



After the Goldrush: The Marketing of Medicare Advantage and Part D Plans

Regulatory Oversight of Insurance Companies and Agents Inadequate to Protect People with Medicare

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Introduction

“Insurers are eagerly anticipating the Medicare market. The Medicare Drug Gold Rush is the title of a conference for health care executives being held this month in New York.” (Robert Pear, New York Times, June 15, 2005).

The Medicare Modernization Act of 2003 (MMA) set off an unprecedented stampede of companies marketing Part D prescription drug plans as well as a wide range of Medicare Advantage plans offering medical benefits to people with Medicare. Although insurance companies have provided Medicare benefits in a managed care setting as an alternative to Original Medicare’s fee-for-service benefits for over a decade, the new Part D prescription drug benefit is only available as an insurance product purchased from commercial companies contracting with the Centers for Medicare & Medicaid Services (CMS). As a result, millions of people with Medicare seeking prescription drug coverage are now in the sights of sales departments and marketing agents for insurance companies selling both Part D stand-alone drug plans and Medicare Advantage (MA) plans.

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The enactment of the drug benefit by Congress in 2003 was accomplished by legislative hikes in reimbursement and profitability for Medicare Advantage plans, triggering an explosion in the number and type of Medicare Advantage plan designs. As consumers struggle to find the best combination of prescription drug and medical benefits for their individual needs, they must navigate a dizzying array of configurations and cost-sharing arrangements. That challenge is exacerbated by aggressive marketing tactics employed by insurance companies seeking to maximize their Part D market share for their more lucrative line of Medicare Advantage products.

This brief examines the marketing of Part D Prescription Drug Plans (PDPs) and Medicare Advantage plans by the insurance companies and their contracted agents selling these products in the field. The use of agents and independent brokers working on a tiered commission system has created financial incentives to enroll people with Medicare into plans, particularly Medicare Advantage plans, with little regard to suitability for the individual. Sales agents are often minimally trained and conduct their sales in face-to-face settings, often in a person's home, in which potential plan enrollees are even more susceptible to manipulation than over the phone.

Lock-in rules that only allow individuals to change plans once a year heighten the consequences of aggressive and deceptive marketing on people with Medicare. The structure of the enrollment season promotes the use of aggressive tactics as well as unsupervised independent brokers focused on maximizing enrollments and has led to targeting low-income people with Medicare. After family members and friends, insurance agents were found to be the most frequently used source of information for prospective Part D enrollees,¹ making the lack of adequate oversight of agent activities particularly problematic. The general

marketing standards for plans promulgated by CMS² have proved inadequate to police the marketplace while state insurance officials have largely been sidelined by statutory preemption of their historic roles in protecting consumers.

In this brief we provide the following:

1. Overview of the current Medicare landscape, including the types of plans offered and rules that govern enrollment.
2. Review of the rules relating to marketing of Medicare products.
3. Discussion of our marketing experiences with a particular kind of Medicare product, Private-Fee-for-Service plans (PFFS), to highlight agent misconduct that advocates have observed.
4. Discussion of Medicare's oversight of Part D and Medicare Advantage plans.
5. Discussion of state regulation of insurance agents.
6. Recommendations for stricter oversight and accountability of plan sponsors and their agents.

1. The Landscape Facing Consumers

Plan Choices

When choosing how to obtain coverage through Medicare, individuals have a range of variables they must consider, based on any current coverage they might have. The first factor individuals must consider is how any outside insurance coverage might interact with Medicare, including whether they or a spouse is still working and has coverage primary to Medicare; they have public or private retiree benefits that supplement Medicare; other government coverage that impacts their Medicare coverage; or privately

purchased Medigap (Medicare Supplement) coverage. Second, individuals must decide if they want to obtain their care through the fee-for-service Original Medicare program (allowing them to see any provider that accepts Medicare) or through a Medicare Advantage plan.

For individuals choosing to remain in Original Medicare, the options for supplemental coverage include purchasing a Medicare Supplemental Insurance policy (Medigap) and a stand-alone Prescription Drug Plan (PDP) for Medicare Part D prescription drug coverage. Medigap plans are standardized, guaranteed renewable and, depending on state law and the circumstances of the individual, premiums may also be controlled. Choosing a Part D plan is more complicated. Premiums vary widely, as do formulary coverage, utilization management rules, copayments, deductibles, and coverage in the gap (or the “doughnut hole”). Part D plans contract with Medicare on an annual basis and are not guaranteed renewable.

More complicated still is the array of options under Medicare Advantage through which enrollees obtain all of their covered Medicare services. The MMA injected new incentives for private companies to offer these and additional products, resulting in a barrage of new plans being offered in areas where they were not previously available. These plan designs include Preferred Provider Organizations (PPOs, which allow enrollees to see out-of-network providers, usually for higher cost sharing); Special Needs Plans (SNPs, designed for “special needs” individuals, including those who are

institutionalized, eligible for both Medicare and Medicaid, or certain individuals with chronic and disabling conditions); Private Fee-for-Service Plans (PFFS, which allow enrollees to see any provider that accepts the plan’s terms and conditions, including uninformed “deemed” providers who have no written contracts with a plan); and, starting in 2007, Medical Savings Accounts (MSAs, which combine a high-deductible health plan with an independent bank account owned by the member into which Medicare makes an annual deposit). The number of MA plans continues to grow nationwide, rising to 3,791 from 3,195 in 2006.³ Some MA plans offer Medicare Part D prescription drug coverage, and others don’t; depending on what type of MA plan individuals are enrolled in (mostly PFFS plans), they may have to obtain separate Part D coverage outside of the MA plan if it is not offered through that plan.

Choosing among these multiple, complex variables determines which doctors, hospitals or other providers an enrollee can use and under what conditions. In addition, each plan typically charges different premiums and cost-sharing amounts for medical services, including some that are higher than the cost-sharing amounts under Original Medicare. Some plans cap annual out-of-pocket spending, but the range of caps varies widely. MA plans that also include Part D benefits add another layer of complexity, with separate deductibles, cost-sharing amounts and spending limits.

