PREDATORY SALES PRACTICES IN MEDICARE ADVANTAGE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

JUNE 26, 2007

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PREDATORY SALES PRACTICES IN MEDICARE ADVANTAGE

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PREDATORY SALES PRACTICES IN MEDICARE ADVANTAGE

TUESDAY, JUNE 26, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:03 a.m., in room 2123 of the Rayburn House Office Building, Hon. Bart Stupak (chairman) presiding.

Members present: Representatives Stupak, Green, Schakowsky, Inslee, Dingell, Whitfield, Walden, Murphy, Burgess, and Barton.

Staff present: Kristine Blackwood, Joanne Royce, Paul Jung, John Sopko, Scott Schloegel, Voncille Hines, Kyle Chapman, Peter Spencer, Alan Slobodin, Matt Johnson, and John Stone.

OPENING STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. STUPAK. This hearing will come to order. Today we have a hearing entitled "Predatory Sales Practices in Medicare Advantage Programs." Each Member will be recognized for 5 minutes for an opening statement. I will begin.

Our hearing will examine the program known as Medicare Advantage which provides insurance options for Medicare beneficiaries. One of its primary objectives was to provide Medicare beneficiaries a wide array of managed-care choices. However, the proliferation of private Medicare insurance plans has come at a price. Investigators for this committee have verified countless stories of deceptive sales practices by insurance agents who prey upon the elderly and disabled to sell them expensive and inappropriate private Medicare plans. These shameful marketing practices targeting our most fragile and vulnerable citizens are the subject of today's hearing.

As often happens in the process of our investigation, usually just before this subcommittee holds a hearing, those being investigated make changes in their practices to appear as though they are addressing the problems at hand. On June 15, seven major health insurance companies, two of which are represented here today, voluntarily agreed to stop marketing one type of Medicare Advantage plan, the Private Fee-for-Service plan, in response to complaints about deceptive sales practices including forged signatures and enrollment of dead people.

Today we will explore how CMS and the insurance industry reached the point where they had to call a moratorium on market-

ing the Private Fee-for-Service Medicare Advantage plans. We will also hear about the real life consequences of fraudulent marketing practices. Unfortunately, many seniors are coaxed into plans that don't adequately meet their health care needs. They don't understand that if they sign up for Medicare Advantage they no longer have the benefits of traditional Medicare coverage.

In some instances the Private Fee-for-Service plans being sold to these individuals result in reduced coverage and higher out-of-pocket expenses that seniors on a fixed income cannot afford. And what most people realize about the Medicare Prescription Drug Improvement Modernization Act of 2003, MMA as it is referred to, is that it created part D of Medicare and launched prescription drug plans run by insurance companies.

But what MMA also did was boost the payments to insurance companies operating managed care alternatives to traditional Medicare and called the private plans Medicare Advantage. Before MMA the Government was paying the private plans 95 percent of the cost of traditional Medicare. Now the Government is paying them 112 to 119 percent of traditional Medicare.

Medicare Advantage is aptly named. It is richly funded to outcompete or privatize traditional Medicare. The launching of part D in combination with the boost in payments to Medicare Advantage plans has resulted in a dizzing array of choices for seniors and disabled persons.

In Houghton, MI, one of the small towns in my district in the Upper Peninsula, Medicare beneficiaries have 54 prescription drug plans to choose from, plus 14 Medicare Advantage plans. And that is nothing compared to other parts of the country. For instance, in Miami there are at least 57 prescription drug plans and 55 Medicare Advantage plans available. A May 2006 report by AARP documented the problems faced by seniors sorting through this maze showing wide-spread confusion and even anxiety over the new Medicare Advantage and prescription drug plans.

At what point does consumer choice become meaningless? When seniors and their families sit down at a kitchen table to figure out what health care program grandma or grandpa need, they should not have to hire an accountant to help make the right choice for them. Now we have a glut of private plans that end up dispatching fleets of sales agents racing each other to get to the local retirement community, assisted living facility or senior center first. We have telemarketers and insurance agents competing for commissions, prizes and trips to Las Vegas based on who sold the most policies in the shortest time.

These abusive practices under Medicare Advantage are very similar to the rampant sales problems witnessed with the launch of the Medigap Insurance in the 1980s. The regulatory model which eliminated Medigap sales fraud should be applied to Medicare Advantage. As with Medigap plans, MA plans should be standardized, States should be able to regulate Medicare Advantage companies and agents, and insurers should be held accountable for their agents' actions.

Our first panel will explore the extent of the problem and the consequences of deceptive sales. We will hear first from David Lipschutz, an attorney for the California Health Advocates. Califor-

nia has had a lengthy experience with Government managed care plans and has often served as the role of the canary in the coal mine. We are especially grateful today for the testimony of three victims of predatory sales practice. Ms. Barbara Clegg-Boodram, a resident of Judiciary House in Washington, DC, home to a large number of seniors and disabled persons a few blocks from here, will testify on behalf of her fellow residents, Edith Williams, Mary Royal and Grady Hammonds. Mrs. Williams, Ms. Royal and Mr. Hammonds were victimized by an agent who failed to properly explain the consequences of their enrollment in Medicare Advantage plans.

Next, we will hear from Kathleen Healey, the director of the Alabama State Health Insurance Assistance Program, SHIP. SHIP is a national program in each State that offers one-on-one free counseling and assistance to people on Medicare. Also, on the first panel is Mr. Lee Harrell, deputy commissioner of the Mississippi Insurance Department. Mr. Harrell will share with us some of the practical problems State regulators face when they investigate deceptive practices under the current structure.

We will hear from the insurance industry in our second panel, Fran Soistman from Coventry Health Care and Gary Bailey from WellCare Health Plans will testify about the efforts of their companies to combat marketing of abuses. They are joined by Ms. Peggy Olson, a licensed insurance agent who has specialized in Medicare coverage since 1985. We will explore with this panel the role of the independent agents, companies' relationship with field marketing organizations, general agents and sub agents, and some of the inherent challenges these relationships pose. We hope each of you will share with us your candid assessments and your constructive ideas.

Finally, we will hear from the Government regulators, Ms. Abby Block, the director of the Center for Beneficiary Choices at CMS, will testify about CMS oversight of Medicare Advantage. She is joined by Jim Poolman, the commissioner of North Dakota Insurance Department, and Ms. Kim Holland, the commissioner of the Oklahoma Insurance Department. These witnesses will discuss steps their departments are taking to investigate questionable practices and to warn seniors in their States so they can avoid being victimized.

The financial windfall to the insurance industry attributable to the Medicare Advantage program has been likened to the gold rush. We are bound to hear today that the industry and CMS have zero tolerance for deceptive sales practice. What we need, however, is zero abuse. Why do so many elderly and disabled continue to be enrolled through confusion, if not trickery, in unsuitable and ultimately costly plans? Hopefully, our hearing will answer some of the questions.

Next, for an opening statement I would like to turn to my friend and ranking member of the committee, Mr. Whitfield from Kentucky.

OPENING STATEMENT OF HON. ED WHITFIELD, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. WHITFIELD. Well, Chairman Stupak, thank you very much for holding this hearing on problematic sales practices of Medicare Advantage plans. And I certainly want to thank at the outset Ms. Clegg-Boodram, Ms. Royal, Mr. Hammonds and Mrs. Williams, who have come this morning to talk about their personal experiences with a a deceptive insurance agent just a few blocks from the Capitol trying to sell them a Medicare Advantage plan.

Today we are focused on Medicare beneficiaries who have been unscrupulously coaxed, misled or fraudulently signed on to plans that they do not really want and we appreciate this panel helping us understand this problem.

It is important to expose problems and gaps in the oversight of Medicare Advantage sales practices and to insure ultimately that the Medicare Advantage program operates to its full potential as a new benefit for Medicare beneficiaries. The program cannot reach that potential when there is a cloud of distrust over the plans created by disreputable sales practices.

The problems we will examine today have occurred amidst a large and rapid spread of Medicare Advantage plans across the country. More than 8 million people are enrolled in private Medicare Advantage plans, up from about 5 million just 3 years ago when the Medicare Modernization Act took effect. The expansion has been particularly rapid for the Private Fee-for-Service version of these plans which accounted for some 500,000 of the 700,000 new enrollees in 2007 so far. These Private Fee-for-Service plans now serve some 1.5 million beneficiaries, strong evidence of their popularity. Because these plans are not as constrained as their managed-care counterparts are by the need for contracted doctor networks, they have spread particularly fast in the rural areas and heretofore have not had much access to what Medicare Part C offers in terms of extra benefits and services, lower premiums and the like. Yet it is with these plans that State and Federal officials, consumer advocates and the health plans themselves have seen the large number of sales problems.

Medicare Advantage relies heavily upon insurance agents to educate people about these plans to assess the beneficiaries needs and to assure they know what they are purchasing. With this in mind I would like to hear specifically from representatives of the two insurance plans testifying today about how they encourage their agents to make sales but at the same time ensure that the enrollees are fully informed. How do they train and monitor their agents? How have they reacted to reported problems?

We should bear in mind that much of this growth in these plans—of sales—has occurred in the shadow of the launching of the Medicare drug benefit. With the intense focus on the drug benefit there may have been less than necessary Federal attention on the growth of the Advantage plans and attendant need for informing physicians and the public about the new offerings.

Mr. Chairman, this hearing comes at an opportune time. The Centers for Medicare and Medicaid Services has issued a new marketing guideline for the upcoming year and I understand that State

regulators and CMS have been working to improve oversight of the marketing practices and most recently seven insurers who account for 90 percent of the Medicare Private Fee For Service market announced a moratorium on sales until CMS certifies they have instituted new marketing provisions.

This is a good juncture for the subcommittee to examine why the sales abuses have occurred and whether the new measures will be sufficient to reduce the problems as we move forward to the future. And I yield back the balance of my time.

Mr. STUPAK. I thank the gentleman.

For an opening statement, the chairman of the full committee, Mr. Dingell, opening statement, sir.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr DINGELL. Mr. Chairman, this is a very important hearing and I thank you and commend you for having it.

I will be blunt. The Medicare Advantage marketing practices that have come to the attention of this committee are disgraceful in the extreme. Frankly, they have come as no surprise to those of us who have long questioned the structure of the Medicare Advantage Program and they tend to be a replication of some of the charges we have seen of some of these same people doing the same thing with regard to Medigap which this committee had to act upon years ago to stop the same kind of outrageous practices again by some of the same people.

I would note that we ought to ask why are Medicare payments for Medicare Advantage beneficiaries on the average 12 to 50 percent higher then those that Medicare pays for beneficiaries enrolled in traditional Medicare. We were told that this is going to be a device which will bring competition and reduce costs. Why should the vast majority of traditional Medicare beneficiaries pay higher monthly premiums to subsidize Medicare Advantage enrollees? And that total subsidy is something on the order of $700 million that is flowing to a group of people through the hands of a group of insurance companies to others who oft times are more affluent.

Wasn't privatization supposed to help contain costs and allow for more efficient delivery of quality health care? In my view Medicare Advantage is not containing costs and there is no evidence that it is providing value to beneficiaries commensurate with its greater cost. On the contrary, as we will hear today the very structure of Medicare Advantage creates conditions ripe for swindling the elderly and disabled. The real beneficiaries of these programs are the insurance companies, which are profiting splendidly. Humana is reportedly earning 66 percent of its net income from sales of Medicare Advantage products this year.

Should our Medicare Trust Fund be subsidizing the insurance industry? And, indeed, there is an interesting thing to note here. The Medicare Trust Fund is being depleted 2 years early by the events that we are discussing today. Clearly, the administration thinks so. The unprecedented overpayments to the insurance industry are part of the administration's agenda to privatize the Medicare system and they are being subsidized by overpayments of somewhere

between 12 and 30 percent. Something that is totally unjustifiable and unsupervised. So far this privatization has neither saved money nor provided verifiable efficiencies. It has created some very interesting things. First, deep confusion over a ballooning array of plans, and second armies of sales agents competing for commissions, cash prizes, trips to Las Vegas for those who sign-up the greatest number of seniors in the shortest time.

The industry will tell us that they need time to work out the kinks in the provision for bringing about more effective, more cost effective, and more coordinated care. But they have had decades to do this. It is undone, and I hope that Mr. Chairman, your labors thus far and that of the committee will help us move this matter forward.

Private managed care options to traditional Medicare have been around since the creation of Medicare. With the introduction of the Medicare Plus Choice Act in 1997, Medicare Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) really took off. In order to encourage cost containment, private insurers were reimbursed between 95 percent and 102 percent of the cost of traditional Medicare. A number of the better run Medicare managed care plans were able to offer additional benefits even at these lower reimbursements.

But after an initial surge in growth many plans started withdrawing from the market citing inadequate payments from the Government even though they were turning in some fine profits. The administration responded in 2003 by throwing still more money at the insurers to prime the Medicare privatization pump. Insurers responded to the lure of big profits by launching a dizzying number and variety of Medicare Advantage plans.

In addition to draining the Medicare Trust Fund, as I mentioned, by 2 years, more quickly, overpayments to the insurance industry serve as a pervasive incentive for insurance companies and agents to aggressively market their products without regard to the seniors' health, financial well-being or ability to deal with the kind of practices which we are seeing.

Let us look at some of the things that the committee has heard. We have received evidence of shameful practices. What are they? Brokers signing up people with Alzheimer's and psychiatric disorders, brokers forging signatures, and signing up dead people, brokers telling people that Medicare sent them and that Medicare is being eliminated and they must sign-up or lose their health coverage.

I want to thank our witnesses for appearing before us today to share with us some of the glaring problems with Medicare Advantage and possible solutions. And I look forward to working with you, Mr. Chairman, and members of the committee, not only to bringing this out but to correcting some of these scandalous abuses. Thank you.

Mr. STUPAK. Thank you, Mr. Chairman.

Next, Mr. Green, for an opening statement, sir.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for holding this hearing on predatory sales practices involved with the enrollment of Medicare beneficiaries in Medicare Advantage plans. While the notion of private Medicare contractors has been around since the 1970s participation in the Medicare Advantage Program has increased dramatically since Congress passed it. The Medicare Modernization Act, which significantly increased payments to Medicare Advantage plans in Harris County, TX, which Houston is a part of, along with seniors who want to participate in Medicare Advantage have to choose among 37 different private plans. Unfortunately, the litany of choices creates a significant confusion among our seniors, confusion that enterprising agents have taken advantage of to enroll seniors unwittingly in various Medicare Advantage plans.

In my State of Texas some of these questionable marketing practices include door-to-door marketing of these plans, which is illegal. We know in other States that agents have paired this door-to-door marketing request with a that a beneficiary fill-out a request for more information, a document that the beneficiary finds later was truly an enrollment form for a Medicare Advantage plan. Some of the tactics offered are so egregious that as part of these bait-and-switch routines their agents reassure seniors they will still be enrolled in Medicare and that their enrollment in a Medicare Advantage plan will not affect their Medicare coverage.

