct to medical providers. This amounts to approximately \$700. month whether there are claims or not. Thus the MA plan company receives nearly \$800. per month per person. In addition these companies may charge a monthly premium of anywhere from \$40. to \$80. per month.

While a senior on original Medicare A and B would, of course, incur the \$96.40 deduction from Social Security plus whatever premium a good Medicare supplement would cost, he or she would be able to intelligently budget monthly expenses for his/her choice of health care. With an MA plan there can be co-pays which can be catastrophic. With a good Medicare supplement, there would be no co-pays. The peace of mind this affords makes the small difference in cost well worth while. Medigap insurers are receiving a small fraction of the high income the MA plans produce but they are spreading their resources only over the seniors who are having claims that month.

MA plan agents stress the premiums seniors are paying for Medicare supplements and simply mention these co-pays very lightly. They say nothing about the staggering costs a senior may incur if they suddenly find they are facing chemo treatments and the oncologist can not participate with an MA plan because he cannot cover his own costs with the co-pay MA plans allow. I have been told of at least 57 Hematology/Oncology practices that have been forced to go out of business this past year because of the heavy losses they have incurred by reason of Medicare cut-backs and MA plans. I have read recently in two or three publications that MA plans cost Medicare approximately \$1,113 more than original Medicare A and B. Also that there at least 9,000,000 seniors on these plans. This seems to translate to in excess of \$9,000,000,000 annual loss to Medicare. How can we afford this?

I recently met with our Congressman and his assistant who handles complaints regarding these MA plans. The assistant told me that he is handling an average of six disenrollments per week. These are being processed on behalf of seniors who have been ignored by the insurance companies when they have demanded disenrollment during re-enrollment period from Nov. 15 to Dec. 31. This fact should certainly dramatically reveal the dishonest practices not only of the sales people but of the companies themselves.

Following are a few examples of people I am or have been helping to disenroll and return to original Medicare A and B. Our Congressman's assistant's statement as well as the people mentioned below reveals there is much disillusion and widespread dissatisfaction being perpetrated by unscrupulous sales people who care nothing for the well-being of one of our nation's greatest treasures - our seniors.

Case A - This is an 87-year-old lady who is incapable of understanding her needs or how to intelligently meet them. She had never shared her personal business with her adult children until after she broke her hip and her daughters acquired power-of attorney, one over her checking account and the other to help her with all business decisions. Shortly before her broken hip, she had been sold an MA plan PLUS a \$10,000 life insurance policy (this at age 84) by an agent from American Progressive Ins. Co. - the MA plan entitled Today's Options. On Nov. 16th, 2007 American Progressive was notified by mail to their home office that she demanded to disenroll as of Dec. 31st and to be notified by mail that this had been done. Her daughter also hand-carried a

copy of said letter to the writing agent. As of Feb. 7th this had been ignored by American Progressive although hours have been spent on phone with Medicare benefit specialists who had assured us the insured was reinstated to original Medicare. To our knowledge, American Progressive is still ignoring our demands; Medicare cannot be billed by providers; and our senior is still incurring very expensive co-pays. On Jan. 24th American Progressive telephoned demanding to know why a complaint was filed. Also, the daughters discovered when they saw the cancelled checks that their mother had not signed the checks. The agent and written the checks and SIGNED HER NAME himself instead of allowing her to sign them. The life insurance premium exceeded \$800. per year. This is clear abuse.

Case B - This case represents another complaint with American Progressive. This lady was led to believe she was purchasing a Medicare supplement when it was in reality an MA plan. The premium was approximately \$39. per month. Since she was in the enrollment period between Jan. 1st and March 31st, 2007 she exercised her option to disenroll and return to Medicare A and B and a good Medigap policy. However, even though she died Dec. 4, 2007 American Progressive is still trying to collect her premium for the full year of 2007.

Case C - This case is about a senior widow and her problems with American Progressive. When the American Progressive came for her appointment her adult son and daughter were also present. She asked the direct question, "Is this a Medicare supplement?" The agent stated that it was. She did not discover the difference until she started getting bills for co-pays which she could not afford and spoke with me after I gave an address to the seniors in my church. That happened March 1, 2007. After an immediate letter demanding disenrollment during the legal period and many, many phone calls, American Progressive finally disenrolled her August 24, 2007.

Case D - This is another heart-rending case again from American Progressive. A very special couple, dearly loved parents, grandparents and members of their church discovered what had been perpetrated on them when the wife had terminal cancer. The grief-stricken husband said to me, "Miss Seymour, the doctor's office says these treatments are going to cost us \$5,000., and Miss Seymour, 'I DON'T HAVE \$5,000'". In order to expedite this critical need to be met we turned to our local Congressman's office and his assistant produced much faster help than we could have through normal channels.

Case E - A widow who had just gone through knee replacement and is also continuing expensive hematology care. The agent who had originally sold her her Medicare supplement came back telling her he could save her a great deal of money by transferring her to a Healthnet MA plan. Without asking her, he checked that the \$59. per month premium should be deducted from her Social Security check. When I pointed this out to her, she said she would NEVER have allowed such a thing. Also, her co-pays for her hematology treatments would run her about \$100. per month since her doctor does not participate with MA plans. I was on a telephone extension with

her when Medicare was called on Jan. 17th, 2008 to advise them that she wanted to return to her previous coverage. Medicare's representative advised us that she would have to wait until Jan. 1st, 2009 for this to happen. When I read the statement about the enrollment period from Jan. 1st to March 31st during which a person could make one change within MA plans OR return to original Medicare we were told that the Medicare representative would have to research this. The salesman had been told that since this senior's Medigap had been paid to Feb 1st she did not want the MA plan to become effective until Feb. 1st. But the MA plan did become effective Jan. 1st, 2007. Thus this lady lost the use of her January Medigap premium which was a value of over \$200., plus the \$100. co-pay to hematology and co-pays for other doctors' calls in January. These costs would have been assumed by the Medigap policy had she been left on original Medicare until Feb. 1st.