Depending on the locality, there may be an overwhelming number of private plan options available to people with Medicare.

EXAMPLE: Los Angeles County—106 Plan Options in 2007

- 55 stand-alone Prescription Drug Plans (PDPs, available statewide)
- 36 “health plans” (29 of which offer Part D coverage):
 - 2 regional PPOs (available statewide)
 - 1 local PPO
 - 24 local HMOs (2 with no Part D coverage)
 - 2 local HMOs available in only parts of the county
 - 6 PFFS plans (4 with no Part D coverage)
 - 1 MSA (prohibited from offering Part D coverage)
- 15 SNPs (limited to certain “special needs” individuals)

Note that this does not include the option available to individuals in PFFS plans without Part D coverage and all MSAs plans to purchase additional, outside Part D coverage through a PDP (source: www.medicare.gov).

Limited Options to Change Plans

Outside of the time period during which individuals first become eligible for Medicare, people with Medicare are generally limited in their ability to enroll in, switch or disenroll from both PDPs and MA plans. During the Annual Coordinated Election Period (ACEP), which lasts from November 15 through December 31 of each year, individuals can start drug coverage and switch MA and PDP plans effective the following January 1.

There is also an Open Enrollment Period (OEP) associated with MA plans that allows for certain changes during the first three months of the year.⁴ (Note that, as discussed below, Congress recently created an additional enrollment period that favors enrollment in one type of MA plan.) In addition, there are Special Enrollment Periods (SEPs) that may be available following certain triggering events; individuals who are dually eligible for Medicare and Medicaid (dual eligibles) or who are enrolled in a Medicare Savings Program have a right to an ongoing SEP that allows them to change plans on a monthly basis.

2. Marketing to People with Medicare

The limited enrollment window and a target population notorious for “stickiness” (an unwillingness to change its insurance coverage⁵) create added pressure on plan sponsors seeking to maximize market share. This inertia among the target population means that, as companies roll out additional plan options, enrollment grows primarily by “stealing” customers from competitors (or, as discussed below, from themselves, as plan sponsors try to encourage their PDP enrollees to switch to MA products).

The limited enrollment window also makes it more economical for companies to use independent brokers, paid on commission and with minimal company oversight, rather than a salaried sales force that has limited ability to enroll new plan members during most of the year. These factors create a marketing climate that is “ripe for abuse.”⁶ The SEP allowing monthly plan switches by dual eligibles makes older adults with low incomes, who have historically been vulnerable to aggressive marketing of dubious financial products like high-interest second mortgages, the principal target of

brokers selling PDP and MA plans outside the annual Open Enrollment Periods.

Marketing of Multiple Part D Products

Several companies in California and around the country sell the full panoply of Medicare-related products, which can include stand-alone Prescription Drug Plans (PDPs that only offer Part D coverage); Medicare Advantage plans (HMOs, PPOs, PFFS, and MSAs), which cover Parts A and B services and can include Part D coverage (known as MA-PDs); and Medicare Supplemental insurance policies (Medigaps), which do not include Part D coverage.⁷ The confusion that people face concerning the Part D benefit alone is greatly compounded when one company offers, and is marketing and trying to sell, various Part D and non-Part D Medicare products. In addition, CMS allows Part D sponsors offering multiple Medicare-related products to market and sell other non-health-related insurance products to people with Medicare.⁸⁹

Varying Commissions

This confusing array of choices allows marketing agents to steer consumers to plans that generate higher commissions as well as revenues for the company, whether or not they are the most suitable for the consumer. Often a consumer's request for information on Part D becomes an opportunity to push enrollment in an MA product offered by the same company that can generate up to five times the commission. Agents typically earn between \$60 and \$80 for each enrollment in a stand-alone PDP but between \$400 and \$500 for enrollment in an MA product.¹⁰ CMS allows companies to pay different commissions to agents for the sale of different products:

“Rate of payment to a marketing representative may vary between plans provided the compensation is in line with the industry standard and is

related to a reasonable measure of marketing representative service, such as the amount of time spent by the marketing representative selling and maintaining the plan. Based on a reasonable measure of marketing representative service, the rate of payment may vary between an MA plan, MA-PD and a PDP.”¹¹

Arguably, agents may take more time marketing and explaining MA products that provide drug coverage and change the way consumers receive Medicare medical benefits. While agents (and plan sponsors) get paid more for MA enrollments, though, there are no corresponding safeguards to ensure that agents actually do engage in more in-depth “service” and “time” necessary to explain MA plans to prospective enrollees, or to confirm that such plans are in fact appropriate for a given individual, such as explaining that one will have to use the plan's network of doctors.

HICAP counselors in California, New York and around the country¹² have handled multiple complaints from consumers who were sold MA products thinking they were enrolling in either a Medigap plan or a stand-alone PDP offered by the same company. Enrollees switching from fee-for-service Medicare to managed care frequently must change providers and face different and sometimes greater cost-sharing structures often not adequately explained by an agent selling them one of these plans. Without safeguards in place to ensure that the difference in products is adequately explained to prospective enrollees, the linking of higher commissions to enrollments in MA products simply serves as a cover for allowing marketing agents to steer customers to products that generate higher-capitated payments for the company.

Some companies may use one plan as a loss leader intending to entice people over time into one of their more profitable plans. Some companies have openly admitted that it is

their strategy to maximize enrollment into their stand-alone PDP products in order to later entice those enrollees to move into the same sponsor's managed care products—a practice called “enroll and migrate.”¹³

A variation on this theme is already occurring: HICAP managers in different parts of California have been told by insurance agents that plan sponsors have given agents lead lists based upon the sponsor's Part D (PDP) enrollment records. This means that a given sponsor “X”—which offers both PDP and MA products—is giving agents a list of individuals enrolled in their PDP product so that agents can market the same sponsor's MA products to the same group of people—at a profit for both the sponsor and the agent. In this instance, the needs of the individual Medicare enrollee must compete with the chance for higher profits by both agents and plans.

