Testimony of
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Before the
Senate Finance Committee
On
"Selling to Seniors: The Need for Accountability and Oversight of Marketing by Medicare Private Plans, Part 2"
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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/MCRAdvPartDEnrolData/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/MCRAdvPArtDEnrolData/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 (RPPOs) 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 voluntary 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 jurisdications 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.

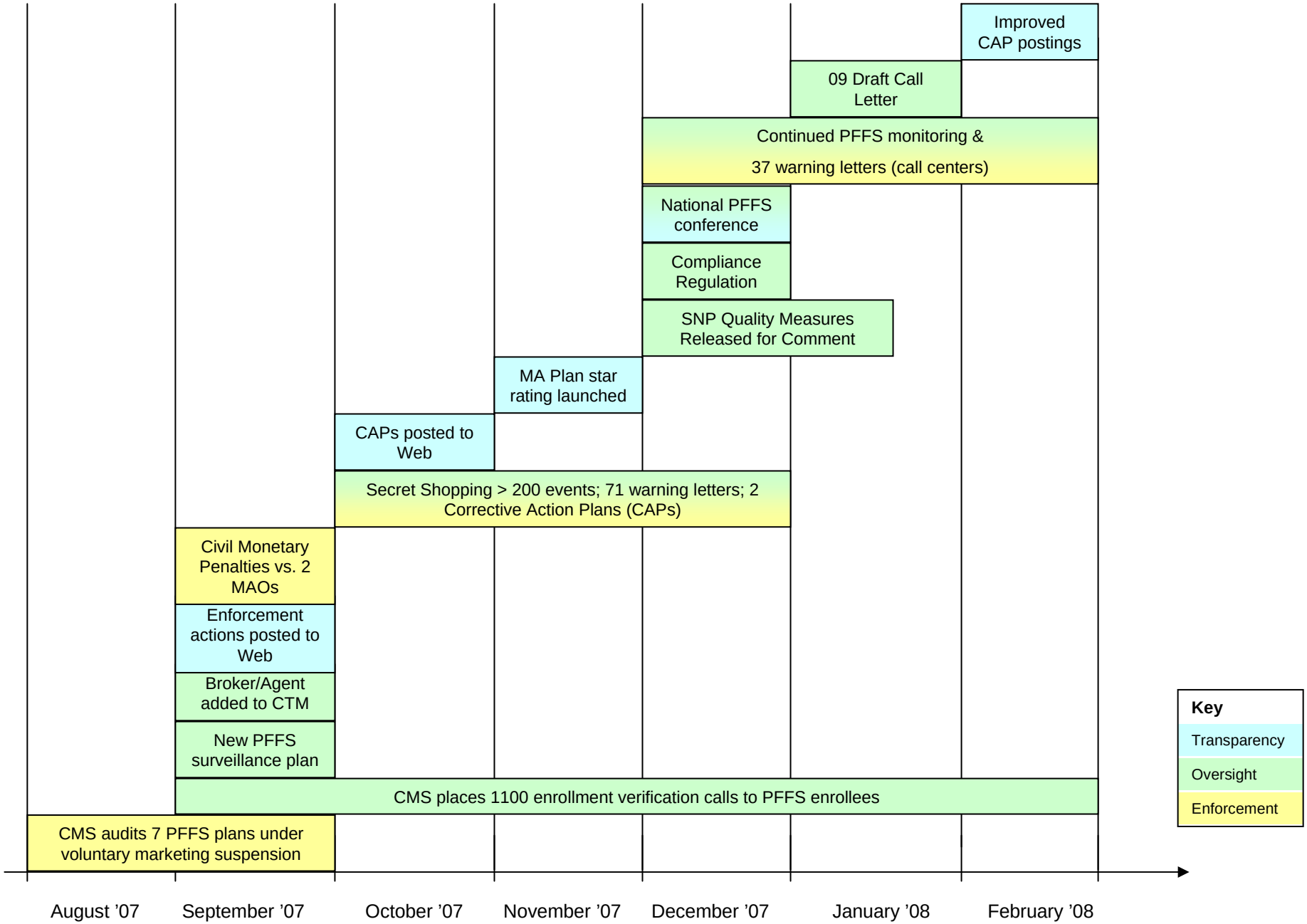
One of the most important developments in this partnership in the past year has been the co-signature of Compliance and Enforcement Memoranda of Understanding (MOU) between CMS and states. To date, forty-seven jurisdictions have signed the MOU, and we have seen positive results from the information sharing 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



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