Cases F and G - These unrelated seniors both were eligible for Medicare as of Feb. 1st, 2008. They had been on COBRA through Jan. 31st. Each had called the Excellus Blue Cross/Blue Shield office saying that they wanted now to be covered by a Medicare supplement. However, in each case they were provided (by mail) with a Medicare Advantage plan without the knowledge or informed consent of the applicant. One found out when they went to their hematologist and discovered they were responsible for expensive co-pays. The other when a friend called her and told her to check and be sure that she had received a Medicare supplement.

Cases H and I - In one of these cases a former employer had as of Jan. 1st, 2008 simply moved their retirees to MA plans with no prior notification or choice. In one case this retiree was forced to discontinue aquatic therapy necessary to treat severe arthritis and keep mobility. She simply could not afford the co-pays for 3-time-per-week treatment which Medicare and a supplement would have covered in full. In the second case, as of April 2007 again without notification or opportunity for choice, the dependent widow of a deceased retiree was moved to an MA plan. She soon incurred breast cancer and her co-pays for chemo have exceeded \$2,000. The insurance company suggested if her oncologist would not participate, she should find another doctor who would. Her immediate reaction, "I DON'T WANT ANOTHER DOCTOR! I TRUST THE DOCTOR WHO IS CARING FOR ME!"

There are many others, but the above cases should give a good insight as to what all the MA plan salespeople are perpetrating on our seniors without regard to their welfare or peace of mind.

Also, I read recently of an MA agent in New York State's southern tier who had been going door-to-door high-pressuring seniors. It is my understanding that this is illegal. Sales interviews for MA plans, by law, can only be a result of an appointment made by telephone so that adult children can be present. The report stated that the NYS Insurance Department had cancelled the offender's license which they well should have.

The financial damage wreaked on unsuspecting seniors and on quality medical practices by these

dishonest agents as well as the additional losses to medical practices caused by cutbacks from Medicare itself is disastrous. Consider the skilled professionals, (doctors, nurses, technicians, and others) being forced out of business and jobs aforementioned and the emotional and medical stress forced on patients who have had to be moved to other practices; this entails unemployment, financial hardship and adjustments which should not be perpetrated on older people at a time when they are facing difficult medical treatment and in some cases terminal illness.

Ideally, entirely removing Medicare Advantage plans from our midst would be most beneficial. However, it is clear these plans are here to stay as they erroneously appear to "control costs and save money" for CMS. Appearances are misleading and these onerous and problematic plans are actually costing the federal government and the patients considerably more money than intended. They are also causing our seniors great emotional distress.

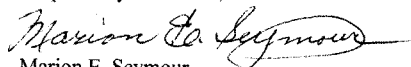
Please stop the illegal and dishonest methods used by private insurance companies to sell these plans, and assist patients in making "informed decisions" regarding standard Medicare vs. Medicare Advantage. It is very clear that patients who suffer from chronic, acute and /or terminal illnesses will have financial losses to great to sustain with Medicare Advantage plans.

Lastly, having the federal government actually pay an obscene dollar amount per head, per month, to remove patients from standard Medicare is more expensive for the federal government with no return on such an investment, and a fiscal disaster for patients.

Please allow me this opportunity to thank you sincerely for your interest in this matter and to urge you as, perhaps, our court of final appeal to take all steps necessary to correct this terrible injustice which is being perpetrated on our American seniors - many of whom have given lifetimes of service to our communities and our country. Indeed some of these treasured folk have given husbands, sons and daughters to defend our freedoms. We need IMMEDIATE ACTION to rectify as much as possible these wrongs.

Thank you, Mr. Chairman, and each of your Committee for allowing me to participate with this statement.

Respectfully submitted,



Marion E. Seymour
Licensed New York State Life and Health Insurance Agent

Following is an addendum to Page 2 at the end of Paragraph 2:

I had here referred to a phone call just received from a young lady who called herself Taisha. It is now the day after receipt of this call. Taisha had hung up without answering my question as to what company she represented. She had asked me if I would be at home at 10:00 A.M. today. I had replied, "Probably not". Supposedly that was the end of this incident.

At about 1:15 P.M. today our doorbell rang. On our porch stood a very attractive, well-dressed young woman and young man. Their very nice-looking car was in our driveway. The young lady opened the conversation stating they were "Medicare Specialists" and were here for our 2:00 P.M. appointment. I stated there was no such appointment, told them that Taisha had hung up when I asked what company she represented, and then asked them why they were here. They both continued to insist they were Medicare specialists and were working in the neighborhood to help seniors better understand Medicare, the NEW benefits which had been added and explain our many options.

They at no time mentioned Medicare Advantage plans until I finally demanded to know what company they were selling for. They then reluctantly admitted they were with Wellcare but insisted that Wellcare was working in conjunction with Medicare to help educate seniors who might be "overwhelmed" in trying to read the government-supplied Medicare 2008 book.

When I told them about Taisha the young man put his hand to his head, assumed a very dramatic expression and said this had ruined his whole afternoon; that he had five appointments today for which he had allowed two hours each to "help" people know what they needed. He showed me the 2008 Medicare publication and asked if I had read it and really understood it. I refused them access to our home and they finally left. Only when I really pinned them down did they admit that they are really Medicare ADVANTAGE specialists.

They certainly deliberately were trying to lead me to believe that they were from Medicare itself which is clearly misrepresentation. I can think of many elderly, both women and men, who would have been taken in by this and without knowing what was happening would have given up their Medicare for an MA plan. Is this not a striking example of elder abuse?