3. Caveat Emptor: The Marketing of PFFS Plans

The link between aggressive marketing and the level of profitability for both agents and insurance companies is most clearly demonstrated through the marketing of Private-Fee-for-Service (PFFS) plans. Of all the MA products, PFFS plans generate the largest capitated payments to the plan, averaging 119 percent of the average cost of care in Original Medicare, well above the MA average rate of 112 percent of the average cost of care under Original Medicare.¹⁴ Enrollment in PFFS plans has skyrocketed, rising to over 800,000 in the fall of 2006, with the number of plans offered increasing 25-fold over two years.¹⁵ At the same time, PFFS enrollments have been at the center of many of the incidents of marketing misconduct and abuse that Medicare counselors in California and New York (and presumably elsewhere) have encountered over the last year.

Approximately half of all new MA plans being offered in 2007 are PFFS plans.¹⁶ These plans, along with Medical Savings Accounts

(MSAs), are not managed care plans, something all previous Medicare private health plan designs were supposed to incorporate. Most major plan sponsors are offering PFFS products, in part because they cost less to set up than other MA plans since they do not require the establishment of the same level of infrastructure, such as a network of providers.¹⁷ Instead PFFS plans are “deemed” by CMS to have an adequate provider network if they agree to pay providers according to the Medicare fee schedule. In addition, PFFS plans are exempt by law from the bid review process required for other MA plans. As a result, CMS does not review the benefit packages offered by PFFS plans to ensure the benefits reflect premiums paid by both Medicare and plan enrollees.

The main selling point for PFFS plans is that they do not restrict enrollees to a specific network of providers. Instead, PFFS plans rely primarily on “deemed” providers who knowingly provide services to plan members and are therefore required to accept the plan's conditions and payments.¹⁸ Providers who refuse to provide services to plan members are non-contracted providers. Generally, both plan representatives and CMS¹⁹ have sought to create the impression that the structure of PFFS plans is comparable to Original Medicare because of the similarity of the cost sharing offered by the plan.

Consumer advocates have also found that many agents selling PFFS plan lack adequate training and understanding of the products they are selling. This is particularly alarming in regard to agents who cold call individuals who are already enrolled in a company's PDP or who have that company's Medigap policy.

In the one-on-one marketing pitch, prospective enrollees are told, “You can see any doctor you want,” or “You can see any doctor that accepts Medicare” without regard to which providers will actually accept the

plan's payments. The reality is quite different. Enrollees can go to any Medicare provider only if the provider is willing to accept the PFFS plan's fees and terms.²⁰

Early experience with PFFS plans available in 2006, though, shows that enrollees have had difficulty finding doctors who will agree to treat them while in other cases providers have discovered retroactively that they are "deemed" to be under contract to the plan and must accept the terms and payment of the plan. Similarly, many doctors are expressing frustration with these plans, including the fact that in some instances the plans can reimburse doctors at rates less than standard Medicare reimbursement rates. In addition, some doctors feel "forced into an unacceptable choice of either abandoning established patients who sign up for [PFFS plans] or having to accept the terms of participation."²¹

While other MA coordinated care plans are required to maintain an adequate provider network, PFFS plans have no such requirement. In many rural communities, people with Medicare may be forced to search for providers outside their community who will accept the terms and payments of a PFFS plan.

Consumers must be vigilant to find out how PFFS plans really work. Buried in marketing materials, for example, might be statements saying that enrollees must see providers who accept a plan's terms and conditions, followed by the phrase "most doctors do."²² Unless a PFFS plan establishes a specific network, though, there does not appear to be a way to substantiate such a claim.

Because of legislation passed in the waning hours of the 109th session of Congress in December 2006, PFFS plans without Part D benefits will be allowed to market to all people with Medicare and enroll individuals in their plans year-round starting in 2007.²³ The legislation allows year-round enrollment in plans that do not offer drug coverage. But the legislation does not allow people to drop out of MA plans after the Open Enrollment Period, which ends March 31, or to start or drop Part D drug coverage during the course of the year. It also maintains a prohibition on people with Medicare receiving drug coverage from a stand-alone drug plan if they are enrolled in a Medicare Advantage HMO or other coordinated care plan. PFFS plans are exempted from this prohibition, giving them an unfair advantage over other MA plans and a larger window within which to market their plans to people with Original Medicare who are receiving drug coverage from a stand-alone Part D plan.

CASE STUDY: Marketing Misconduct by Insurance Agents Selling PFFS Plans

When it comes to instances of potential marketing misconduct related to the sale of Part D and Medicare Advantage plans in California, HICAP programs overwhelmingly report problems associated with agents selling PFFS plans. Here are some selected examples:

- One HICAP manager reported that in her county service area in central California, 33 primarily Spanish-speaking people with both Medicare and Medicaid were switched into a SecureHorizons PFFS plan that their doctors refused to accept.
- In a different county bordering another state, at least 12 people with Medicare were convinced to join a SecureHorizons PFFS plan prior to the Part D enrollment deadline on May 15, 2006. Most of these individuals quickly discovered that their doctors refused to accept this plan. Some thought they were buying the company's Part D prescription drug plan or its Medigap policy, which would not have changed the way they got their other Medicare benefits. At least one of these individuals was threatened with the loss of his employer-sponsored retiree benefits when he was sold a Part D plan on top of his existing benefits and incurred \$15,000 in uncovered health care expenses while making the switch back to his retiree plan.
- Ms. R, a conservator for a person with Medicare who lives in assisted living, reported that an agent came to her door in late December 2006, uninvited, after driving up and down her block. He had a clipboard in hand that had a list of names, one of which was her client's, with Ms. R.'s address as a contact. The agent began to ask if her client, who was enrolled in a particular sponsor's PDP product, was aware of the same sponsor's PFFS plan and the current limited Open Enrollment Period then in effect. He extolled the "improved program with more benefits" for current enrollees in the PDP plan. He opened a folder and showed the "improved" eye care and hearing aid care benefits and personal items allowed each month under the PFFS plan. He told her any doctor could bill the plan instead of Medicare, and, "you can choose your own doctor." She was then told that she needed to make a decision by the end of month, and he would have to pick up the application after she filled it out and "signed here." He asked her to call him when she had completed it so that he could pick it up. The agent told her he had talked to 39 clients, and 36 of them had already signed up.