These tactics involve the use of half-truths that seize upon the trust that is built for more than 40 years now between seniors and the Medicare Program. Medicare is a trusted brand name that seniors equate with balance, cost-sharing and open access to providers. After being duped in the Medicare Advantage plans many seniors now feel misled and frustrated. They can't necessarily see their family doctor they have trusted for decades and they can't do anything about it until the next open enrollment period.

In Houston we are proud to be the home of M.D. Anderson Cancer Center, one of the top cancer centers in the Nation. Most cancer centers that are across the country do not accept Medicare Advantage plans yet the sales practice of bundling part D and part C plans has denied many of the seniors the access to these world-renown cancer centers. Unknowing beneficiaries find out too late that their part D enrollment included enrollment in a corresponding part C plan and their dis-enrollment from part B. In fact, Memorial Sloan-Kettering had to proactively send letters to its Medicare patients to educate them on the distinctions between parts B and C so that more beneficiaries wouldn't fall for those bundling tactics and lose their access to cancer care.

The Texas Department of Insurance gets daily complaints about the marketing practices of Medicare Advantage plans. Unfortunately, the Medicare Modernization Act tied their hands and preempted State insurance commissioners from having enforcement authority over these practices. Unlike was mentioned earlier in Medigap coverage from decades ago, CMS doesn't have the time or the resources to adequately enforce consumer protections. If the recent agreements between CMS and seven Private Fee-for-Service plans are any indication, the agencies are relying on the industry

to police itself. CMS in this particular program is in need of strong congressional oversight and I want to thank the chairman for making it a priority for our subcommittee.

As a member of the Health Subcommittee I hope we can learn from this investigation and enact some much needed consumer protections for our Medicare beneficiaries so they can renew their trust in the Medicare Program. I look forward to hearing from our witnesses today and I thank you for sharing your experience. With that, Mr. Chairman, I will yield back my time.

Mr. STUPAK. Thank you, Mr. Green.

Ms. Schakowsky, for an opening statement, please.

OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you. Thank you, Mr. Chairman.

First, I would like to associate myself with Chairman Dingell's remarks regarding overpayments to Medicare Advantage plans, even those that are not engaged in predatory marketing practices. Since the creation of Medicare Advantage plans in 2003 and the subsequent ability to market those plans in 2005, there has been an explosion in the number of Medicare Advantage products on the market. This has brought serious new challenges to beneficiaries who must navigate the chaos of varying programs with different cost-sharing provisions. It has also posed serious questions about the State agencies ability to regulate the sales and marketing of these programs.

Fast forward now to 2007 and you have got seven private insurers who cover the largest number of Private Fee-for-Service beneficiaries voluntarily suspending their marketing programs from Medicare Advantage plans in light of serious reports of predatory sales practices. Something has gone terribly awry.

Inappropriate sales practices, manipulation and coercion have no place in personal decisions about health care. For many people insurance agents rank right up there as a source of information about their Medicare plan options, that is why I have serious concern about States' lack of tools for regulating the insurance sales industry, particularly in light of accounts of our most vulnerable members of society being targeted.

Dual-eligibles who are more likely to live alone or likely to suffer from mental or psychiatric disorders, and who are more likely to have higher levels of chronic diseases or serious disabilities are especially susceptible and particularly targeted by predatory sales practices. This is primarily due to their ability to switch plans on a monthly basis. These characteristics also make it all the more important that they maintain appropriate coverage throughout the year.

As I suspect we will hear from our witnesses today the appalling sales practices employed by some of these bad actors can cause immeasurable damage to a person's financial stability, prospects for regaining coverage in the future and overall personal health and safety. I look forward to working with the subcommittee to end these practices once and for all. I think we need to look at the commission structure of the insurance industry sales industry, the wide variety among plans and most importantly the lack of author-

ity and oversight granted to CMS to regulate sales agents and plan sponsors. This is a very timely hearing as the committee looks for ways to truly improve health care, efficiency and quality. And I truly want to thank the witnesses for being here today and look forward to hearing what you have to say.

I yield back.

Mr. STUPAK. I thank the gentlelady.

Mr. Burgess, opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman, and thanks for calling this hearing. We are going to be gathering some information on potential abuses by insurance brokers and agents marketing Medicare Private Fee-for-Service and Medicare Advantage plans. And I think we are all struck by those who would either prey on the elderly or defraud the U.S. taxpayer. Those brokers and agents who violated the trust of their customers must be dealt with in a way that limits their ability to ever do that again.

Medicare beneficiaries rely on information that these individuals provide to be accurate, they rely on it to be truthful as they evaluate the different health plans to meet their specific needs. When a broker or agent seeks financial gain by defrauding these customers, and these customers are our parents, they are our brothers or our sisters, they are our grandparents, when these agents seek financial gain by defrauding those customers they erode the trust that makes up the foundation of the Medicare Program.

The American Association of Insurance Plans has recently set forth a new initiative that sets up the responsibilities that go beyond existing guidelines and make clear that health plans are committed to giving Medicare beneficiaries peace of mind. The American Association of Insurance Plans will work with the Centers for Medicare and Medicaid Services to implement new steps on training, retraining, monitoring to ensure compliance, including requiring beneficiary attestation on enrollment applications and other steps to confirm that beneficiaries understand the plan they have chosen. In addition, plans must strengthen the mechanisms to promptly and effectively address non-compliance, including working with an actual Association of Insurance Commissioners, the Center for Medicare/Medicaid Services, different beneficiary groups and broke organizations and insure that new uniform processes and criteria be adopted to report serious broker misconduct in these areas as well as misconduct by the agent or the plan employee.

I am grateful that the industry has taken some proactive steps to address this issue. Whatever we do to reinforce this initiative the solution should not delegate authority to the various States because of the national characteristic of many of these plans. An idea that may have merit is to create a national database of brokers or agents that engage in predatory or fraudulent sales of plans. That way the plans know how to steer clear of certain individuals when contracting with independent brokers and agents. I also thank the witnesses for giving of their time in being with us today and pro-

viding valuable insight into this problem and, Mr. Chairman, I will yield back the balance of my time.

Mr. STUPAK. I thank the gentleman.

Next I will turn to ranking member of the full committee, better known as the winning manager of the baseball team last night, Mr. Barton from Texas.

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BARTON. Well, thank you, Mr. Chairman, that was the best played game I would say in the last 20 years; no errors or very few errors and the Republicans caught the breaks at the right time. Praise the Lord, but it was a good game and Washington charities are about $90,000 richer as a consequence. You, as usual, played a very good game.

I do appreciate you and Ranking Member Whitfield holding this important hearing on the Medicare Advantage Program. Medicare Advantage is an important part of Medicare. Congress has worked hard to expand the benefits to those who choose this particular type of program, and it looks like it is a very popular program since there are more than 8 million seniors who have enrolled in Medicare Advantage plans so far.

Having said that no part of government is immune from responsible oversight. I believe that responsible oversight is important but it does not include second-guessing successful and popular programs to death or taking benefits away from Medicare beneficiaries who paid for them. I want to assure the enrollees in Medicare Advantage that their new benefits are not going to be taken away.

I hope this hearing will be a means to strengthen the program and ensure those enrollees that they get the benefits that they have chosen as they enrolled in this particular type of Medicare Program. We have a real responsibility to prevent any program and its agents from preying on the weak and the vulnerable. To the extent that there are abusive sales practices in Medicare Advantage we should find them and we should stop them. Mr. Chairman, you and Ranking Member Whitfield are going to have my full support for a straightforward inquiry into what may be a very serious problem.

Let me also note that I appreciate your efforts as chairman to focus this hearing on the consumer protection elements of Medicare Advantage marketing. Reports of any consumer practices among some sales agents are troublesome, especially when misleading or abusive sales tactics target the seniors, the poor and the disabled. If there are gaps in regulatory oversight or in our marketing guidelines or in our enforcement authorities we should fill them and we should do so in a bipartisan basis very quickly.

Medicare Advantage has sought to harness the free market to improve what its beneficiaries can receive in terms of increased choice, increased competitive benefits, and different payment options. I think this is a good thing. Yet a free market approach does not mean a sales free-for-all where agents can have their will over the interests of the beneficiary. CMS has obligations, the health plans have obligations, and indeed even the sales agents have obligations to ensure consumers receive necessary information to make

informed choices. Let me emphasize, we will hold to account those who fail the Medicare Advantage patient. And we are going to do that beginning in this hearing, Mr. Chairman. You will have the Republicans full support on that.

There are areas that need attention. This is demonstrated by the health plans and CMS' own recent actions to put in disclaimers and to improve communication about what the plans are all about. It is a fair question why it took so long to do that. Why weren't problems like have happened anticipated? What else needs to be done?

I am perplexed at some of the problems that I understand continue to exist. For example, Private Fee-for-Service plans are popular, people like them, they offer benefits that you cannot get in traditional Medicare. Private plans also are potentially more attractive then traditional Medicare managed care to doctors and hospitals because these plans pay at the same rates and even more in some cases then Medicare pays. This is a selling point to beneficiaries and should be to health care providers. So why does CMS continue to code these plans as HMOs in the common data file potentially causing physicians to turn beneficiaries away? This is not an insurance agent problem. This is a CMS problem and it needs to be fixed.

I would like to echo you, Chairman Stupak, and Mr. Whitfield, to say that I am seeking constructive information today from all parties to identify problems accurately, be confident that appropriate measures are in place to reduce abusive sales practices. Again, Mr. Chairman and Mr. Whitfield, thank each of you for holding this hearing today and I look forward to hearing what the witnesses have to say.

Mr. STUPAK. Thank you, Mr. Barton.

Well, that concludes the opening statements by Members. We have our first panel assembled. Mr. Lipschutz, an attorney with the California Health Advocates, Ms. Kathleen Healey, director of the Alabama State Health Insurance Assistance Program, Mr. Harrell, deputy commissioner of the Mississippi Insurance Department, Miss Brenda Clegg-Boodram, a resident of the Judiciary House housing complex here in DC, and you are representing your fellow residents, but they are all at the table. It is Ms. Royal, Ms. Mezey, you are an attorney on behalf of the residents of Judiciary House, correct, and Mr. Hammonds, correct, and Ms. Williams.

Since you are all assembled, it is the policy of this subcommittee to take all testimony under oath. Please be advised that witnesses have their right under the rules of the House to be advised by counsel during their testimony and Ms. Mezey, I understand you are to provide that counsel to the residents there. OK. Does anyone else wish to be represented by an attorney or counsel here before they testify today? OK. As I said all testimony is taken under oath so I am going to ask you to rise and raise your right hand to take the oath. Ms. Williams, if you just want to sit there and just raise your right hand that will be fine.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect all witnesses answered in the affirmative so we will begin with opening statements. You have 5 minutes for opening statement. We have your opening statements

so if you want to paraphrase or summarize that would be great. Mr. Lipschutz, we will start with you, please.

STATEMENT OF DAVID LIPSCHUTZ, STAFF ATTORNEY, CALIFORNIA HEALTH ADVOCATES

Mr. LIPSCHUTZ. Chairman Stupak, Ranking Member Whitfield, and distinguished committee members, thanking you for giving me the opportunity to testify today. My name is David Lipschutz and I am a staff attorney at California Health Advocates, an independent, non-profit organization dedicated to education and advocacy on behalf of Medicare beneficiaries in California. We do this in part by providing technical assistance and training to the network of State health insurance programs known in California as HICAP. Our experience with Medicare is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting Medicare beneficiaries.

We recognize that Medicare Advantage plans can be a suitable option for some people with Medicare, but as the Medicare Program has grown and become more complex during the last year and a half, consumers and consumer advocates have witnessed an alarming epidemic of abuse surrounding the sale of Medicare Advantage plans primarily, Private Fee-for-Service plans. In the next few minutes I would like to highlight some of the abusive practices we have seen and point out how CMS' recent cumulative response to misconduct will help but does not go far enough in curbing some of the root structural causes of misconduct.

Medicare Advantage marketing misconduct ranges from outright fraudulent practices to the misrepresentation of plans due to agent ignorance or failure to ensure that consumers understand what they are enrolling in. Examples of predatory sales practices occurring in California and across the country include the following.

Medicare beneficiaries are being signed-up for plans without their consent or knowledge through a variety of means including forged applications. Agents are using scare tactics to convince people to join plans such as saying you will lose your Medicaid unless you join, or are being lied to, such as Medicare is going private, you must pick a plan.

Individuals who sought one type of product such as a PDP or a Medigap go to an agent and end up in a Medicare Advantage plan that they did not want. Individuals dually eligible for Medicare and Medicaid, who in most cases already have comprehensive benefits, are being targeted to enroll in plans that may not be suitable for them. And in one of the more common scenarios agents will make sales at senior or disabled housing facilities, either after dropping by unannounced or after presentations arranged under false pretenses. For example, agents will say they are from Medicare and want to talk about changes to the program without disclosing that they are in fact insurance agents selling a product.

Damage that occurs as a result of marketing misconduct can range from access and continuity of care issues when new enrollees cannot find providers who will take their plan and forgo treatment as a result, to financial, including unexpected out-of-pocket costs or the loss of previously held insurance, such as retiree coverage. Undoing the damage for individuals can be challenging as plans

can be unresponsive in obtaining relief to the Medicare Program can sometimes be delayed.

CMS has recently responded to the overall problem of misconduct by implementing new requirements for Private Fee-for-Service plans and announcing the voluntary suspension of marketing by certain Private Fee-for-Service plan sponsors. For our outstanding questions, perceived shortcomings and specific recommendations concerning these new requirements I will refer to our written testimony.

In short, these new requirements will be helpful but they stop short of stemming the full-range of abuse we are seeing and they should be applied to all Medicare Advantage and part D prescription drug plan sales, not just Private Fee-for-Service plans. CMS action has culminated in the recent voluntary suspensions by certain plan sponsors. While this announcement has had a loud bark, it will likely have a soft bite as far as curbing ongoing marketing abuses. At least some of the plans were already under corrective action plans or have announced that they are already close to meeting the new requirements, meaning the suspension will likely be short-lived. In addition, the suspension is in place between the major enrollment periods when most people make plan changes. So impact on enrollment numbers and company bottom line is expected to be minimal.

CMS and the insurance industry place the blame for marketing misconduct on a few rogue agents. Attention to the misconduct of agents committing abuse is certainly warranted but plans should not escape scrutiny for their role in this problem. One of the primary forces driving inappropriate sales, we believe, is profit. The high payments Medicare Advantage plans receive and the commissions plans pay to agents that drive them to steer people towards Medicare Advantage products over PDPs regardless of whether it is the best option for the individual. Plans motivate their sales forces to maximize enrollment through contests, TVs, trips to Vegas, and cash bonuses for benchmark numbers of sales. At the same time plans fail to properly oversee and train their contracting agents, many of whom appear to lack an understanding of the products they are selling.

As a result of these factors underlying marketing abuse coupled with the dramatic growth in the types, numbers and variation of Medicare Advantage plans being sold across the country, 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. In order to more effectively address widespread marketing abuses recommendations in our written testimony include achieving payment parity between Medicare Advantage and original Medicare. Applying the standards governing the sale of Medigap plans to Medicare Advantage and part D sales which better protect prospective enrollees and curb abuses driven by agent commissions. And standardizing and simplifying the Medicare Advantage and part D benefits so that Medicare beneficiaries can make meaningful comparisons and plans can be held accountable for providing adequate benefits. Thank you for this opportunity to testify.

