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ON

MEDICARE ADVANTAGE IN MISSOURI

BEFORE THE

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Senate Special Committee on Aging
On
Medicare Advantage in Missouri
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Good morning, Senator McCaskill. I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) oversight of sales and marketing by Medicare health plans – specifically, Medicare Advantage (MA) organizations.

Building on lessons learned and information gathered during 2006 and 2007, CMS has continued to strengthen its oversight of MA organizations this year. Examples of our recent compliance and oversight improvements include: posting summaries of corrective actions taken against MA organizations on the CMS web site; establishing five-star ratings for plan performance; embarking on an extensive secret shopping program of plan marketing events that has led to compliance actions and more accurate sales presentations; requiring private-fee-for-service plans to call new enrollees to verify their desire to join the plan; and most recently, proposing an extensive set of new regulations related to marketing and beneficiary protections.

Fundamentally, before a plan sponsor is allowed to even participate in the MA program, it must submit an application and secure CMS approval. CMS performs a comprehensive review of each application to determine whether the sponsor meets program

requirements. Participation one year is no guarantee that the plan will be permitted to participate in future years. Every year, plans also must submit formulary and benefit information for CMS review prior to being accepted for the following contract year. For each plan sponsor, CMS establishes a single point of contact (Account Manager) for all communications with the plan. Account Managers work with plans to quickly resolve any problems, including compliance issues.

CMS also collects and analyzes performance data submitted by plans, internal systems, and beneficiaries on an ongoing basis. We have established baseline measures for the performance data and have been tracking results over time. Plans not meeting the baseline measures are contacted by CMS and compliance actions are typically initiated. Actions range from warning letters all the way through civil monetary penalties and removal from the program, depending on the extent to which plans have violated program requirements. All violations are taken very seriously by CMS, with beneficiary protection the foremost concern.

Oversight efforts are not limited to CMS's efforts alone. CMS has strengthened relationships with State regulators that oversee the market conduct of health insurers, including MA organizations. Specifically, CMS worked cooperatively with the National Association of Insurance Commissioners (NAIC) and State Departments of Insurance to develop a model Compliance and Enforcement Memorandum of Understanding (MOU). This MOU enables CMS and State Departments of Insurance to freely share compliance and enforcement information, to better oversee the operations and market conduct of

companies we jointly regulate and to facilitate the sharing of specific information about marketing agent conduct. Missouri was very involved with the drafting of the MOU and signed it on April 16, 2007.

As noted, CMS recently issued a proposed regulation – Revisions to the Medicare Advantage and Prescription Drug Benefit Programs – as a continuation of efforts to enhance compliance and oversight of the MA program over the past months. The proposed rule would incorporate into regulation a number of requirements that CMS previously applied through operational guidance. It also would introduce several new MA plan requirements. The new proposed prohibitions on door-to-door marketing and cold-calling as well as new proposed requirements pertaining to broker/agent commissions are even more stringent than what the insurance industry recently endorsed as necessary regulatory improvements to the program.

The proposed rule would make a number of changes to requirements for Special Needs Plans (SNPs), a type of MA plan that provides coordinated care to individuals in certain institutions such as nursing homes, and those who are eligible for both the Medicare and Medicaid programs and/or have certain severe or disabling chronic conditions. These plans are required to adhere to the same marketing guidelines and other general MA program requirements. Among other things, the proposed rule would add the following additional requirements: plans would be required to have documented arrangements with States to facilitate coordination of Medicare and Medicaid benefits; plans would be required to verify beneficiaries' SNP eligibility prior to enrollment; plans would be

required to include in contracts with providers language specifying that the beneficiary is not liable for costs that are the responsibility of the State under Medicaid; and, finally, plans would be required to have models of care specifying delivery of care standards specific to the types of special needs individuals enrolled in the plan.

Similarly, to discourage "churning" of beneficiaries from plan-to-plan each year in a manner that earns agents and brokers the highest commissions, the proposed regulation would establish commission structures for sales agents and brokers that are level across all years and across all MA plan product types (for example, HMOs, PPOs, and private fee-for-service plans). These requirements are designed to ensure that beneficiaries are receiving the information and counseling necessary to select the best plan based on their needs.

In addition to the proposed regulation, CMS is using several mechanisms to ensure that MA organizations conduct marketing activities that are compliant with existing regulations and marketing guidelines. We have been very clear that organizations are responsible for the actions of sales agents and brokers whether they are employed or contracted. They must ensure that agents/brokers are properly trained in both Medicare requirements and the details of the products being offered. Employees of an organization or independent agents or brokers acting on behalf of an organization may not solicit Medicare beneficiaries door-to-door for health-related or non-health-related services or benefits. Employees, brokers and independent agents must first ask for a beneficiary's permission before providing assistance in the beneficiary's residence, prior to conducting any sales presentations or accepting an enrollment form in person.

CMS continues to make significant progress in overseeing MA organizations. With ongoing effort and vigilance, I am confident we will see continued high levels of plan compliance with program requirements, along with significant improvements where necessary on this critical front. Thank you again for the opportunity to speak with you today. I now would be happy to answer any questions you may have.