Targeting the Most Vulnerable

Because individuals who have both Medicare and Medicaid (dual eligibles) have the right to switch Part D and MA plans on a monthly basis, they have become a principal target of MA plan marketing during the months of the year when most other people with Medicare are barred from switching plans. Dual eligibles are more susceptible to high-pressure marketing and more vulnerable to interruptions in their health care. They are more likely to live alone and to suffer from

mental or psychiatric disorders and have higher levels of chronic diseases and serious disabilities.²⁴ Plans are marketed with little regard as to whether their provider networks, supplemental benefits and cost-sharing structure are beneficial to people with Medicare and Medicaid.

Because Medicaid generally covers the Medicare cost sharing for dual eligibles in the Original Medicare program and often offers additional benefits like dental and vision care, the principal benefit of enrolling in an MA

plan—reduced Medicare cost sharing—is not relevant to this population. In reality, enrollment in an MA plan can in fact increase the cost-sharing burden on dual eligibles because providers may inappropriately bill plan members and not state Medicaid programs for the cost sharing due from patients under the MA plan's benefit structure.

Dual eligibles may benefit from enrollment in an MA plan that coordinates care or improves access by making a wider network of providers available to them. If providers in the MA plan's network also accept Medicaid, then dual eligibles can receive these benefits (and, in some states, continue to have Medicaid pay their Medicare cost sharing). The experience of Medicare counselors over the last year, however, shows that many plans that target dual eligibles make no effort to encourage network providers to also accept Medicaid or to educate them that patients who are dually eligible should not be billed, regardless of whether the state Medicaid program pays their cost sharing for them.

Since enrollment in a particular MA plan may be of dubious benefit to a dually eligible individual, plan agents resort to using a range

of aggressive tactics, false promises and inducements to enroll dually eligible individuals.

Over the last half of 2006, and beginning of 2007, many HICAP programs reported that they have experienced agents aggressively marketing PFFS plans to their dual eligible clients. Dual eligibles targeted by PFFS marketers are led to believe that state Medicaid programs (including California's Medi-Cal) will pay their cost sharing for them.²⁵ Dual eligibles are also being told that they can have access to additional benefits such as vision, hearing and dental only if they join a PFFS plan. However, they might already have access to these services under their state Medicaid benefit, and thus may be enticed to join a plan that they do not need and may expose them to new out-of-pocket expenses. Additionally, these plans are being marketed in areas where major local providers have made it clear that they will not accept a PFFS plan (for example, a major clinic serving dual eligibles in the Santa Cruz area has informed the local HICAP manager that it will not accept WellCare's PFFS plan, despite heavy marketing of this plan to dual eligibles in that area).

CASE STUDY: Targeting Dual Eligibles for Medicare Advantage Plans

The Medicare Rights Center (MRC) Client Services staff is finding a number of instances in which insurance brokers are using fraudulent marketing activities to push dual eligibles into plans that they do not need and are not appropriate for them, namely Medicare Advantage Health Management Organizations (HMOs) and Private Fee-for-Service (PFFS) plans. Many of the tactics that are being reported by people with Medicare are inappropriately aggressive and can often be attributed to insurance brokers working for particular companies (this is not something that is seen across all plans).

More specifically, MRC caseworkers are seeing the most number of problems occurring with insurance brokers who work for WellCare, Health First and Touchstone. People with Medicare in New York State have reported

- brokers coming unsolicited to their doors and posing as government Medicare representatives;
- brokers offering \$200 drugstore coupons for signing up with a plan;
- brokers telling people with Medicare that they “must” sign up for their plan by a certain date or else they will be fined by Medicare;
- brokers telling dual eligibles that they will lose their Medicaid or Medicare coverage if they do not sign up for that particular plan;
- brokers going door-to-door in senior homes after they were invited to one of the apartments;
- plan representatives setting up in the lobbies of senior centers with their marketing materials, ready to process enrollments and give presentations;
- brokers fooling dual eligibles at a senior center into signing up for an MA plan by telling them they were signing up for a raffle to win prizes;
- insurance brokers working for Health First telling dual eligibles that they needed three cards to receive medical services: their Medicare, Medicaid and Health First cards;
- brokers misrepresenting the coverage offered by downplaying formulary restrictions and doctors’ networks, or telling people with Medicare that they will not need referrals to see specialists (when they will);
- brokers giving potential enrollees false information about their doctors being part of the plan’s network (the enrollees are subsequently billed large sums of money when they continue to see their doctors who are actually out of network);
- plans advertising services already covered under Medicare/Medicaid as uniquely covered under MA plans (such as dental and transportation coverage);
- brokers presenting appeals processes as very easy to navigate and taking very little time.

As a result, dual eligibles are being signed up for plans that do not have their doctors in their networks and do not cover the drugs that they take. They are facing large bills that they should not have and cannot afford, and do not understand why they cannot get the medical services to which they previously had access. They have been enrolled without their knowledge into new plans, and some have enrolled into many plans, which has confused their coverage and billing, their doctors and the plans themselves.

4. Medicare Oversight

CMS articulates certain marketing standards that plan sponsors and agents must follow, but it has largely delegated oversight and enforcement of these guidelines to the plans themselves. In other words, plan sponsors are largely left to police their own conduct and oversee the activity of agents and other downstream marketers who are selling their products.

As noted by Toby Edelman in a Kaiser Family Foundation report on the oversight of Part D plans, "... CMS appears to view its enforcement role narrowly. CMS gives plan sponsors considerable authority to monitor and correct their own behavior, as well as the behavior of those they contract with, and has said that it will work with plans on day-to-day compliance issues and limit its civil enforcement to 'large, repeat and/or egregious' violations."²⁶

Rather than using its regulatory powers to constrain plans' marketing practices, CMS relies on the complaint process to raise warning flags. As Abby Block, CMS director of the Center for Beneficiary Choices, explained to *Congressional Quarterly*, "That's not done through a formal audit process but done through all of the usual signposts of complaints, comments from beneficiaries and so forth. We look at those very, very carefully. We want to make sure they're marketed carefully and accurately."²⁷

Even on its own terms, this oversight strategy fails.