[The prepared statement of Mr. Lipschutz follows:]

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PREDATORY SALES PRACTICES IN MEDICARE ADVANTAGE
U.S. House of Representatives
Committee on Energy & Commerce
Hearing by the Subcommittee on Oversight & Investigations
June 26, 2007
Written Testimony of California Health Advocates

SUMMARY

As the Medicare program has grown and become more complex during the last year and a half, consumers and consumer advocates have witnessed an alarming epidemic of abuse surrounding the sale of Medicare Advantage (MA) plans, primarily – but not exclusively – Private Fee-for-Service (PFFS) Plans.

Examples of misconduct surrounding the sale of MA plans range from outright fraudulent practices to the misrepresentation of plans that appears to be the result of either an agent not understanding the product s/he is selling, and/or the applicant not understanding the way the plan works.

Many consumers encounter difficulty "undoing the damage" of marketing misconduct due to problems obtaining resolution from plans and the Centers for Medicare and Medicaid Services (CMS).

CMS has taken certain measures in response to reports of marketing misconduct, and while some of these new requirements may help educate beneficiaries and providers about PFFS plans, most do not apply to other types of MA plans nor do they go far enough to stem abusive conduct surrounding the sale of MA and PDP plans.

We urge Congress and CMS to address several underlying, structural issues at the root of marketing misconduct, including: payments to Medicare Advantage plans; agent commission structures; the wide variation in plan benefits and designs; and the lack of adequate oversight and training of agents by plan sponsors.

We provide several specific and broad recommendations, including standardizing Medicare Advantage benefits, imposing existing Medigap protections on MA and Part D plans, and allowing states to play a greater regulatory role over plans.

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I. INTRODUCTION

Chairman Stupak, Ranking Member Whitfield, distinguished Committee Members, thank you for the opportunity to testify today. My name is David Lipschutz and I am a staff attorney at California Health Advocates (CHA). CHA is an independent, non-profit organization dedicated to education and advocacy efforts on behalf of Medicare beneficiaries in California. Separate and apart from the State Health Insurance Program (SHIP), we do this in part by providing support, including technical assistance and training, to the network of California's Health Insurance Counseling and Advocacy Programs (HICAPs) which offer SHIP services in California. CHA also provides statewide technical training and support to social and legal services agencies and other professionals helping Californians with questions about Medicare. Our experience with Medicare is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting Medicare beneficiaries.

Among the various options that Medicare beneficiaries have to access services through the Medicare program, we certainly recognize that Medicare Advantage (MA) plans can be a suitable choice for some. Since MA plans are offered by private insurance companies, as are all stand alone Part D prescription drug plans (PDPs), enrollment is generally pursued and performed by these companies and their contracting agents who compete with one another for the attention of (and dollars that follow) Medicare beneficiaries. Abuse surrounding the marketing and sale of Medicare products is not a new phenomenon. However, during the last year and a half, consumers and consumer advocates have witnessed an alarming epidemic of abuse surrounding the sale of Medicare Advantage plans.[1] Examples of some of these predatory practices are outlined below.

While we have witnessed marketing abuses concerning stand-alone Part D prescription drug plans as well as other Medicare Advantage plans, the majority of marketing problems we have seen stem from the sale of Private Fee-for-Service (PFFS) plans.[2] The Centers for Medicare and Medicaid Services (CMS) has taken certain measures in response to reports of marketing misconduct, culminating in a recent announcement of a voluntary suspension of marketing by seven PFFS plan sponsors until new guidelines specific to PFFS plans are implemented. While some of these new requirements may help educate beneficiaries and providers about PFFS plans, most do

[1] See, e.g. a January 2007 report issued by CHA and the Medicare Rights Center entitled "After the Gold Rush: The Marketing of Medicare Advantage and Part D Plans – Regulatory Oversight of Insurance Companies and Agents Inadequate to Protect Medicare Beneficiaries" available at: http://www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf .

[2] CHA recently had the honor of testifying before the House Ways & Means Committee, Subcommittee on Health, during a hearing on PFFS plan on May 22, 2007; CHA's written testimony is available at: http://waysandmeans.house.gov/hearings.asp?formmode=view&id=5966 and http://www.cahealthadvocates.org/advocacy/2007/CHA_WaysMeans_testimony_0522.html

not apply to other types of MA plans nor do they go far enough to stem abusive conduct surrounding the sale of MA and PDP plans. In order to more effectively combat marketing misconduct and ensure that Medicare beneficiaries are making informed decisions about products that may be suitable to their individual needs, several underlying, structural issues must be addressed by both Congress and CMS, including: payments to Medicare Advantage plans; agent commission structures; the wide variation in plan benefits and designs; and the lack of adequate oversight and training of agents by plan sponsors. In addition to discussing these issues, we provide recommendations to stem further marketing abuse as well as improve the Medicare Advantage program in general in order to better serve Medicare beneficiaries.

II. MARKETING MISCONDUCT

The introduction of the Part D prescription drug benefit coupled with the dramatic growth in the types and numbers of Medicare Advantage plans being sold across the country have increased both the complexity of and confusion surrounding the Medicare program, leading to an environment that is ripe for abuse. The current landscape and choices facing Medicare beneficiaries, examples of how agents have exploited these choices, and the difficulty of undoing the damage of bad choices due to marketing misconduct are discussed below.

Medicare Landscape

The Medicare Modernization Act injected new incentives for private companies to offer a range of new products to Medicare beneficiaries, greatly increasing the number

and types of plans available, all of which have significant flexibility to design their benefits and cost-sharing structures. When choosing how to obtain coverage through Medicare, an individual has a range of variables s/he must consider, based upon any current coverage s/he might have. 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 available through Original Medicare, Medicare supplemental insurance plans (Medigaps), Medicare Advantage (MA) plans, and retiree or other coverage. There are multiple variations between and among these different options. Some individuals are eligible for both Medicare and Medicaid, or some other program that can help pay for some or all of their costs.

Within the Medicare Advantage program there are multiple plan designs, including: Health Maintenance Organizations (HMOs); Preferred Provider Organizations (PPOs); Special Needs Plans (SNPs); Private Fee-for-Service (PFFS) plans; and Medical Savings Accounts (MSAs). Some MA plans offer Medicare Part D prescription drug coverage, others don't. Depending upon what type of MA plan an individual is enrolled in, s/he may have a right to obtain separate prescription drug coverage outside of their MA plan. Depending upon where an individual Medicare beneficiary lives, there may be an overwhelming number of private plan options available to him/her.[3] Some of these combinations of Medicare, private and employer plans are compatible with one another while other combinations do not coordinate, and enrollment into a new plan might

[3] E.g., by our count, there are 106 plan options available in Los Angeles County in 2007: 55 stand-alone prescription drug plans (PDPs), available statewide; 36 "health plans" (including 2 regional PPOs, 1 local PPO, 26 local HMOs [2 of which are only available in parts of the county], 6 PFFS plans and 1 MSA); and 15 Special Needs Plans (SNPs). See www.medicare.gov.

terminate or jeopardize eligibility for existing coverage. Further, although there are multiple options for beneficiaries, most individuals are limited in their ability to change plans during the course of the calendar year.

Behind these private plan options, of course, are companies and their contracted agents trying to sell them to Medicare beneficiaries. Some agents and plans are able to exploit the complex choices facing Medicare beneficiaries by steering them towards certain products, regardless of whether it is the best option for an individual. As a result, 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. 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. Some have lost or jeopardized their eligibility for coverage they already had, such as retiree or Medicare supplemental (Medigap) insurance.

Examples of Misconduct

Marketing misconduct surrounding the sale of Medicare Advantage plans ranges from outright fraudulent sales practices to the misrepresentation of plans that appears to be the result of either an agent not understanding the product s/he is selling, and/or the applicant not understanding the way the plan works (but the agent makes the sale anyway).

Medicare Advantage Private Fee-for-Service (PFFS) plans have been at the center of many of the incidents of marketing misconduct and abuse reported by Medicare counselors in California and across the country. Despite their meteoric rise in enrollment

over the last couple of years, they are perhaps the least understood type of MA plan due, in part, to their departure from the coordinated (or managed) care model of most other MA plans. Often these plans are pitched as allowing individuals to see any provider that they want, without an adequate explanation that a provider must agree to accept the terms and conditions of a given plan, and that providers are free to refuse to do so. Despite CMS efforts to make this clearer to prospective enrollees and providers (discussed below), many providers appear to remain unwilling to treat PFFS plan enrollees. In addition, CMS has done nothing to restrict the targeting of individuals dually eligible for Medicare and Medicaid (dual eligibles) for these plans, despite the apparent lack of suitability of many such plans for dual eligibles.[4]

While the majority of marketing abuse cases we are aware of involves PFFS plans, the following types of abuses have occurred surrounding the sale of other types of MA plans as well.

- Medicare beneficiaries are being signed up for plans without their consent or knowledge.

Example: Mrs. N., a 78-year old dual eligible living in Sacramento on less than $800 a month, was approached outside her housing complex by an agent selling a PFFS plan and asking many questions. Mrs. N. answered the agent's questions, but says she did not sign up for the plan, yet later received the PFFS plan's enrollment materials. As she began to rack up hundreds of dollars in bills for medical expenses, her daughter asked the company for a copy of the enrollment application, and found that her mother's signature was forged.

[4] For a discussion of PFFS access to care concerns, the targeting of dual eligibles, and other issues relating to PFFS plans, see CHA's 5/22/07written testimony before the House Ways & Means Health Subcommittee available at: http://waysandmeans.house.gov/hearings.asp?formmode=view&id=5966 and http://www.cahealthadvocates.org/advocacy/2007/CHA_WaysMeans_testimony_0522.html

- Prospective enrollees are told outright lies in order to scare them into joining plans, such as "Medicare is going private" or that they will lose their Medicare or Medicaid unless they sign up for a particular plan.
- Individuals who sought out one product end up in another they did not want, primarily impacting Medicare beneficiaries who were sold MA products thinking they were enrolling in either a Medigap plan or a stand-alone PDP offered by the same company. (Beneficiaries switching from Original Medicare to managed care often 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.)
- Individuals dually eligible for Medicare and Medicaid (dual eligibles) are being targeted by some sponsors of MA plans, even though certain plans (notably many PFFS plans) may not suitable for them. In part, dual eligibles are targeted because they are one of the few groups of individuals who can change plans on a monthly basis. While many PFFS plans appear to target dual eligibles, sponsors of other plans pursue them as well.

Example: Ms. T, a dual eligible living in the Central Valley of California, was visited by an agent at her home who told her that the HMO the agent was selling would pay "all of her medical costs" and pressured her to enroll in the plan. Ms. T. subsequently found that neither her primary care physician nor her specialists accept her plan, and she has had to pay out of pocket for co-payments and diabetic supplies she could not obtain through her plan.

- Medicare Advantage plans, in competition with one another, try to "poach" members of other plans offering comparable coverage.

Example: Ms. O, a Ventura Co. resident who was enrolled in HMO "A" in 2006, decided to change plans for 2007 and enrolled in HMO "B" in November 2006 (effective 1/1/07). In December 2006, HMO "A" called her numerous times and sent her letters trying to convince her to remain in their plan, but she repeatedly informed them that she no longer wanted the plan, and had enrolled in a new plan. Nonetheless, Ms. O found herself in her old plan, HMO "A" as of January 2007. With the help of her local HICAP program, she was able to fix the problem and re-enroll in her desired HMO "B." In March 2007, Ms. O received a phone call from an agent asking her to re-enroll in HMO "A"; she again said no and asked not to be contacted anymore. She soon found, however, that she had been disenrolled from HMO "B" -- her desired plan – and was back in HMO "A." She called 1-800-MEDICARE but was told there was nothing they could do. When she called HMO "A" to tell them she did not want to be in their plan, and did not authorize enrollment, she was told that she would have to call 1-800-MEDICARE again. With the help of HICAP and a subsequent call to 1-800 MEDICARE, she was able to get back into her desired plan.

- Despite CMS's prohibition of unsolicited door-to-door sales by agents selling MA and PDP products, this practice continues unchecked.
- Agents will cold call an individual but not appropriately identify themselves and/or the purpose of their call, and will later show up at the person's house.
- Agents misrepresent themselves as being from Medicare, Social Security, or even the local State Health Insurance Program (SHIP). Others do not identify themselves as agents selling plans, but instead as a "Certified Medicare Advisor" or "Senior Advisor" who would like to pay a friendly visit to educate you about changes to Medicare.
- Some agents take advantage of individuals with limited English proficiency by making sales when neither the agent nor the applicant can adequately communicate with one another.

Example: Ms. G., a 72 year old dual eligible living in California's Central Valley who is limited English proficient and relies on family members to assist her with her medical and financial needs, received an unsolicited visit from an agent while she was home alone. Ms. G. subsequently found herself enrolled in a PFFS plan, and learned that her primary physician does not take the plan.

- Agents sell plans at senior or disabled subsidized housing complexes or senior centers either without invitation or under false pretenses such as giving a presentation about "Medicare changes." After a minimal (or no) presentation about a particular plan, the agents enroll a large number of beneficiaries all at once, without taking the time to explain the plan and the consequences of enrollment to each individual.

Example: Mr. & Mrs. S, who live in a senior housing complex in Butte County, CA, attended a presentation at their complex by a sales agent who had set up the presentation with the resident manager under the guise of presenting on "changes to Medicare", but did not disclose that he was an insurance agent. After the presentation on "Medicare Plan C," the agent sold several PFFS plans, but had not disclosed the way PFFS plans work, and had indicated that most providers take the plan. Along with several residents, Mr. & Mrs. S. signed up for the PFFS plan, and dropped their Medigap insurance. They subsequently found that their providers refused to accept their plan.

- Some agents have been outright abusive to prospective enrollees either in an attempt to make a sale at any cost, or in response to complaints made about an agent's previous conduct.

Example: Mrs. B, who lives in a mobile home in rural Northern California, was cold called four times by an agent seeking to enroll her in a PFFS plan. When Mrs. B expressed hesitancy, the agent became verbally abusive towards her, cursed and asked for the phone numbers of her doctors. After giving the agent her address, the agent told her that he would come and stand on her doorstep if she refused to sign up for the plan.

Undoing the Damage of Marketing Misconduct

Many victims of marketing abuse who are enrolled in plans that they did not want do not know where to turn. Many Medicare beneficiaries are unaware of both their rights and their ability to get help from SHIP programs and other types of assistance. Plan sponsors – who are charged with policing the activity of their agents – often prove less

than helpful when beneficiaries complain to them about marketing abuse; plans are often unable to fix enrollment/disenrollment problems, discourage disenrollment from their plan, or simply inform the individual that "nothing can be done."

