Testimony by
Patrick O'Toole, Vice President-Medicare Sales
Humana Inc.

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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 study[3] 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 report[5] 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 that, "these care management services are possible only in the context of the MA

[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

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.