As the HHS Office of Inspector General discovered in a recent report, many Part D plans have failed to adequately even develop plans to ensure internal compliance with CMS regulations, including those governing marketing. Among the failures cited were failures to establish internal procedures for monitoring abuses and failure to properly educate staff about Medicare legal and regulatory requirements. It also appears that plans are not adequately training their

contracted agents and brokers about the plan sponsors' products.

For example, several HICAP programs have reported that they have been contacted by local agents selling MA products—PFFS plans in particular—in order to obtain information about the products they themselves are selling, including how these plans work for dual eligibles. **This is a clear indication that PFFS plan sponsors are not adequately training their sales force, particularly with respect to how these plans work for dual eligibles.**

Oversight by complaint tracking alone also fails to capture the full scope of abusive marketing; only a fraction of the instances of abusive marketing will likely come to light. Many people with Medicare are afraid to report suspected abuse, do not do so in a timely manner, do not realize the conduct violates Medicare rules, or find the process too burdensome. If a person with Medicare does complain to a plan, and the plan actually follows up to investigate, it is often too long after the fact and the person is unable to remember detailed information. People with Medicare do not have a clear sense of how to lodge marketing complaints and no idea of what the results are of filing such complaints. This discourages reporting, furthering reducing the number of instances of abusive marketing that may come to CMS' attention.

By its very nature, oversight by complaint tracking deals with each instance of abusive marketing in isolation, failing to address a pattern of abuse with sanctions and tighter regulations. As a result, the general standards that CMS has put forward amount to little more than gentle admonitions; there is no clear sense whether they are in fact followed by the plans.

For example, CMS regulations require that Part D plans "[e]stablish and maintain a system for confirming that enrolled beneficiaries have in fact enrolled in the PDP and understand the rules applicable under

the plan.”²⁸ Despite this admonition to plans, though, consumer advocates have found that many people with Medicare have been enrolled in Part D or Medicare Advantage plans they do not understand, did not want or are inappropriate for their needs.²⁹ Some have faced greater cost-sharing requirements than their previous coverage, and some have been cut off from doctors who refuse to accept the plan they enrolled in.

Salespeople themselves may not clearly understand differences in how these plans provide benefits for Medicare-covered services, or they may be enticed by the higher compensation for enrolling people in one type of plan over another. Either way the result is often the sale of a product that the new members do not fully understand and

may be detrimental to their care and/or pocket books.

For example, there have been many reports in California of people who thought they signed up for one company’s Medigap plan only to find out later they had been enrolled in the same sponsor’s Regional PPO plan with unexpected cost sharing in the form of a large deductible and unexpected copayments.

In the absence of a CMS determination of marketing misconduct, which allows the affected individual a Special Enrollment Period (SEP) right to change plans midyear, these people are stuck in plans they did not want and may face a permanent loss of their Medigap policy even if CMS grants a retroactive disenrollment.

CASE STUDY: Caught on Film—Regulation by Proxy?

In November 2006, local TV station KSDK-TV (St. Louis, Mo.) reported that UnitedHealth Group—the Part D plan sponsor with the largest number of enrollees nationwide—suspended sales of its Medicare Special Needs Plan (SNP) in Missouri after an undercover report by the TV station caught independent agents misrepresenting the plan to potential customers. Using hidden cameras, reporters recorded two insurance agents implying that the would-be buyer would be stupid not to sign up, that the state of Missouri had come up with the plan, that it would cost her nothing, and that her doctor would accept the plan, called MedicareComplete.

KSDK reported that in response, UnitedHealth officials terminated their relationship with the insurance agency in question and said the two agents had been fired. UnitedHealth admitted that the agents’ insults to the woman on tape “showed egregious misconduct.” The report also said that federal Medicare officials and Missouri state officials had both launched a review (KSDK-TV, St. Louis, as reported on <http://home.healthleaders-interstudy.com/index.php>, November 16, 2006).

While Medicare counselors report this type of agent behavior on a regular basis, this story begs the question: if these agents had not been caught “red-handed” on tape, would the plan have otherwise monitored these agents’ activities? Would CMS have taken action if the plan had not been exposed on the nightly news and voluntarily stopped marketing its product in the service area?

Under the current lax regulation and oversight of marketing activities, we are left to wonder whether the insurance agency and the fired agents didn’t move on to another Medicare sponsor and start selling their products.

CASE STUDY: In-Home Enrollment Only Option Given by PDP

Advocates in California and New York have both received reports that certain Part D plans are informing prospective applicants that the plan is only accepting enrollment through in-home visits—in other words, an individual cannot enroll in a plan via the telephone or internet and must meet with an agent in the individual's own home.

Even if in-home enrollment is not the only option given by plans, plans encourage prospective enrollees to exercise this option. For example, just before the beginning of the 2006 Annual Enrollment Period, Health Net ran a nearly full-page ad in a local newspaper stating, in part, "Just for meeting with us in your home, you'll get this FREE CD ..." (*San Francisco Chronicle*, page A18, November 8, 2006).

In conversations with CHA and MRC, CMS has acknowledged that in-home sales have the highest "closing rate" regarding plan enrollment. That is not surprising since CMS also acknowledged that such sales are also higher pressure (CHA and MRC phone call with CMS Central Office staff, December 2006).

In response to complaints about similar practices from all across the country, on December 1, 2006, CMS issued a memo to plans reminding them of their obligations under the Medicare marketing rules, including "ensur[ing] that sales agents do not imply that a face to face meeting is required for a beneficiary to receive information about a Medicare plan."

5. State Regulation of Part D Plans and Insurance Agents Marketing Such Plans

Part D Plans

Under state law the California Department of Insurance (CDI) handles complaints about insurance companies and the Department of Managed Health Care (DMHC) handles complaints about health care service plans such as HMOs and PPOs. However, Congress stripped them of that authority over Medicare Part D and Medicare Advantage plans, effectively deregulating these companies and their Medicare insurance products and undermining state regulation and enforcement.