Consumers and consumer advocates report problems both seeking resolution through and lodging complaints with 1-800-MEDICARE and CMS. Processing Special Enrollment Periods (SEPs) and retroactive disenrollments can be problematic as there are no standard timelines for CMS to render decisions, follow up is inconsistent, and often decision-making about whether to grant such requests is passed back to the plans themselves or CMS contractors. Advocates report very mixed results when trying to use CMS processes to resolve enrollment and disenrollment disputes, with timeliness and level of feedback often dependent upon which CMS personnel ends up with a particular case. Sometimes disenrollment due to marketing misconduct – or other reasons – can take many weeks (or months), and, in some instances in which beneficiaries are retroactively disenrolled from a Medicare Advantage plan with Part D prescription drug coverage, can leave a beneficiary with no Part D coverage at all. Undoing the damage of marketing misconduct often requires the extensive involvement of advocates, a type of assistance many people do not know how to access.

III. CMS'S RECENT RESPONSE to MARKETING MISCONDUCT

Marketing misconduct surrounding the sale of Medicare Advantage plans has received growing attention from the public, the advocacy community, the media and Congress. Over the last several months, CMS has issued the 2008 Call Letter to MA and Part D plans which proposed some new requirements relating to the marketing of PFFS

plans[5], and in late May released new guidance for PFFS plans, some to be implemented immediately and some before the start of the next Annual Election Period (AEP). Recent CMS activity surrounding marketing abuse culminated on June 15th, 2007, when CMS held a press conference announcing that in response to concerns about marketing practices seven insurance companies signed an agreement to suspend voluntarily the marketing of their Private-Fee-for-Service (PFFS) products.[6] CMS stated that the suspension for a given plan will be lifted only when CMS certifies that the plan has systems and management controls in place to meet all of the conditions outlined in CMS's 2008 Call Letter and the May 25th Guidance.

New PFFS Requirements

Some of the new requirements imposed by CMS will be helpful in educating beneficiaries and providers about PFFS plans and will hopefully stem at least some marketing abuse. Here is a brief review of some of the key new requirements, along with some unanswered questions, perceived shortcomings, and specific recommendations for improvement:

Disclaimer Language – CMS is requiring disclaimer language in marketing material that will more accurately describe how PFFS plans work, including the option of physicians to decline to accept the terms and conditions of a given plan. While CMS requires that

[5] For comments specific to the 2008 Call Letter, see Joint Comments submitted by National Senior Citizens Law Center, Center for Medicare Advocacy, Inc., Families USA, Medicare Rights Center, California Health Advocates and Pennsylvania Health Rights Project; some of these Joint Comments are incorporated herein; the Joint Comments are available at: http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391/article.2007-04-26.0125948225/at_download/attachment

[6] See 6/15/07 press release on CMS website at: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2214&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

the disclaimer language be included in all sales presentations (both public presentations and private meetings with beneficiaries), it is unclear how this will be done – and enforced – during face-to-face meetings. Although written marketing materials will "prominently display" such language – how will this be presented to individuals in person?

- Given the confusion over how PFFS plans work for dual eligibles (which can vary by state), there should be disclaimer language specific to dual eligibles (re: cost-sharing and access to Medicaid benefits). CMS should require that any information the plan does provide about state Medicaid benefits is accurate, and should be confirmed by the state Medicaid agency.

Verification Calls – PFFS plan sponsors are required to conduct outbound education and verification calls to all beneficiaries requesting enrollment to ensure that they understand plan rules. Education letters must follow an unsuccessful attempt to contact the beneficiary. CMS provides model scripts and letters but the model scripts for verification calls do not provide an enrollee with the option to disenroll (or cancel the enrollment) during the verification phone call itself. The education letter explains the limits on an individual's enrollment options but does not explicitly warn enrollees that failure to disenroll immediately will leave them locked in to the plan for the remainder of the year.

- Although these requirements do not reference languages other than English, we believe that verification calls must be placed in the primary language of the caller; for example, many instances of marketing misconduct we are aware of in California involved the sale of plans to individuals who spoke Spanish or Chinese

as their primary language, and as a result were not able to adequately communicate with agents who did not speak their language (but signed them up for plans anyway).

- Moreover, while we believe that verification calls can be an important tool to combat marketing misconduct, there are not enough requirements in place to ensure that such calls will be effective. We continue to hear from individuals who received such calls (from companies that have already been required to do so through CMS corrective plans) yet still are confused about what they were told and who still wish to disenroll. Even when conducted by plans and duly recorded, verification calls can still fail to work as intended if a plan fails to recognize that an enrollee does not adequately understand the way the plan works.[7] In order to eliminate plan bias, verification calls should performed by an entity independent of the plan.

Reporting of Scheduled Sales Presentations -- Under CMS's new requirements, all PFFS plans must provide their CMS Regional Office Plan Manager with a schedule of all sales and marketing events it will conduct in the following month so that these presentations can be subject to CMS "secret shopper" monitoring.

- CMS should go farther by requiring agents to submit copies of all flyers and other ads announcing events, and disclose how and under what circumstances events are scheduled. As referenced above, there are many reports of agents scheduling presentations at senior/disabled subsidized housing residences or centers under the guise of discussing "Medicare changes" or "Medicare Part C" without

[7] See, e.g, Oklahoma Insurance Department Limited Market Conduct Report of Examination of Humana Insurance Company for the period as of September 15, 2006.

disclosing that it is their intent to sell a product, leading many residents and managers duped into thinking that they are getting a substantive presentation instead of a sales pitch. Will plans and agents report these "educational" presentations as sales presentations?

- Further, this reporting requirement presumably applies to neither in-home sales visits by agents nor unscheduled, drop-in visits to senior centers and subsidized housing facilities, all locations in which the most egregious marketing violations appear to occur. Secret shopper programs, while helpful, appear to be reliant upon information that plans and agents provide regarding scheduled sales presentations. Such efforts will not effectively prevent prohibited door-to-door visits or monitor unscheduled, unsolicited sales at residences/facilities that often result in mass, one-time plan enrollments. In order to curb this practice, *we call for prohibitions against marketing in these facilities, particularly in facilities with large numbers of low income, vulnerable dual eligibles.*
- More broadly, CMS should implement reporting requirements surrounding how each sale/enrollment is made, including additional information collected by agents in the field. CMS and plans should verify whether enrollments are performed during scheduled events. How was contact with the beneficiary instigated? Who initiated the contact? What was date of the call/visit? If a sale is made in an individual's home, when was the call to set up the visit made to the prospective enrollee? How much time did the agent spend explaining the product to the individual?

- Among other things, there should be a minimum time that agents must spend explaining plan features to prospective enrollees (for example, if there are 30 enrollments in a senior/disabled housing complex performed in one hour, the plan features are clearly not being explained to applicants).

Finally, while it appears that the majority of marketing misconduct has surrounded the sale of PFFS plans, there are still many abuses concerning the sale of other Medicare Advantage and stand-alone PDPs. These new rules (and the above recommendations) should apply to all Medicare Advantage plans, not just sponsors offering PFFS plans.

Will the Voluntary Suspensions of PFFS Marketing Do Any Good?

Despite much media attention paid to the voluntary suspension of PFFS plan marketing by several sponsors, it is questionable whether the suspension will actually curb marketing abuses in the long run or have any meaningful deterrent impact on the companies involved. At least some of these plans were already operating under corrective action plans that required them to implement some of the new rules, meaning CMS might "clear" plans to begin marketing again in the short term. While giving dual eligibles a reprieve from aggressive marketing, this suspension will not greatly impact PFFS plan enrollment since it is between Medicare enrollment periods when most individuals are able to make plan elections (the Medicare Advantage Open Enrollment Period, or OEP, from January through June, and the Annual Election Period, or AEP, from November 15th through December 31st). Not only will this suspension have a

minimal impact on plan enrollments, but the industry also projects that it will have minimal impact on finances, including share prices, of these companies.[8]

Despite the added benefit of some of CMS's new requirements for PFFS plans, and the temporary voluntary suspension of some sponsors selling these plans, none of these actions address deeper, structural problems that are behind the epidemic of marketing misconduct surrounding the sale of all Medicare Advantage plans.

IV. UNDERLYING CAUSES of MISCONDUCT REMAIN UNADDRESSED

In the press release announcing the agreement by some plans to voluntarily suspend the marketing of their PFFS plans, CMS focuses attention on agents selling the plans, stating that "'there are a few bad actors that need to be removed from the system for good'" and declares that "CMS is proactive in protecting beneficiaries from rogue agents."[9]

Attention to agents who are engaged in misconduct is certainly warranted. The plan sponsors themselves, though, must shoulder a large portion of the blame for marketing misconduct. They push agents to maximize sales but do not adequately prepare them through training and monitor them through oversight. CMS contributes to the problem by allowing the plans to operate with maximum flexibility with seeming impunity.

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[8] See, e.g., HealthLeaders-InterStudy's Special Analysis Report: "New Agreement On Medicare PFFS Keeps Critics At Bay"

[9] See 6/15/07 press release on CMS website at: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2214&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

Agent and Plan Profit

One of the primary forces driving inappropriate sales of certain plans, we believe, is profit: 1) the high payments that Medicare Advantage plans receive (particularly PFFS plans)[10]; and 2) the varying commissions that plans can pay agents selling Medicare products. The current commission structure employed by most (if not all) plans – and allowed by CMS – permits marketing agents to steer consumers to plans that generate higher commissions as well as revenues for the company, regardless of whether such products are the most suitable choice for an individual consumer. We have found that it is not uncommon for insurance companies to pay up to five times the commission for a Medicare Advantage enrollment versus a stand alone Part D prescription drug plan (PDP) enrollment.[11]

The link between aggressive marketing and the level of profitability for both agents and insurance companies is clearly demonstrated through the marketing of private-fee-for-service (PFFS) plans. Based upon our collective experiences with cases of marketing misconduct associated with the sale of Medicare products, we believe that higher commissions paid for enrolling beneficiaries in PFFS plans in particular (and Medicare Advantage plans in general) have rewarded overly aggressive and unscrupulous behavior by agents, resulting in real harm to beneficiaries. Plans and agents that steer people towards PFFS plans may be driving up costs borne by the Medicare program since PFFS plans currently receive more in overpayments than other plans. All Medicare

[10] See, e.g., MedPAC Report, March 2007, finding that MA program payments are 112% of original Medicare fee-for-service levels, and PFFS payments reached up to 119% -- report available at: http://www.medpac.gov/chapters/Mar07_Ch04.pdf

[11] See, e.g., "Oklahoma Chides Insurer in Medicare Marketing Case" by Robert Pear, *New York Times*, May 15, 2007 – the Oklahoma Insurance Dept. found that Humana paid agents selling MA plans "five times as much as the commission for selling" a PDP; also see "What Stakeholders Should Expect from Medicare Part D in 2007," presentation by Gorman Health Group (December 2006); also, CHA conversations with various agents, plan and CMS representatives.

beneficiaries are therefore subsidizing PFFS plans, whether or not they are enrolled in one.

Oversight and Training of Agents

CMS has largely delegated oversight and enforcement of marketing guidelines to the plans themselves. 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.

Plans appear to exert considerable effort to motivate their contracting sales-forces to maximize sales through contests, including TVs, trips to Vegas, and extra money for extra volume of enrollments. Plan efforts to properly train their contracting agents, though, fall short as many agents appear to be uneducated or even misinformed about the products they are eagerly trying to sell. Consumer advocates have found that many agents selling MA plans (particularly PFFS plans) lack adequate training and understanding of the products they are selling and are also unaware of the impact that enrolling in these products might have on prospective enrollees. This is particularly alarming because agents who convince individuals to enroll in an MA plan can disrupt current drug or supplemental insurance coverage and even trigger an irrevocable loss of retiree coverage. As we have experienced in our conversations with several agents, even those who are trying to do the "right thing" sometimes find it hard to obtain adequate information about the plans, from the plans themselves.

CMS's new requirements for PFFS plans includes testing of agents, but there are no real training and testing standards in place. In its 2008 Call Letter, CMS "considers"

requiring PFFS plans to provide documented training of marketing agents and brokers on Medicare Advantage policy as well as unique aspects of the PFFS product. CMS's press release concerning the voluntary suspension says "All representatives selling the product to beneficiaries on behalf of the plan sponsor will pass a written test that demonstrates their thorough familiarity with both the Medicare program and the product they are selling." While these are clearly desirable goals, current plan requirements do not ensure this outcome.

Finally, as noted above, the growing number of private plans, plan types, benefit structures and complex interactions between these factors are making it more difficult for Medicare beneficiaries to meaningfully compare plans and make informed decisions about how they want to access their benefits through the Medicare program. Our policy recommendations below seek to address some of the underlying structural problems with Medicare Advantage that contribute to misconduct during the sale of Medicare products.

V. POLICY RECOMMENDATIONS

In our joint report with the Medicare Rights Center entitled "After the Gold Rush" we made several recommendations about the marketing of Medicare Advantage and Part D plans.[12] CMS has recently offered some proposals to address marketing abuses, but we believe that these measures do not go far enough to fix the entire range of marketing misconduct surrounding the sale of MA plans. More fundamental changes are required in order to adequately protect Medicare beneficiaries from fraud and misrepresentation.

[12] See: http://www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf

With respect to Private Fee-for-Service (PFFS) plans, which account for the majority of marketing misconduct that we are aware of, we believe that problems concerning these plans relate not only to their sale, but to their structure. In our recent testimony before the House Ways & Means Health Subcommittee, we made several recommendations specific to PFFS plans.[13] Most of these recommendations, though, are not addressed by CMS' recent new requirements. Perhaps most pressing, we urge Congress and CMS to carefully review the sale of PFFS plans to individuals dually eligible for Medicare and Medicaid.

- Unless PFFS plans can prove that they both provide meaningfully better and more comprehensive benefits than those currently available through state Medicaid programs and are accepted by a broad range of providers in a given service area (including physicians, hospitals, clinics, etc.), *we call for a ban on the sale of PFFS plans to dual eligibles.*

There are further steps CMS should take to combat marketing abuses. In addition to the recommendations contained in the text above, we ask CMS to implement the following:

- Mandatory agent training – CMS should require all MA plans (and PFFS sponsors in particular) to provide a standard curriculum with accompanying testing by an outside 3rd party. Minimum training should include an overview of Medicare and all types of products (MA, PDP, Medigap) and how Medicare interacts with other coverage such as Medicaid, retiree coverage, VA, etc. In addition, agents should

[13] CHA's written testimony is available at:
http://waysandmeans.house.gov/hearings.asp?formmode=view&id=5966 and
http://www.cahealthadvocates.org/advocacy/2007/CHA_WaysMeans_testimony_0522.html

be required to provide information to each prospective enrollee about how to reach their local SHIP program.

- Standardize and streamline the process through which plan enrollment and disenrollment disputes are handled, including Special Enrollment Periods (SEPs) and retroactive disenrollment requests. Absent a meaningful, standardized appeals process designed for these issues, resolution of beneficiary problems will remain inconsistent and incomplete.
- Public disclosure of corrective actions – when advocates file complaints with Medicare about plan conduct, the results of these complaints, if any, are rarely made available. In an effort to encourage Medicare beneficiaries to report bad plan conduct – and to deter plans from engaging in such conduct – CMS should make sanctions and other corrective plans/efforts it imposes on plans publicly available and easily accessible, including through their website.