While states retain their authority over people who are licensed to sell these plans (agents and brokers), they have no control over the benefits, provider contracts, appeals, the practices of a plan, the advertising it uses, or

the actions of the sponsoring companies.³⁰ Federal law preempts state regulation of these federally approved plans with the exception of a requirement that Part D companies apply for a state license. Yet CMS may temporarily waive even this limited state power in certain instances.³¹

Thus, individuals cannot rely on state regulatory agencies for assistance when they encounter a problem with a Part D plan, and, instead, must depend on federal personnel and federal rules for resolving them. Consumers who experience any problems with these plans must seek help from CMS, which, in turn, usually directs them back to their plans for any complaints.

Marketing Agents

Federal law does not preempt states in regard to their licensing authority over agents who sell Part D products. CMS requires Part D plans to use a licensed agent to market their plan when the state requires a license for that activity, as most states do. There is a

practical gap, however, when a state agency with authority over the seller of an insured product under Part D is faced with determining if and when the state's rules have been violated when the sale involves a product not approved under state law or is written by a company that has a federal waiver from state licensure. Even when a company is licensed, the state has no jurisdiction over the product and often no clear understanding of how that product delivering a public benefit works, or how and when a sale is inappropriate according to federal regulations.

In addition, CMS has no process or system that Medicare private plans must use to deal with the actions of agents selling their Medicare insurance products. Each plan is left to devise its own methods for dealing with these issues.

The California Department of Insurance, in an early attempt to head off bad sales practices, issued a formal notice to all life insurers and agents that describes the application of state laws to marketing and sales practices by insurers and agents in regard to Part D insurance products.³² The issuance of this notice did not seem to have any effect on many agents in California, though, who engaged in the inappropriate sale of PFFS plans to people with Medicare.

While the actions of several agents engaging in misconduct have been reported to the California Department of Insurance, the Department will need to have a thorough understanding of Medicare MA and Part D products to evaluate the appropriateness of the coverage that was sold and apply the state's rules regarding agent conduct to those sales.

CMS expects the MA or PDP company to comply with a reasonable request by a state agency to investigate an agent who is marketing the company's plan, but it is doubtful that among the marketing misconduct cases that have been reported to

the department that the plan or the sponsoring company has much information to supply. Sponsoring companies often have an existing relationship with a distribution system that may involve contracts with large brokerage firms that in turn contract with local insurance agencies that contract with individual agents. CMS oversight of plans does not take into account contracting arrangements with these downstream groups or entities that market and sell Medicare insurance products. A chain of supervision and responsibility must be developed and enforced to ensure that bad actors are dealt with quickly and appropriately.

Although a sponsoring company may fire an agent following one or more complaints, that agent can continue selling Medicare insurance products for any other company with which he or she is appointed, or any other product the agent is able to sell under a state license.

Neither the plans nor CMS has a system for notifying other companies when an agent is terminated for cause. The National Association of Insurance Commissioners (NAIC) recently negotiated a model Memorandum of Understanding that each state will need to sign that will allow the transfer of information between state insurance departments and CMS about companies and agents. However, there is a low probability that agents who commit wrongful acts will ultimately be subjected to state regulatory action due to the complexity of selling a public benefit through a commercial insurance product.

6. Recommendations and Conclusion

There is an urgent need for Congress, CMS and the states to stop abusive marketing practices and protect people with Medicare who are its victims. When older adults and people with disabilities are deceived into enrolling in a private plan that is unsuitable

for them, it can prevent them from receiving the medical care they need:

- They may be unable to see a doctor they know and trust and who is familiar with their health care problems.
- They may lose coverage for vital medicines that are not covered or subject to restrictions under the new plan.
- They may face cost sharing for prescription drugs or medical treatments that is unaffordable and forgo care as a result.
- They may be burdened with high medical bills when, unaware of the restrictions imposed by their new plan,

they see a doctor who does not accept their plan.

CMS has allowed Part D and Medicare Advantage plans to police their own marketing activity. Allowing plans and their agents “maximum flexibility” to sell their products has come at the expense of adequate consumer protections. CMS should not be concerned with the “balance” between the interests of insurance companies profiting from the Medicare program and people with Medicare themselves. The Medicare program should favor and protect those it was created to serve—the older Americans and people with disabilities entitled to coverage through the program.

Congress must act to:

1. Repeal lock-in and allow people with Medicare to change MA plans and prescription drug plans during the course of the year.
2. Revise federal preemption of state laws, including allowing state regulatory agencies to oversee the marketing activities of plans and condition state licensure of plans on adherence to state marketing rules.
3. Repeal the provision that allows PFFS plans to enroll people year-round. This gives an unfair advantage to a type of MA plan that offers the least in benefits, costs the Medicare program the most money and has been at the center of the most egregious marketing abuses.
4. Give people with Medicare the choice of a drug coverage option under the government-run Original Medicare program. This way if people with Medicare do not want to have to deal with private plans and their marketing agents, they do not have to.

CMS must act to:

1. Require 24-hour written advance notice of what products will be marketed at a home visit. This will help prevent agents from “upselling” an MA plan for someone seeking enrollment in a stand-alone drug plan.
2. Require plans to indicate when an enrollment application is completed during a home visit and keep records, subject to audit, describing when and how the agent/broker was invited by the enrollees into their home. This will enable better policing of plans that have ignored requirements that they receive an invitation before visiting someone’s home, or used subterfuge to receive such invitations.

3. Require plans to accept enrollment over the phone and require plan call centers to disclose this option (e.g., “I can enroll you over the phone”). This will discourage plans steering individuals toward in-home visits, where individuals are more susceptible to high-pressure sales tactics.
4. Prohibit plans from offering differential commissions based on what type of plan is selected by the enrollee. Basing higher commissions on the amount of time necessary to explain a plan option serves as a convenient rationale for allowing plans to reward agents who sell plans that generate more revenue, whether or not the plan is suitable for the consumer. Agents should receive compensation based not solely on initial enrollment into a plan but also based on continued enrollment. This would ensure stability in plan enrollment and encourage agents to sell appropriate coverage and is the compensation system used for most insurance products.
5. Develop and require more comprehensive disclosure documents to ensure that people with Medicare will understand the changes they are making to the way they get their Medicare benefits. For instance, MA marketing materials should clearly disclose—in plain language—that purchase of this product may change how the individual receives Medicare-covered services. Managed care products should clearly warn potential members that enrollment may limit which doctors and other providers they can see. Such an important disclosure should not be buried in fine print.
6. Require Part D sponsors to market each product separately (e.g., an advertisement can’t say, “you can buy any of our products or buy our Medicare plan”). This will encourage better explanation and understanding of each type of product being sold.
7. Prohibit agents from selling unrelated products (e.g., annuities and life insurance) during a Medicare product solicitation or sales session.
8. Require that all MA and Part D product names clearly specify what they are. Instead of “value,” “reward,” “gold,” “silver,” etc., there should be clear descriptive terms in the name of each product, such as “HMO” or “PDP” and a proscribed disclosure developed by CMS to alert people with Medicare to any changes they are making to their health care delivery system.
9. Hold sponsoring companies accountable for the actions of agents selling their insurance products.
 - a. When an agent engages in misconduct while selling a plan’s product, the plan should be forced to take corrective measures, including the imposition of monetary sanctions against the sponsors and agents.
 - b. Agents should undergo mandatory training on Medicare and Part D with a curriculum outline and disclosure documents established by CMS.
 - c. People with Medicare harmed by these practices should be held harmless and any debt they have incurred should be the responsibility of the sponsoring company.
10. Require Part D plans to report all complaints about their agents to CMS and to the appropriate state regulatory agency.
 - a. CMS should keep records of the agents reported to them and work with the appropriate state agency to resolve those complaints.
 - b. CMS should provide technical training to state insurance departments to help them understand how the purchase or replacement of coverage is related to a state’s rules for inappropriate or abusive sales.

- c. Agents fired by one company selling Medicare products should not be allowed to sell another company's Medicare products.
11. Require plans that market to dual eligibles to have provider networks that include a sufficient number of doctors and other providers that accept Medicare and Medicaid to allow dual eligibles reasonable access to a range of primary doctors, specialists, rehabilitation therapists and other providers. Plans marketing to dual eligibles must educate network providers on how to bill state Medicaid departments for cost sharing.
12. Prevent plans from implying that enrollment is required to receive benefits already covered by Medicaid (vision, dental, etc.), or that enrollment is necessary to maintain Medicaid coverage.
13. Require PFFS plans to poll major providers (e.g., hospitals, clinics, doctor groups) in areas where they are sold to determine if an adequate number of providers will treat plan enrollees and accept the terms and conditions of the plan (otherwise, enrollees will be faced with a potential dearth of providers willing to treat them).
14. Establish and advertise an independent national Medicare private plan complaint hotline that will keep record of complaints about plans from people with Medicare and will not send people back to their plans with their complaints.

States should act to:

1. Enforce and expand current protections under state law to all Part D and MA sales. For example, the following California Insurance Code sections can and should be used to better protect people with Medicare:
 - 790.03 prohibits misrepresenting the true nature of the company or product or inducing a person to lapse, forfeit or surrender existing coverage.
 - 780 prohibits misrepresentation of the policy.
 - 781 prohibits making any misrepresentative statement to induce a person to take out insurance, refuse to accept, or to lapse, forfeit, or surrender existing coverage.
 - 785 requires that all insurers, brokers, agents, and others engaged in the business of insurance owe prospective insured age 65 or older a duty of honesty, good faith and fair dealing in the sale of insurance with certain exceptions that do not include most insurance with health benefits.
2. Impose fines and penalties on both companies and agents violating any existing state laws in the solicitation or sale of any Medicare Part D product.
3. Expand and apply existing law applying to other products to cover Medicare products as well. For example, California's SB620 (California Insurance Code §789.10) requires agents to provide written advance notice 24 hours before an agent enters an individual's home to sell life insurance or annuities. The notice declares the intent to propose these products and enumerates various rights the individual has, such as the right to have another person present during the sales session. This protection could help prevent many of the most egregious marketing abuses reported about the Medicare private health plans.
4. Coordinate all of its regulatory efforts with CMS to ensure that any agent or broker disciplined for the solicitation or sale of a Medicare Part D product is barred from selling any other Medicare Part D product in the state where the violation occurred or any other state.

Congress, CMS and the states would better serve people with Medicare by tightening the restrictions on plan and agent conduct to ensure that consumers can make better, informed decisions about their Medicare coverage options.

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¹ See MedPAC, "Report to the Congress: Increasing the Value of Medicare" on choosing a plan: 49% of people with Medicare cited using family members or friends as resources when they made their Part D decisions. Other sources of assistance were insurance agents (17%), Part D plans (8%), pharmacists (3%), doctors (1%), counselors (6%), nursing home/senior housing (3%), and employer/union (2%) (June 2006)

(http://www.medpac.gov/publications/congressional_reports/Jun06_EntireReport.pdf); see also Center for Medicare Advocacy's discussion of report at

http://www.medicareadvocacy.org/PartD_06_07.13.MedPACReport2.htm.

² See, e.g., 42 CFR §423.50(f).

³ "What Stakeholders Should Expect from Medicare Part D in 2007," presentation by Gorman Health Group (December 2006).

⁴ For example, during the MA-OEP, individuals can pick-up, change or drop MA coverage. However, individuals can neither pick up Part D coverage nor drop Part D coverage altogether and cannot change from one PDP to another PDP. See, e.g., 42 CFR §422.62; Medicare Managed Care Manual, ch. 2.

⁵ See, e.g., Kaiser Family Foundation report, "Seniors and Medicare Prescription Drug Benefit," which found that one in 20 older adults (5%) who are enrolled in a Medicare drug plan say they expect to switch plans for 2007, compared with 66% who do not expect to switch and 29% who are uncertain (December 19, 2006).

⁶ "What Stakeholders Should Expect from Medicare Part D in 2007," presentation by Gorman Health Group (December 2006).