Unless payment to Medicare Advantage is on par with the Original Medicare program, and commissions are more uniform, financial incentives will continue to contribute to abusive sales of these products. In addition, there are several ways in which the Medicare Advantage program in general can be improved to better serve enrollees. We offer the following broad recommendations:

- Product standards and simplification – we believe that MA and Part D plans should be standardized and simplified so that Medicare beneficiaries can make meaningful comparisons, and plans can be held accountable for providing adequate benefits. Among other things, standardization should include limits on out-of-pocket spending, and a requirement that MA plans charge no more cost-

sharing for services than what is charged under Original Medicare (e.g. inpatient and SNF stays, home health services, Part B drugs, DME, etc.)

- Apply the standardization and simplification requirements of the NAIC Medigap Model Act and Regulation to all Medicare Advantage and Part D plans, including:
    - Loss ratio standards to limit administrative costs and ensure adequate funds for medical care
    - Guaranteed renewability requirements to ensure stability of benefits
    - Suitability requirements to ensure the right set of benefits is sold to meet individuals' need
    - Required disclosures that include notice of availability of SHIP counseling
    - 30 day "free look" to allow time to examine plan documents and seek counseling
    - Replacement disclosure and standards to ensure that people understand differences between current benefits and replacement coverage
- State enforcement of marketing standards – all plans supposedly have protections in place, but marketing abuses continue; in addition, CMS has so far been lax in its oversight role of plans. Unless there is enforcement by state regulators that penalizes plans – instead of just agents – abuses will continue. States should be empowered to enforce marketing guidelines along the same lines as the Medigap Model.
- Commission standards – the current commission structure employed by plan sponsors creates an incentive to sell certain MA plans over PDP plans, regardless of whether it is the best option for an individual. Medicare should require plans to

adopt the concept of limiting replacement commissions to discourage inappropriate replacements (in other words, an agent should not get the same commission for selling a person a second PDP or MA plan versus the first time they enroll in one). Further, because enrollment in PFFS plans raise costs to Medicare, commission structures that create incentives for sale of PFFS plans over subsidized Medigap plans may bear scrutiny under anti-kickback and fraud and abuse statutes.

- Eliminate the lock-in provision – instead of restricting most beneficiaries to making plan choices to certain times of the year, we believe that all Medicare beneficiaries should be allowed to change plans on a monthly basis. Coupled with the recommendations we make above re: suitability standards and replacement commissions, this would allow enrollees to undo bad choices more easily.

VI. CONCLUSION

Although CMS and the insurance industry would like to blame Medicare Advantage marketing problems on a handful of insurance agents engaged in fraudulent activity – a "few bad apples" – the entire Medicare Advantage orchard is subject to rot as long as underlying structural problems continue to remain. Marketing abuses will continue unchecked unless: 1) plans are truly held accountable for the actions of those who sell their products; and 2) beneficiary protections outlined above are put into place. Congress and CMS must act to ensure that Medicare beneficiaries are able to access

timely and quality health care as well as make informed decisions – without undue influence – about how they wish to access their benefits through the Medicare program.

Thank you for the opportunity to provide these comments.

Mr. STUPAK. Thank you.

Ms. Healey for 5 minutes, please.

STATEMENT OF KATHLEEN HEALEY, DIRECTOR, STATE HEALTH INSURANCE ASSISTANCE PROGRAM, ALABAMA DEPARTMENT OF SENIOR SERVICES

Ms. HEALEY. Thank you, Chairman Stupak, Ranking Member Whitfield and members of the subcommittee for the opportunity to speak on the predatory sales practices in Medicare Advantage.

SHIPs are State-administered grant programs funded by CMS. SHIPs are housed in State Departments of Aging, Departments of Insurance and in one State, the Medicare Quality Improvement Organization. Nationally, SHIPs receive significantly less than $1 per beneficiary from CMS. SHIP is a volunteer-based program and we ask a lot of the volunteers who join us. The SHIP network is the only personalized community-based, systematic and established source of one-on-one Medicare beneficiary counseling in the United States. We must know all of Medicare from parts A, B, C and D, to coordination of benefits, Medigap, long-term care insurance, preventative benefits and Medicaid. Our services are free, unbiased and confidential.

Today's Medicare environment is very complex. The numerous and various options offered by private plans has exponentially increased the demand for SHIP services. These new products offered by private companies have presented a challenge for beneficiaries unused to a myriad of choices. It is not that people with Medicare are incapable of making a wise choice; it is that the system often prevents an informed choice. Unscrupulous agents seeking only a fast commission provide misleading information and utilize questionable sales tactics to encourage beneficiaries to sign-up for their plan. Let us look at some of the examples from Alabama that our clients from SHIP have experienced.

Despite the prohibition on door-to-door marketing, agents arrive on residents' doorsteps stating that the President sent them or that they represent Medicare. These agents bear business cards touting themselves as Medicare specialists, senior service specialists, not insurance agents.

Agents ask beneficiaries to show them their Medicare cards and if applicable their Medicaid cards to verify that the beneficiary is on Medicare. Later the beneficiaries find out they were enrolled in the plan without their knowledge. After a sales presentation agents ask beneficiaries to sign forms verifying that the agents have met with the beneficiaries or they ask beneficiaries to sign forms in order to receive their free gifts. What the beneficiaries are actually signing is the plan's Medicare Advantage application form. Agents repeatedly use red, white and blue business cards that look like miniature Medicare cards.

Telephone marketing has been equally aggressive. Repeated phone calls to beneficiaries have become increasingly threatening using scare tactics and misrepresentation. One plan called the same person five times in 1 day. Telemarketers have called beneficiaries stating that Medicare needs to send an agent to their homes to correct a mistake in the Medicare and You book that all beneficiaries receive. Telemarketers have told beneficiaries that

Medicare is going out of business or that Medicare is being turned over to the plan.

Agents will arrive early if they know that the beneficiaries have requested friends or relatives with them during the appointment. By the time of the appointment and the arrival of the trusted third party, the agents have already enrolled the beneficiaries and gone on their way. When beneficiaries learn that they deceptively enrolled in Medicare Advantage plans they try to sort out the challenges and problems on their own. Too often they discover it is not an easy problem to fix and they require assistance. SHIPs provide that needed help.

Deceptive marketing has a profound impact on a person's access to health care and well-being. CMS has told SHIPs on several occasions that the responsibility to fix the problem lies squarely with the Medicare Advantage plans. Consequently, SHIP contacts the plans. In some instances we must contact 1–800-Medicare as we piece together a case history. There are two main stumbling blocks which often stymie SHIP case resolutions efforts.

First, SHIP has no official, dedicated lines to plans or 1–800-Medicare numbers. Second, 1–800-Medicare refers directly to SHIPs. Each SHIP has seen an increase in case work volume. These cases are also increasingly complex and require an extraordinary amount of time to resolve. Mandatory access to plans and the necessity that these companies recognize SHIP and our efforts on behalf of beneficiaries would be one key to more efficiency in handling the complaints and problems we receive. However, that still doesn't address the fundamental marketing problems and processing delays that get the beneficiary in the pickle in the first place.

The most recent solutions presented by CMS and the State Departments of Insurance are a start, however, they are not the complete answer. It does no good to establish rules and regulations about what agents may or may not do or what type of marketing the plans may or may not undertake and not speak directly to the very population these plans and agents are targeting. There must be a prevention message about health insurance fraud aimed at Medicare beneficiaries. Medicare beneficiaries must know the red flags to look for and how they can protect themselves.

SHIP is ideally situated to deliver the insurance fraud prevention message to Medicare beneficiaries since we already have the infrastructure in place. However, SHIPs are severely under-funded and consequently under-resourced so it is difficult for many SHIPs to provide the proper tools to beneficiaries. The Alabama SHIP is in the process of developing an insurance fraud prevention campaign which includes tools that empower our seniors. However, we do not have adequate funding or resources to implement such a program. With less than a dollar per beneficiary for our entire program and more than 750,000 Medicare beneficiaries in our State alone our task is daunting. I urge you to support an increase in SHIP funding nationwide. Preventing the deceptive enrollment into Medicare Advantage plans including Private Fee-for-Service plans would greatly diminish the casework of SHIPs and CMS regional offices. Please help SHIP provide the tools to prevent Medicare beneficiaries from becoming victims and give State enforcement

agencies the teeth to bring both insurers and agents to task for fraudulent actions.

I want to thank the committee for holding this hearing. I have shared with you only a handful of examples they are not the only ones or even the most egregious. Rather, they are representative of the problems experienced by thousands of beneficiaries nationwide. I hope these experiences I have shared with you will help serve as a catalyst for the development of real solutions so Medicare beneficiaries may rest assured that their health care, whether it is original Medicare or Medicare Advantage, is truly their choice. Thank you.

[The prepared statement of Ms. Healey follows:]

TESTIMONY OF KATHLEEN HEALEY

Thank you, Chairman Stupak, Ranking Member Whitfield and members of the Subcommittee for the opportunity to speak on the predatory sales practices in Medicare Advantage and the challenges facing our Medicare beneficiaries and State Health Insurance Assistance Programs (SHIPs) throughout the United States.

State Health Insurance Assistance Programs (SHIPs) have been in existence for more than 15 years and are designed to help seniors and people with disabilities understand their health care coverage options. We are state-administered grant programs funded by the Centers for Medicare and Medicaid Services (CMS). SHIPs are housed in state Departments of Aging, Departments of Insurance and, in one state, the Medicare Quality Improvement Organization. Nationally, SHIPs receive significantly less than $1.00 per beneficiary. While some states receive state funding in addition to their Federal grant, many states rely solely on Federal funding.

SHIP is a volunteer-based program and we ask a lot of the volunteers who join us. Many programs operate with one or two staff members and rely on volunteers to educate, counsel, and assist Medicare beneficiaries in their community. The SHIP network is the only personalized, community-based, systematic and established source of one-on-one Medicare beneficiary counseling in the United States. We must know all of Medicare—from Parts A, B, C and D to coordination of benefits, Medigap, long-term care insurance, preventive benefits and Medicaid. Our services are free, unbiased and confidential. Our dedication is strong.

SHIPs respond on a community level to Medicare beneficiaries:

• SHIPs educate beneficiaries about Part D, the Medicare Prescription Drug benefit, and the extra financial help available through the Low Income Subsidy and Medicare Savings Programs.

• SHIPs help beneficiaries understand their Medicare benefits by explaining which services are covered under which part of Medicare.

• SHIPs help beneficiaries determine if a Medigap policy is good for them and explain the benefits of each policy.

• SHIPs help beneficiaries understand the various public and private long-term care financing options that are available.

• SHIPs help beneficiaries resolve disputes with Medicare or a private Medicare plan.

• SHIPs provide consistent, unbiased counsel for beneficiaries and their caregivers, often in times of crisis.

• SHIPs educate seniors, those with disabilities, caregivers, and providers of medical services on all aspects of Medicare.

In Alabama, our volunteers and staff have been interviewed on television and radio. We have been quoted in newspaper articles, newsletters and magazines. We are a trusted resource. Nationally, SHIP staff and volunteers have educated and counseled millions of people and have distributed hundreds of thousands of informational flyers and tip sheets at enrollment and educational events.

Wherever Medicare beneficiaries have gathered, SHIPs have been there. We make presentations to retirees and also visit senior centers, congregate housing sites, libraries and churches. We also make presentations to state and county provider groups. Over the past two years, with the implementation of Medicare Part D (drug benefit) and the rapid expansion of Medicare Advantage plans, SHIPs have educated beneficiaries and their caretakers, provided enrollment assistance, counseled and resolved problems encountered by beneficiaries. We continue to monitor ongoing issues that have not been resolved, and provide reassurance to beneficiaries that there is an entity they can turn to when they do not know where else to go. We

have worked with our CMS Regional Offices, hosted CMS Mobile Office Tour events, and implemented new CMS mandates. We have reached out to create partnerships to better serve Medicare beneficiaries and to reach hard-to-reach populations.

Medicare's environment today is very complex. The numerous and varied options offered by private plans has exponentially increased the demand for SHIP services. Demand has increased not just from Medicare beneficiaries and their families and caregivers, but also from health care providers and community leaders. SHIPs are the essential, local resource for seniors and people with disabilities.

The Advent of Medicare Advantage and Prescription Drug CoverageThese new products, from stand-alone prescription drug plans to Medicare Advantage plans offered by private companies, have presented a challenge for Medicare beneficiaries unaccustomed to myriad of choices. Never before have beneficiaries had to select from so many different plans offering various options and levels of coverage. Never before have they had so many independent agents, whether welcome or unwelcome, selling health insurance plans. It is a new experience for many of our clients and this opportunity for choice has also created significant challenges.

Many times SHIPs have said that having choices, especially with prescription drug coverage, can be a good thing. At the same time, SHIP staff and volunteers have warned Medicare beneficiaries to guard their information; to keep their Medicare card as safe as possible as they would their credit card or Social Security number. The warnings have been inadequate because unscrupulous agents continue to lure unsuspecting and ill-informed beneficiaries into plans they do not want nor necessarily need—especially if they are on both Medicare and Medicaid (also known as dual-eligible).

Keep in mind, Medicare Advantage products may provide good coverage for some beneficiaries. If a beneficiary makes an informed choice, has sufficient resources to cover co-payments and knows that his health care providers will accept it, private fee for service (PFFS) and other Medicare Advantage plans can work very well. It is not that people with Medicare are incapable of making a wise choice; it is that the system often prevents an informed choice. The choices available are not meaningful when Medicare beneficiaries do not understand how the plans are structured or how to discern true benefits from the flood of sales material coming their way. Unscrupulous agents, seeking only a fast, and high, commission, provide misleading information or utilize questionable sales tactics to encourage beneficiaries to sign up for their plan.

Medicare Advantage Marketing PracticesLet's look at some widespread examples from Alabama that our SHIP clients have experienced:

• Despite the prohibition of door-to-door marketing, agents arrive on residents' doorsteps stating that "the President" sent them or that they represent Medicare. These agents bear business cards touting themselves as "Medicare specialists" or "senior services specialists," not insurance agents.

• Agents ask beneficiaries to show them their Medicare cards and, if applicable, their Medicaid cards, to verify that the beneficiaries are on Medicare. Later, the beneficiaries find out they were enrolled in the plan without their knowledge. If they are dual-eligibles, the applications often state that the beneficiaries are not Medicaid recipients.

• Agents ask some beneficiaries, after an initial visit, to take them around their apartment building or neighborhood so the agent could visit and sign up their neighbors. These agents ask the beneficiaries to introduce them to friends and relatives who are Medicare beneficiaries and who may or may not live in the same neighborhood. In one situation, an agent told the residents of a senior residential apartment complex that Medicare and a specific PFFS company had assigned the agent to that apartment building and that no other company was supposed to be there.

• After a sales presentation, agents ask beneficiaries to sign forms merely verifying that the agents have met with beneficiaries or they ask beneficiaries to sign forms in order to receive "free" gifts. What the beneficiaries are actually signing is the plan's Medicare Advantage application form.