⁷ See, e.g., CMS Marketing Guidelines, page 14. Medigap insurers can market Part D products (both MA-PDs and PDPs) to their enrollees.

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⁹ See, e.g., CMS Marketing Guidelines, pages 112-3. Agents and brokers can sell those or other non-health-related products offered by the same or other companies in the same sales session. Some of these third parties (downstream contractors) who advertise or sell Part D products take advantage of the confusion around the new Part D benefit arrangements and make enticing offers by mail, over the phone or in person offering to help people with Medicare with these complex new choices. In the process some may advertise or sell products completely unrelated to Medicare Part D such as burial policies, annuities or long-term care insurance. When these products are offered for sale during the same session that an agent is soliciting (marketing) someone for a Part D product, it increases the risk that individuals might mistake the relationship between these unrelated products, and/or believe that they are obligated to buy such products together.

¹⁰ "What Stakeholders Should Expect from Medicare Part D in 2007," presentation by Gorman Health Group (December 2006); also, e.g., during a CMS Region IX Stakeholders call on September 28, 2006, a CMS official described going to an industry conference and speaking with brokers and agents who said that for stand-alone PDPs, they normally get \$80-\$100 in commission per enrollee, whereas each enrollment into an MA plan earned them \$400-\$500 in commissions.

¹¹ CMS Marketing Guidelines, pages 131-2.

¹² The marketing activities described in this brief are drawn from the experiences of direct counseling of people with Medicare provided by MRC and the work of the State Health Insurance Assistance Program (SHIP), known as the Health Insurance Counseling and Advocacy Program (HICAP) in California, as supported by CHA.

¹³ See, e.g., "Plan A: Hook Them with Part D," *Business Week* (January 30, 2006), cited in Toby Edelman, "Oversight and Enforcement of Medicare Part D Plan Requirements: Federal Role and Responsibilities," Kaiser Family Foundation (September 2006).

¹⁴ http://www.medpac.gov/public_meetings/transcripts/1108_1109_medpac.final.pdf.

¹⁵ http://www.medpac.gov/public_meetings/transcripts/1108_1109_medpac.final.pdf.

¹⁶ CMS Region IX Stakeholders call on September 28, 2006.

17 See, e.g., “Special Report: CMS Announces MA Plans—Medicare Advantage Plan Designs Favor PFFS in 2007” by Roy Moore, HealthLeaders-InterStudy press release (October 19, 2006), at http://home.healthleaders-interstudy.com/index.php?p=press-archive-detailed&pr=pr_10182006MAPPlans.

18 PFFS can also contract with providers to form a network. Most PFFS plans, however, are “deemed” by CMS to have adequate provider networks by virtue of paying Medicare rates.

19 In an early draft of the *Medicare and You* handbook for 2006, CMS grouped Original Medicare and private fee-for-service plans in a single category named Medicare Fee-for-Service Plans. After objections from House Democrats, private fee-for-service plans were included among the other Medicare Advantage options. See, e.g., April 6, 2005, letter to CMS Administrator McClellan from Representatives Rangel, Dingell, Waxman, Stark and Brown.

20 A provider will become a “deemed” contracted provider of a PFFS plan and treated as if she or he has a contract in effect with the plan if the services are covered in the plan and are furnished, and, before furnishing the services, the provider was informed of an individual’s enrollment in the plan and given a reasonable opportunity to obtain information about the terms and conditions of payment under the plan. See, e.g., 42 CFR §422.216(f).

21 See American Medical Association House of Delegates, New Mexico Delegation, “Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans” Late Resolution: 1001 (I-06), received October 25, 2006.

22 See Humana’s web site description of its Humana Gold Choice PFFS plan: “You can choose to see any provider who accepts Medicare patients. But make sure the providers you see agree to Humana’s terms and payment conditions. Most doctors do, but it’s smart to ask in advance” at <http://www.humana-medicare.com/medicare-advantage-plans/humana-gold-choice.asp>.

23 Tax Relief and Health Care Act of 2006 (H.R. 6111), signed into law December 20, 2006; see Division B, Title II, §206: “Limited Continuous Open Enrollment of Original Medicare Fee-for-Service Enrollees into Medicare Advantage Non-Prescription Drug Plans.”

24 Kaiser Family Foundation, “Dual Eligibles, Medicaid’s Role in Filling Medicares, Gaps,” March 2004 <http://www.kff.org/medicaid/upload/Dual-Eligibles-Medicaid-s-Role-in-Filling-Medicare-s-Gaps.pdf>.

25 See, e.g., WellCare PFFS plan brochure (WellCare 2006 NA_10_06); see also WellCare press release touting the benefits of the Duet PFFS plan to dual eligibles (October 2, 2006); in addition, HICAPs report that many agents are promising dual eligibles verbally that the state will pay their cost sharing.

26 Toby Edelman, “Oversight and Enforcement of Medicare Part D Plan Requirements: Federal Role and Responsibilities” Kaiser Family Foundation (September 2006), quoting CMS’ “Part D Oversight Strategy” (October 24, 2005).

27 Rebecca Adams, “Democrats Eager to Cut Private Stake in Medicare,” *CQ Weekly* (January 8, 2007).

28 42 CFR §423.50(f)(2)(ii).

29 This problem is not limited to California: e.g., at least half of participants from 13 SHIP programs surveyed by the Kaiser Family Foundation “reported client problems due to plan marketing.” See Kaiser Family Foundation report, “Early Experiences of Medicare Beneficiaries in Prescription Drug Plans—Insights from Medicare State Health Insurance Assistance Program (SHIP) Directors,” p. 9 (August 2006).

30 See 42 USC §1395w-112; 42 CFR §423.401, et seq.

31 See 42 USC §1395w-26(b)(3); 42 USC §1395w-112(c).

32 See California Department of Insurance Notice (November 18, 2005) at <http://www.insurance.ca.gov/0200-industry/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/NOTICE-on-Annuity-and-Part-D-Sales2.pdf>.

California Health Advocates: <http://www.cahealthadvocates.org/>

Medicare Rights Center: <http://www.medicarerights.org/>