• Agents encourage beneficiaries to enroll in plans stating the beneficiaries would not pay anything for medical care and if they did not sign up, the beneficiaries would be penalized by Medicare. Not wanting this "penalty," the beneficiaries, who are often dual-eligible, enroll in the plans.

• Agents tell beneficiaries that the private fee for service (PFFS) plan they are offering is supplemental insurance.

• One agent continued to visit a building where he enrolled many of the residents. When residents complained to the agent about receiving bills for co-payments from their health care providers, the agent took the bills and said that he would straight-

en them out with the plan and call the beneficiaries back. They did not hear from him again and the unpaid bills were turned over to collection agencies.

• Agents have repeatedly used red, white and blue business cards that look like miniature Medicare cards.

• Telephone marketing has been equally aggressive. Repeated phone calls to beneficiaries have become increasingly threatening, using scare tactics and misrepresentation. One plan called the same person five times in one day. Telemarketers have called beneficiaries stating that Medicare needs to send an agent to their homes to correct a mistake in the Medicare and You handbook that all beneficiaries receive. Some telemarketers insist that they are calling from Medicare and they tell beneficiaries that they will lose their Medicare if they do not sign up for the telemarketer's plan. Telemarketers have told beneficiaries they have the plan that the government won't tell beneficiaries about and it could save beneficiaries money. Telemarketers have told beneficiaries that Medicare is going out of business or that Medicare is being turned over to the plan.

• Agents will arrive early if they know that the beneficiaries have requested friends or relatives to be with them during the appointment. By the time of the appointment, and the arrival of a trusted third party, the agents have already enrolled the beneficiaries and gone on their way.

In many instances, beneficiaries do not even realize they are no longer enrolled in Original Medicare. Beneficiaries learn of their enrollment into Medicare Advantage plans when a health care provider refuses to see them because the provider does not accept the terms and conditions of the new plan—most often a private fee for service (PFFS) plan—the provider is out of the plan's network, or the beneficiary begins to receive bills from providers for unpaid services or co-payments.

When beneficiaries learn that they have been deceptively enrolled in Medicare Advantage plans, they try to sort out the challenges and problems on their own. Too often they discover that it is not an easy problem to fix and that they require assistance. SHIPs provide that needed help. Deceptive marketing has a profound impact on a person's access to health care and well-being. The best way to have a clear picture of the problem is to have the rest of the story—the before and after the misrepresentation or deception by the agent:

Example 1: Ms. J is a 61-year-old disabled woman. She has had both Medicare and Medicaid (a dual-eligible) for several years. In January 2007, she went to her local pharmacy for assistance in finding a Part D plan. Her pharmacist signed her up with Company D's prescription drug plan. Several months later, an agent with Company D came to her home and asked her if she would like to sign up for free supplemental insurance since she did not have any. He also told her that by signing up she would not lose any of her current benefits and she would receive additional coverage that Medicare does not provide.

In May 2007, she went to her family doctor and discovered that she was no longer covered by Original Medicare and that her doctor did not take Company D's private fee for service (PFFS) plan. She contacted Social Security and was given the number for SHIP.

SHIP discovered that Ms. J was not enrolled in the Part D plan that could save her the most money, so we changed her drug coverage plan to something that would work better for her. At the same time, we also faxed and mailed a request for her to be disenrolled from Company D's private fee for service plan.

Example 2: Ms. F is an 80-year-old widow. She has been on Original Medicare with Company X's Medigap policy providing her with supplemental insurance. Ms. F takes care of Ms. G who is her 55-year-old disabled daughter. Ms. G has been a full dual-eligible (which means she has both Medicaid and Medicaid) for many years. Ms. F chose Company X's prescription drug plan (PDP) for herself and her daughter in January 2007. In February 2007, an agent from Company X came to her home and asked her if she would like to make her life easy by having her and her daughter's medical coverage simplified by having Company X serve as their supplemental insurance. She explained that her daughter had Medicare and Medicaid; therefore, she did not need supplemental insurance. The agent countered this by saying she would get extra benefits for her and her daughter at no additional cost and that their current benefits would not be affected. Ms. F then enrolled herself and her daughter into Company Xs plan—a private fee for service (PFFS) plan.

Two months later, Ms. F took her daughter to see her specialist. When they arrived, Ms. F was asked to make a co-payment. When she inquired why (because they had never paid one before), she was told that her daughter no longer had Medicare and Medicaid. Ms. F went home and contacted the agent who sold her the plan and was told that she could not get out of the plan. Ms. F contacted SHIP. Our office contacted Company X and was told she could disenroll. We then faxed and mailed a request for Ms. G and Ms. F to be disenrolled from the plan.

Example 3: Mrs. H and Mr. I are in their seventies. Both have been on Original Medicare for years and have a supplemental insurance policy (a Medigap) with Company M. In March 2007, Mrs. H received a call from Company B's agent inquiring about her supplemental coverage. He wanted to know how expensive the coverage was. Mrs. H told him that it was rather expensive and that she was concerned because it was going up every year. He then asked if he could come by and talk to her and her husband about a supplemental plan with his company that was not expensive. Once the agent arrived, he told them they were eligible for a free supplement to Medicare through his company. Mrs. H inquired about the cost that they would have to pay up front to see their doctor and was told that they would only have to pay a $10 co-payment and that they could drop their policy with Company M.

Two days after enrolling in the plan, Mrs. H and Mr. I went to their local senior center and heard a presentation given by the SHIP coordinator on Medicare Advantage. It was not until they heard the presentation that they realized the agent had given them misleading information.

After leaving the senior center, Mrs. H went home and contacted the plan and asked if she and her husband could be disenrolled. She was told they could not. She contacted SHIP. We sent a request to be disenrolled for Mrs. H and Mr. I. They were successfully disenrolled on May 1, 2007.

Example 4: Ms. C is disabled. She has been a dual-eligible, having both Medicare and Medicaid, for many years. She has suffered from seven strokes and is required to see numerous specialists. In January 2006, she was auto-enrolled in Company A's prescription drug plan (PDP). In April 2006, she was suddenly disenrolled from Company A because she had been auto-enrolled into five other prescription drug plans, all of which began to cancel each other out.

In May 2006, Ms. C was not enrolled in a PDP and she had to pay for her medications without any help. One day in May 2006, she was shopping with her parents at a retail store and saw a Company A agent. She asked the agent if he could sign her up for the stand-alone prescription drug plan (PDP) she first had in January 2006; however, the agent, knowing she was receiving Medicaid benefits, signed her up for Company A's private fee for service (PFFS) plan even though she repeatedly told him she only wanted drug coverage.

After Ms. C enrolled with what she thought was Company A's PDP, she received a card from Company B, another company. Company B paid for her prescriptions until August 2006. Company B was cancelled in August because Company A (the plan into which she was enrolled in May) reflected on the Medicare system in August. Ms. C decided it was best to contact CMS about her problems. CMS filed a complaint on her behalf.

Meanwhile, she began receiving calls and bills from her physicians as a result of unpaid medical bills. Ms. C was shocked because she was under the assumption that Medicare and Medicaid were still paying her bills. She had no idea that Company A was supposed to be paying. When she tried to get her physicians to file with Company A, she discovered that they did not accept Company A. Ms. C contacted CMS again because she had over $900,000 in unpaid medical bills. CMS forced Company A to pay the unpaid bills and to process her disenrollment from its plan.

Unfortunately for Ms. C, she began receiving collection letters from Company A because of unpaid premiums. The premium was over $33 per month. Her income was $643 per month. Ms. C contacted Company A and the collection agency because she did not think she should have to pay for the plan since she never asked for it. Both Company A and the collection agency told her that there was nothing she could do but pay the bill. Ms. C began to send regular payments of whatever amount she could afford. The collection attempts still continued, only stronger.

Ms. C found out about the SHIP program and contacted our office. We have worked with Ms. C to stop the collection efforts and to have the premiums written off by Company A. In late June 2007, we received a letter stating that the plan would not seek payment for the premiums.

These are just some of the examples of how the marketing practices impact Medicare beneficiaries and impede their access to health care. We send complaints to the CMS Regional Office when we need a retroactive disenrollment and to provide examples of what we are seeing at the local level.

CMS has told SHIPs on several occasions that the responsibility to resolve problems lies squarely with Medicare Advantage plans. Consequently, SHIPs contact the plans. In some instances, we must also contact 1–800-MEDICARE as we piece together a case history.

There are two main stumbling blocks which often stymie SHIP case resolution efforts:

1. SHIP has no official, dedicated lines to plans or 1–800-MEDICARSHIPs have had to be resourceful to serve the beneficiaries. With no "named" plan contacts from CMS nor required dedicated phone lines for SHIPs to utilize in case resolution for plans or 1–800-MEDICARE, state SHIPs have developed workable solutions to get the job done. We find our own contacts at plans. When we run into issues where the "scripts" used by the customer service representatives with the plans and with Medicare are incorrect or miss the point, we muscle our way up the chain of command to find someone who can solve the problem. We try not to refer cases to the CMS Regional Offices if we can solve them ourselves because we know of the backlogs and time delays that can result. These time delays often cause additional issues as beneficiaries hesitate to seek necessary medical care, unsure of their health insurance coverage.

2. 1–800-MEDICAR refers directly to SHIPsThroughout the existence of Medicare Advantage and Part D, SHIPs have consistently experienced Customer Service Representatives (CSR) at 1–800-Medicare referring beneficiaries to SHIPs for assistance. The CSRs follow scripts for the calls. It is not unusual to have a SHIP counselor or even a SHIP director or program staff member contact 1–800-MEDICAR for assistance only to be referred back to the state SHIP.

Each SHIP has seen an increase in casework volume. These cases are also increasingly complex and require an extraordinary amount of time to resolve. However, we have been doing the best we can given our limited Federal funding and staff resources. Mandatory access to plans and the necessity that these companies recognize SHIP and our efforts on behalf of beneficiaries would be one key to more efficiency in handling the complaints and problems we receive. After all, access is critical to handling cases in a timely fashion. That still does not address fundamental marketing problems and processing delays that get the beneficiary in the pickle in the first place.

Are the solutions proposed by CMS to address predatory marketing practices enough?The most recent solutions presented by CMS and the state Departments of Insurance are a start, however, they are not the complete answer. Yes, a State Department of Insurance can pass regulations that would require each insurance agent to leave a business card with the beneficiary. And yes, they could also require agents to identify themselves as insurance agents and inform the person that they are representing a product, not Medicare or Medicare supplements. And, if they violate these provisions and other marketing guidelines, these agents could be subject to discipline. As you know, CMS will be requiring more of the plans beginning in 2008.

Is the problem real? In a recent press release CMS has stated that it has received only 2,700 complaints nationwide, a relatively minimal number. It is my impression that not all cases are being reported. For example, SHIPs do not refer all cases to CMS. We handle them ourselves. Additionally, from my involvement with elder abuse and legal assistance with our agency, I have learned that for all the elder abuse cases that are reported, there are just as many or more that go unreported. Perhaps a better gauge is the number of Medicare Advantage disenrollment requests that have been filed.

Beneficiaries must receive information on how to prevent becoming a victim of unscrupulous marketing practicesCMS has taken steps in the right direction by announcing some new corrective actions. However, CMS has failed to mention the prevention message that must be delivered to Medicare beneficiaries. It does no good to establish rules and regulations about what agents may or may not do, or what type of marketing the plans may or may not undertake, and not speak directly to the very population these plans and agents are targeting. How would a beneficiary know that they should be very suspicious of an insurance agent who comes to his or her door unannounced and without an appointment?

There must be a prevention message—not about health care—about health insurance fraud aimed at Medicare beneficiaries. Medicare beneficiaries must know the red flags to look for and how they can protect themselves. A comprehensive media campaign with a simple message would be a start.

SHIP is ideally situated to deliver the insurance fraud prevention message to Medicare beneficiaries since we already have the infrastructure in place. I have seen it work in Alabama. Our SHIP has been able to educate beneficiaries and those who have heard the message have been empowered. For example, an agent attended a senior center when the director was absent hoping to make a sales presentation and enroll attendees. Unfortunately for the agent, the seniors had also been taught by SHIP what questions to ask agents and how the PDPs and Medicare Advantage plans work. The seniors were able to determine fact from fiction and literally ran the agent out of the building.

However, SHIPs are severely under-funded and consequently under-resourced so it is difficult for many SHIPs to provide the proper tools to beneficiaries. An adequately funded, comprehensive educational and media campaign with a unified message aimed at beneficiaries would achieve dramatic results. The campaign could arm Medicare beneficiaries with the information they need to protect themselves from unscrupulous insurance companies and their agents.

The Alabama SHIP is in the process of developing an insurance fraud prevention campaign which includes tools that will empower our seniors. However, we do not have adequate funding or resources to implement such a program. With less than a dollar per beneficiary for our entire program and more than 750,000 Medicare beneficiaries in our state alone, our task is daunting. Developing the media campaign and printing and disseminating these materials to the target population is expensive. I urge you to support an increase in SHIP funding nationwide.

Preventing the deceptive enrollment into Medicare Advantage plans, particularly private fee for service (PFFS) plans, would greatly diminish the casework of SHIPs and CMS Regional Offices. Please help SHIPs provide the tools to prevent Medicare beneficiaries from becoming victims and give state enforcement agencies the teeth to bring both insurers and agents to task for unscrupulous and/or fraudulent actions.

I want to thank the Committee for holding this hearing. I have shared with you only a handful of examples; they are not the only ones, or even the most egregious. Rather, they are representative of the problems experienced by thousands of beneficiaries nationwide. I hope the experiences I have shared with you will help serve as a catalyst for the development of real solutions so Medicare beneficiaries may rest assured that their health care—whether it is Original Medicare or Medicare Advantage—is truly their choice.

Mr. STUPAK. Thank you.

Mr. Harrell, deputy commissioner of Mississippi Insurance Department, your opening statement, please, sir.

STATEMENT OF LEE HARRELL, DEPUTY COMMISSIONER, MISSISSIPPI INSURANCE DEPARTYMENT

Mr. HARRELL. I appreciate the chairman for allowing us to come speak. I am Lee Harrell, deputy commissioner of insurance for the State of Mississippi and on behalf of commissioner of insurance George Dale. We appreciate the opportunity to share with you the experiences we have had in Mississippi related to Medicare Advantage plans.

I am not here to demonize CMS or the plan sponsors but we want to walk through what we are seeing in Mississippi and it is going to be typical of what you are going to hear today from your other witnesses, I believe. You will hear about problems today, there are a lot of problems in the Advantage program. We don't need to get into a blame game but we need to work together to find a solution to protect our senior citizens.

Aside from the specific unfair misleading and the fraudulent marketing practices that are in my written testimony that you have heard today, we have also seen other general problems with agents who sell these plans. Agents being hired to sell only during the open enrollment periods, these agents get licensed around the first of October, sell through December, than let their license lapse until the following year, in other words the equivalent of seasonal help. By far the biggest problem is lack of sufficient training of agents. One of the companies who touts the best training of its agents gives 10 hours of instructional training all in one sitting.

The biggest problem we are seeing in making a case against agents alone is the fact that the primary witnesses are often elderly persons who because of their age or physical condition may be-

come easily confused or simply cannot accurately remember the sequence of events. Even if they are able to provide the department with clear and accurate information about the tactics used by the agent, by the time the matter gets to a hearing their memories may not be as clear. Also, many elderly victims are not able or are unwilling to attend a hearing and sometimes they are simply too embarrassed to even report that they have been a victim.

Some of these specific types of complaints we have received in Mississippi are door-to-door solicitation or cold calls by agents without having been invited by a Medicare recipient to do so. Agents claiming to be from Medicare and sometimes presenting a red, white and blue card designed to look like a Medicare card. The agent has a recipient complete a request for more information form which turns out to be an application for a Medicare Advantage plan. The agent asks a recipient to sign a form just to show my boss that I have contacted you, which again turns out to be an application form. The agent assures the recipient that enrollment in this plan would not affect the recipient's Medicare coverage without mentioning that the recipient may not be able to go to the same health care provider or other facility. And that he may be required to pay a co-pay. Recipients being enrolled without their knowledge without having any contact with the agent, it is believed that recipient's personal information was fraudulently obtained and that does not mention the problems of having the recipient victim disenrolled or un-enrolled in the plans they were improperly enrolled in.

Our Department of Insurance has obtained the licenses of two agents involved in Medicare scams. The first license was revoked on a finding that the agent retained recipient's personal information from a home health agency. The recipients were enrolled in a plan without their knowledge or consent. There was also evidence in that case where the mother of the daughter was bedridden and unable to write or communicate but according to the agent she signed the form to sign-up in the Advantage program. That agent has been indicted in Mississippi for these allegations.

One of the agents was revoked for door-to-door solicitation of Medicare Advantage plan in two low-income housing areas. As a result of that the Department of Insurance sent a team of lawyers and investigators into the complex to interview the victims. Some of them were afraid to talk to us because they did not know who they could trust. We were able to obtain 21 affidavits. Some of the people who did not take affidavits based on their mental condition. At the 11th hour prior to the hearing the attorney for the agent subpoenaed all 21 victims and was going to make them travel 150 miles to Jackson, Mississippi to testify.

We were in the process of investigating a third agent for similar practices when that agent surrendered his license. From 2006 to the present, the Mississippi Department of Insurance received over a thousand complaints on Medicare Advantage plans alone in part because we are the people they know. They are not familiar with CMS and they are not generally going to call a stranger in Atlanta, Georgia when their insurance commissioner is right there at home. These complaints represent at least twice as many complaints as we normally receive on all other topics combined. We speak to sen-

ior groups across the State about these practices and how can they avoid the problems. Mississippi takes seriously its duty to protect its consumers while promoting a healthy insurance market. But the way the current Medicare Advantage system is designed we are precluded from fully meeting that duty. Clearly, the piecemeal approach to enforcement is not working nor is it realistic to expect that it will. We suggest as a regulatory model the current system for regulating Medigap insurance, which is the States enforce Federal minimum standards. If you don't think there is a problem I urge you to contact your respective insurance department or more important go out to the senior citizen groups in your respective States and talk to them, ask them. I think someone said somewhat earlier that these are our parents, our grandparents and our aunts and uncles. We have to find a way to protect the senior citizens. I appreciate you allowing me to testify today.

[The prepared statement of Mr. Harrell follows:]

TESTIMONY OF LEE HARRELL, DEPUTY COMMISSIONER OF INSURANCE, STATE OF MISSISSIPPI, PRESENTED TO UNITED STATES HOUSE OF REPRESENTATIVES, COMMITTEE ON ENERGY AND COMMERCE

PREDATORY MARKETING PRACTICES AND ENFORCEMENT ISSUES RELATED TO MEDICARE ADVANTAGE PLANS

My name is Lee Harrell, Deputy Commissioner of Insurance for the State of Mississippi, and on behalf of Commissioner George Dale and myself, we appreciate the opportunity to share with you the experiences we have had related to Medicare Advantage Plans in Mississippi.

Typically, an insurance company wishing to do business in Mississippi will apply for a Mississippi license. This requires the submission of various information related to the financial condition of the company; approval of the products to be sold and the forms to be used related to said products, including advertising materials; and the approval of the rates to be charged for such products. After a company is licensed, the Department of Insurance (hereinafter "Department"), continues to monitor the company's financial and market conduct activities, including a company's marketing practices, through examinations, the filing of various required reports, investigation of complaints, and the like.

Additionally, the company is required to file for a "certificate of authority" for each agent hired to sell any of the company's products. This lets the Department know which agents are selling for what company, serving the twofold purpose of: 1) confirming that the agent is actually authorized to act for a given company; and 2) confirming that the company is responsible for both the product sold and the means by which such product is marketed by its agents. It has always been this Department's position that the company is responsible for its agents through these certificates of authority, and that the companies can therefore be held accountable for the actions of its agents.

In the case of Medicare Advantage Plans, the regulation of the companies selling such plans is left primarily to CMS, and the states are preempted, except in the areas of licensing and solvency, from regulating Medicare Advantage products. Further, the companies are not required to file for certificates of authority for the agents selling these plans, so the Department has no idea which agents are selling for any given company unless or until a complaint is filed against one of those agents.

Aside from the specific unfair, misleading, and/or fraudulent marketing practices which will be discussed below, we have seen many general problems with the agents who sell these plans, including, but not limited to:

1) Agents being hired to sell only during the "open enrollment" periods. These agents get licensed around the first of October, sell through December, then let their licenses lapse until the following year. In other words, the equivalent of "seasonal help."

2) As a result of the above practice, there is little loyalty to the company or the product. Agents can, and frequently do, move from company to company, with little or no oversight; e.g., they may be fired by a company, or think they can get a better deal, so they move to another company. Similarly, if too many complaints are registered in a given geographic area, these agents simply concentrate their efforts elsewhere.

3) By far the biggest problem is lack of sufficient training of agents. The company who touts the "best" training of its agents gives 10 hours of instruction – all in one sitting. Some agents in the "zero premium" counties (areas for which no additional premium, beyond the existing Part B premium, is charged) believe

> that all they are selling is an add-on to a person's existing Medicare coverage, giving them dental and vision care. There is no appreciation or understanding of the fact that the person will no longer be enrolled in traditional Medicare Parts A and B, but that the coverage provided, while generally the same as that provided by Medicare, will now be provided through a private insurer. Some agents also do not understand that there may be co-pays required where there were none before. Many insureds who are accustomed to going to the doctor, showing their Medicare card, getting their treatment, then going about their business, are surprised to learn that either their doctor does not accept the particular Medicare Advantage Plan, or that they will have to pay out-of-pocket for the co-pay before they can be treated.

Even though the states have very limited jurisdiction over the companies selling Medicare Advantage products, most, including Mississippi, have taken the position that they do have jurisdiction over the agents themselves. This position is not without its limitations. First, there is a potential legal question as to whether or not a state has jurisdiction over an agent's conduct in relation to an underlying product over which that state has no jurisdiction whatsoever. While Mississippi's position is that it does have authority over a licensed agent selling any type of insurance in our state, there remains at least the hint of uncertainty as to our enforcement ability.

The biggest problem in making a case against the agent alone is the fact that the primary witnesses are often elderly persons who, because of their age or physical condition, may become easily confused, or simply cannot accurately remember the sequence of events. Even if they are able to provide the Department with clear and adequate information about the tactics used by an

agent, by the time the matter gets to hearing their memories may not be as clear. Also, many elderly victims are unable or unwilling to attend a hearing, and sometimes they are simply too embarrassed to even report that they have been a victim.

In a usual case, if the Department saw a pattern of agent misconduct such as we have seen in the Medicare Advantage market, not only would the agent(s) be subjected to disciplinary action, but the companies themselves would be noticed to appear before the Department. This leads back to the original assertion that the company is responsible for the acts of its agents. As alluded to above, many of these agents have no real stake in the products they are selling. It may simply be a part-time, time-limited job for them, or they know they can go elsewhere should trouble arise. On the other hand, the companies who have contracted to sell Medicare Advantage products do have a very real interest in complying with CMS's marketing standards, and they are usually willing to correct any problems on a more or less voluntary basis.

The specific types of complaints we have received include:

1. Door-to-door solicitation (or "cold calls") by agents without having been invited by a Medicare recipient to do so.

2. Agents claiming to be from Medicare and sometimes presenting a red, white, and blue card designed to look like a Medicare card.

3. The agent has the recipient complete a "request for more information" form, which turns out to be an application for a Medicare Advantage Plan.

4. The agent asks the recipient to sign a form "just to show my boss that I have contacted you," which, again, turns out to be an application form.

5. The agent assures the recipient that enrollment in his Plan will not affect the recipient's Medicare coverage, without mentioning that the recipient may not be able to

go to his same health care provider/facility and/or that he may now be required to pay a co-pay.

6. Recipients being enrolled without their knowledge and without having had any contact with an agent. It is believed that the recipients' personal information was fraudulently obtained and used without their knowledge.

7. Recipients who have been improperly enrolled in a Plan find it very difficult to become disenrolled from the Medicare Advantage Plan and re-enrolled into Parts A and B. If premiums were deducted from the recipient's Social Security check, there is an extremely long delay in having those payments stopped, with payments sometimes continuing to be deducted after the recipient has been disenrolled from a given Plan.

I have attached a copy of a letter from Commissioner Dale to Senator Thad Cochran, and which was sent to the entire Mississippi delegation, which sets out the above scenarios, as well as others, in more detail.

To date, Mississippi has obtained the licenses of two agents in relation to Medicare Advantage sales. The first license was revoked upon a finding that the agent had obtained recipients' personal information from a home health agency. These recipients were enrolled in a Medicare Advantage Plan without their knowledge or consent. In this case, the Department was able to garner the testimony of a participant in the scheme. There was also evidence from a mother whose daughter was bedridden and unable to write or communicate, but yet who was enrolled in a Medicare Advantage Plan. The agent has also been indicted for these actions.

The second agent was charged with door-to-door solicitation of a Medicare Advantage Plan in two low-income housing projects for senior citizens. This case highlights the evidentiary problems inherent in these cases. As part of the investigation, lawyers and an investigator from

the Department interviewed numerous residents of the complexes (though some were afraid to talk to us because they did not know whom they could trust). We were able to obtain approximately 21 affidavits, including two from family members who stated their relatives were not competent enough to understand what they had done. Several affidavits were not taken, because of the mental state, or memory, of the recipient. At the eleventh hour, the attorney for the agent sought to subpoena all 21 affiants and force them to travel 150 miles to Jackson, Mississippi to testify. Further, several affiants, who were competent at the time their affidavits were taken, had deteriorated to the point that their testimony would have been essentially ineffective.

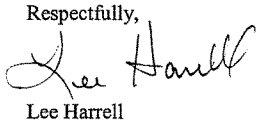
We were in the process of investigating a third agent for similar door-to-door solicitation, when that agent surrendered his license on other grounds.

From 2006 through the present, we have received over 1,000 complaints on Medicare Advantage Plans, alone, in part, because we are who the people know. They are not familiar with CMS, and are generally not going to call a stranger in Atlanta, Georgia, when their Insurance Commissioner is right here at home. These complaints represent at least twice as many complaints as we normally receive on all other topics combined. To the best of our ability, we investigate the complaints received, and bring charges in those cases where we have enough solid evidence. We work closely with our Mississippi Department of Human Services, who helps recipients disenroll from plans into which they were improperly enrolled, and helps them re-enroll into Parts A and B. We have issued several press releases warning recipients of the various scenarios used by these agents (copies attached), and we speak to senior groups across the state about these practices and how they can avoid problems. We are developing a brochure

with tips about questions to ask, what to watch out for, and the like, that will be made available to consumers in the near future.

Mississippi takes seriously its duty to protect its consumers, while promoting a healthy insurance market, but the way the current Medicare Advantage system is designed, we are precluded from fully meeting that duty. Clearly, the piecemeal approach to enforcement is not working, nor is it realistic to expect that it will. We suggest as a regulatory model the current system for regulating Medigap insurance, in which the states enforce federal minimum standards. This system has virtually eliminated the abusive Medigap sales and marketing practices that were rampant in the nineteen eighties and early nineteen nineties. As noted in the attached letter to Mississippi's congressional delegation, we stand ready and willing to lend support to Congress as you consider these critical issues facing our senior citizens.

Respectfully,



Lee Harrell
Deputy Commissioner of Insurance
State of Mississippi

GEORGE DALE
Commissioner of Insurance
State Fire Marshal

LEE HARRELL
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May 11, 2007

ALSO VIA FACSIMILE: 202.224.9450

Honorable Thad Cochran
United States Senate
113 Dirksen Senate Office Building
Washington, D.C. 20510-2402

Re: Abusive Medicare Practices

Dear Thad:

As you may know, the Mississippi Department of Insurance ("Department") has been inundated with complaints from senior citizens and their family members concerning Medicare-related Part C and D Plans. These Plans have been marketed to seniors in Mississippi during designated open enrollment periods for approximately two years. I would estimate that the Department has received approximately 1000 complaint calls from seniors expressing confusion and serious concerns regarding these Plans.

Some complain that they have been enrolled in a Part C and/or D Plan without fully understanding the particular Plan's terms, while others assert they were enrolled without their knowledge or consent. Many complaints deal specifically with improper marketing practices by producers. We have also received complaints regarding a lack of access to care and the failure of medical providers to recognize or accept Part C Plans.

Particular scenarios actually encountered by the Department include the following:

(1) The producer engages in door-to-door solicitations or outreach prior to being invited by a Medicare recipient, which is directly prohibited under federal Medicare rules.

(2) The producer actually claims to be a representative from Medicare, and presents a red, white and blue card to the Medicare recipient that looks like a recipient's card.

(3) The producer has the agent complete a "request for more information" form, when in fact, the form is an enrollment form for whatever Part C or D plan the producer is selling.

(4) The producer asks the Medicare recipient to sign a form "just to show my boss that I have contacted you."

(5) The producer assures the Medicare recipient that enrollment in a Part C Plan will not affect his/her Medicare coverage. While this may be true of some portion of Medicare plans, the Department has found that the recipient no longer receives benefits under the traditional Medicare Part A and B framework, which is extremely confusing to recipients.

(6) In a particularly serious case, the Department found that several recipients had no knowledge of being enrolled in a Medicare Part C Plan, and had never had any contact at all with the producers responsible for enrolling them. It is believed that the recipients' personal information was obtained fraudulently, and was used on the plan enrollment forms.

(7) Having enrolled in a Part C Private Fee For Service Plan, the Medicare recipient receives medical care from his/her treating physician, but is told that the physician does not accept assignment from Part C Plans. The recipient is then required to pay the bill up front, and otherwise has difficulty in locating alternative providers who will recognize Part C Plans.

(8) Having been improperly enrolled in a Medicare Part C Plan, many Medicare recipients have found it extremely difficult to get disenrolled from the Part C Plan and re-enrolled in Medicare Parts A and B. This can be even more treacherous where the recipient's part C premiums were being deducted from his/her social security check. In such cases, we have seen instances where the recipient was disenrolled from Part C, has not been re-enrolled in parts A and B, but is still having Part C premiums deducted from the social security check.

Members of my staff have worked diligently with the Centers For Medicare & Medicaid Services and with Colonel Don Taylor, Executive Director of the Mississippi Department of Human Services, to assist Seniors and educate them regarding these problems, but as you know, state regulators have very limited jurisdiction over the Medicare Program in general, and over Part C and D Plans specifically. Primary jurisdiction over all facets of the Medicare Program rests primarily with the federal government. While I and my staff want to continue doing all we can to be of assistance, given the current regulatory structure for Medicare, we must look to our Congressional leaders for an effective and comprehensive solution to the problems outlined above.

I stand ready and willing to lend support to you and members of your staff as you consider these critical issues facing our senior citizens.

Sincerely,

George Dale
Commissioner of Insurance

GEORGE DALE
Commissioner of Insurance
State Fire Marshal

LEE HARRELL
Deputy Commissioner

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Mississippi Insurance Department

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FOR IMMEDIATE RELEASE
George Dale, Commissioner of Insurance/State Fire Marshal
Mississippi Insurance Department
Jackson, Mississippi
Wednesday, April 11, 2007
For additional information, please contact
Donna J. Cromeans, Public Relations Director 601-359-3569

ABUSIVE MEDICARE INSURANCE SALES PRACTICES SPREADING THROUGHOUT STATE

Seniors Urged to be Vigilant in Selecting Program

(Jackson)-Commissioner George Dale today announced that the Mississippi Insurance Department (MID) is joining State Senator Terry Burton (Lauderdale, Newton, Scott Counties) and Colonel Don Taylor and the Mississippi Department of Human Services (MDHS) in alerting Mississippi's senior citizens to be aware that abusive sales practices relating to Medicare Insurance, first reported late last year, are spreading rapidly throughout the state.

According to complaints, some Medicare recipients are being enrolled in these plans without fully understanding their terms, and in some cases, without even knowing they have been enrolled. All Medicare recipients and their family members are urged to be vigilant when selecting a Medicare Part C or Part D plan, and if an agent uses abusive sales practices, to contact the MID immediately.

"My office is receiving calls daily from seniors who have been victims. It is unacceptable to have these individuals preying on some of the most vulnerable citizens in the state. I want people to know that the exploitation of our senior citizens by these unscrupulous sales people and the companies that condone such exploitation will not be tolerated. Every effort will be made to stop those practices and protect our seniors," said Senator Burton.

Although the Medicare Program is under federal regulation, Commissioner Dale is concerned with reports that some agents are continuing to use a variety of confusing and deceptive sales practices to sell Medicare- related Part C and D Plans.

"From the calls we continue to receive we're learning that the problem we first recognized in the northern part of the state is now spreading further and further south. We are finding that some individuals preying on our state's seniors and senior oriented communities are using tactics that are confusing and downright deceptive and it must be stopped. Abusive sales practices will not be tolerated by this department. Anyone engaging in such practices will be subject to severe regulatory action by the MID, such as suspension or revocation of a license and/or a fine," said Commissioner Dale.

The Commissioner is quick to point out that these plans could be beneficial to some people and not all agents are engaging in these deceptive practices. However, he did note that the MID, working with state and local law enforcement, has successfully revoked the license of one agent and have a number of others under investigation.

Companies offering Medicare plans are subject, under federal regulation, to strict marketing guidelines for such plans, which include prior approval of marketing material. MID will consider any deviation from or violation of federal Medicare Marketing Guidelines to also be a violation of the Mississippi Insurance Code.

Among the abusive Medicare Part C and D practices being reported are door-to-door solicitations. Conducting a door-to-door solicitation or outreach prior to being invited by a Medicare recipient is prohibited. If someone comes to your door without you having invited them, do not let them into your home. Also, do not give that person any information about yourself or let him or her see any of your personal documents. Especially do not sign anything for that person.

"The Mississippi Insurance Counseling and Assistance Program (MICAP) of MDHS's Division of Aging and Adult Services, is designed to answer seniors' questions about health insurance. Our volunteers are trained to answer questions, compare policies, organize paperwork, help with claims and filing appeals on Medicare, Medicaid, supplemental insurance and other coverage. I would strongly encourage any senior with questions to contact one of the 10 Area Agencies on Aging offices throughout the state," said Colonel Don Taylor, Executive Director of MDHS.

Anyone who suspects they have been the victim of abusive Medicare Insurance sales practices is urged to contact MID as soon as possible at 1-800-562-2957. For any other questions regarding Medicare Part C and D policies, they should contact MDHS at 1-800-948-3090.

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SCENARIOS USED IN ABUSIVE MEDICARE PART C AND D SALES PRACTICES

A number of scenarios are currently being reported to the Mississippi Insurance Department (MID) as being in use by these agents. Commissioner George Dale urges all Medicare recipients that if you find yourself in a similar scenario, such as the ones described below, a red flag should go up and you should contact the MID immediately. Scenarios that are proving to be of particular favorites to the agents using abusive sales practices include:

1). The agent will actually claim to be from Medicare. In many instances, the agent will present a red, white, and blue card that looks like a Medicare recipient's card.

2). The agent will have the Medicare recipient fill out a "request for more information," form, when in fact the "request" form is actually an enrollment form for whatever Part C or D plan the agent is selling.

3). The agent will ask the Medicare recipient to sign a form "just to show [my] boss" the agent contacted the recipient.

4). The agent assures the Medicare recipient that enrollment will not affect his/her Medicare coverage. While this may be true of some portion of Medicare plans, MID is finding that the recipient no longer receives benefits under traditional Medicare Part A and B policies. Often the recipient discovers this fact when a health care provider informs them that Medicare has declined to pay a charge.

5). The agent tells the Medicare recipient that enrollment in the plan he or she is selling will not cost anything. Nothing is free. The agent receives a commission from the sale and premiums will be collected from policyholders.

6). In a particularly serious case, MID found that several recipients had no knowledge of being enrolled in a Medicare Part C plan, and had never had any contact at all with the agent responsible for enrolling them. It is believed that the recipient's personal information was obtained fraudulently, and was used on the plan enrollment forms.

GEORGE DALE
Commissioner of Insurance
State Fire Marshal

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Deputy Commissioner

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FOR IMMEDIATE RELEASE
George Dale, Commissioner of Insurance/State Fire Marshal
Mississippi Insurance Department
Jackson, Mississippi
Tuesday, December 19, 2006
For additional information, please contact
Donna J. Cromeans, Public Relations Director 601-359-3569

DALE ALERTS MISSISSIPPI SENIORS OF MEDICARE SCAMS

(Jackson)-Commissioner of Insurance George Dale today cautioned Mississippi senior citizens that, according to complaints received by the Mississippi Insurance Department (MID), some agents are using a variety of confusing and deceptive sales practices to sell Medicare-related Part C and D plans. According to the complaints, some Medicare recipients are being enrolled in these plans without fully understanding their terms, and in some cases, without even knowing they have been enrolled.

Dale urged all Medicare recipients and their family members to be vigilant when selecting a Medicare Part C or Part D plan and if an agent uses abusive sales practices, to contact the Mississippi Insurance Department immediately. He also reassured all Medicare recipients that the MID is working closely with state and local law enforcement agencies to identify and locate agents and companies using abusive sales practices. The investigations have already resulted in the revocation of the license of one agent, while a number of other investigations are on-going.

"While there are many good agents who provide a valuable service, some are taking advantage of our seniors and other Medicare recipients, preying on some of the most vulnerable citizens in our state. These citizens are particularly susceptible to abusive sales practices. This Department is mindful of how confusing and difficult it must be for the many Mississippi Medicare Part C and D recipients trying to select a plan from the various coverages that are offered. Abusive sales practices will not be tolerated by this department. Anyone engaging in such practices will be subject to severe regulatory action by the MID, such as suspension or revocation of a license and/or a fine," said Dale.

Companies offering Medicare plans are subject primarily to federal regulation. In particular, there are strict marketing guidelines for such plans, which include prior approval of marketing material. MID will consider any deviation from or violation of federal Medicare Marketing Guidelines to also be a violation of the Mississippi Insurance code.

Among the abusive Medicare Part C and D practices being reported to the MID are door-to-door solicitations. Conducting a door-to-door solicitation or outreach prior to being invited by a Medicare recipient is prohibited. If someone comes to your door without you having invited them, do not let them into your home. Also, do not give that person any information about

yourself or let him or her see any of your personal documents. Especially do not sign anything for that person. Contact MID immediately or have a family member do so.

"The number of calls we receive is growing daily. We are finding that some individuals preying on our state's seniors and senior oriented communities are using tactics that are confusing and downright deceptive and it must be stopped," Dale said. Dale is quick to point out, however, that these plans could be beneficial to some people, and not all agents are engaging in these deceptive practices.

Anyone who suspects they have been the victim of one of these Medicare scams is urged to contact MID as soon as possible at 1-800-562-2957.

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SCENARIOS USED IN ABUSIVE MEDICARE PART C AND D SALES PRACTICES

A number of scenarios are currently being reported to the Mississippi Insurance Department (MID) as being in use by these agents. Commissioner George Dale urges all Medicare recipients that if you find yourself in a similar scenario, such as the ones described below, a red flag should go up and you should contact the MID immediately. Scenarios that are proving to be of particular favorites to the agents using abusive sales practices include:

1). The agent will actually claim to be from Medicare. In many instances, the agent will present a red, white, and blue card that looks like a Medicare recipient's card.

2). The agent will have the Medicare recipient fill out a "request for more information," form, when in fact the "request" form is actually an enrollment form for whatever Part C or D plan the agent is selling.

3). The agent will ask the Medicare recipient to sign a form "just to show [my] boss" the agent contacted the recipient.

4). The agent assures the Medicare recipient that enrollment will not affect his/her Medicare coverage. While this may be true of some portion of Medicare plans, MID is finding that the recipient has been completely disenrolled from Medicare Part A and B. Often the recipient discovers this fact when a health care provider informs them that Medicare has declined to pay a charge.

5). The agent tells the Medicare recipient that enrollment in the plan he or she is selling will not cost anything. Nothing is free. The agent receives a commission from the sale and premiums will be collected from policy holders.

6). In a particularly serious case, MID found that several recipients had no knowledge of being enrolled in a Medicare Part C plan, and had never had any contact at all with the agent responsible for enrolling them. It is believed that the recipient's personal information was obtained fraudulently, and was used on the plan enrollment forms.

Mr. STUPAK. Thank you for your testimony.

Ms. Clegg-Boodram, on behalf of your residents there at Judiciary House, care to state a few words?

STATEMENT OF BRENDA CLEGG-BOODRAM, JUDICIARY HOUSE, ACCOMPANIED BY MARY ROYAL, GRADY HAMMONDS, EDITH WILLIAMS, AND JENNIFER MEZEY, SUPERVISING ATTORNEY, LEGAL AID SOCIETY OF THE DISTRICT OF COLUMBIA

Ms. CLEGG-BOODRAM. Good morning.

Mr. STUPAK. Good morning.

Ms. CLEGG-BOODRAM. My name is Brenda Clegg-Boodram. I live at Judiciary House which is a DC housing authority property for seniors and disabled people of low income. I am accompanied by Grady Hammonds, Edith Williams and Mary Royal. We all are residents in the Judiciary House which is located in Chinatown section of Washington, DC. Our population is deemed independent living. I volunteer as the acting president and treasurer for the resident counsel which acts as a liaison between DC housing and other social service organizations.

The Judiciary House is as I said a housing authority property which provides low-income housing to the most vulnerable population in the city. The elderly and disabled tenants do not and many times cannot understand paperwork. Although the tenants are deemed capable of independent living in reality for much of this population this is not true.

I was approached in late January 2007 by two gentlemen who identified themselves as having good news about Medicare Part C. At this point I was not aware that they were selling insurance. Initially I thought they worked with Medicare. Darnell Keys and T.C. were sent to my office by the property manager's office. They advised me that they had information about Medicare. They proceeded to explain that Medicare had recently approved part C which was specifically for eyes, dental and hearing. And as I understood them this would be in addition to Medicare Part A, B and D.

They asked me when could they do an educational presentation to my tenants and advised that they would provide the posters. I advised that I had already had the Legal Aid Society lawyers to assist my tenants with their health care and their prescription coverage. They advised that they understood and they told me that they were not dealing with part D for prescription coverage.

I felt confident that these men understood and I treated them like any other health outreach. I provided them with a date and about a week later they gave me the posters. At this point they did give me some paperwork about Coventry and I again reminded them that Legal Aid had already reviewed and assisted my participating tenants for appropriate insurance and prescription coverage. I posted the posters but I did not read the information about Coventry.

I arranged for them to do their presentation at two of our tenant meetings. One meeting took place in the resident council office and the other in the community room. I was not ever told that they were selling insurance or that they intended to change my tenants' health coverage. It was my understanding that they were going to

add Medicare Part C to their current coverage. They did two presentations in the month of February 2007. About 3 or 4 weeks later Mary Royal came to me and advised that her coverage was changed. Then Grady Hammonds, Edith Williams and there were other tenants who complained. They could not get their medications and that their physicians and hospitals did not accept and/or know about this insurance company and calling customer service did not help.

Please note, this incident created a health crisis for our witness Ms. Edith Williams, who has MS and had to be treated by an emergency room visit and subsequently she had to pay cash for her medications because they had changed her Medicare Part D drug coverage. She did not have all the money and over a period of 2 weeks or more she suffered physically and she had to scrape-up money for her meds.

I contacted Jennifer Mezey, supervising attorney of the Legal Aid Society of the District of Columbia. Attorney Mezey helped Mary Royal, Grady Hammonds and Edith Williams with their dis-enrollment. I know that there are other tenants in my building who need the assistance of Ms. Mezey to dis-enroll but they are unable to ask for help and they are still suffering.

I believe that there is a lack of responsible coverage of care for seniors, mental, emotional and sometimes the physically disabled. And I feel that there should be measures taken to prevent these types of incidents from occurring.

This statement is also a question, where is the accountability? Who makes sure that the population who can least afford these types of mistakes are protected? I know of individuals in other States who are having similar problems so this is not a local but rather a national problem. We barely survived the Medicare Part D problems and, in fact, there are citizens who are unable to advocate for themselves who do not understand and are stuck with inadequate health care and prescription coverage as a result of part D. We seriously need more checks and balances written into the regulations.

I really think that this is not just a rogue salesman problem and I think that you guys who create these programs fail in the detail aspect of these programs and you need to look at it seriously because you are hurting the people who can't help themselves and some of these people worked for you guys in the service industry. We all can't be rich or famous or whatever. We do these little jobs like cleaning and all of that so detail really makes a difference and the salesmen are not the only ones who are responsible and I thank you for the privilege of making this statement.

[The prepared statement of Ms. Clegg-Boodram follows:]

Witness Statement of Judiciary House Tenants

Introduction

My name is Brenda Clegg-Boodram. I live at Judiciary House which is a DC Housing Authority Property for Senior and Disabled People of Low Income. I am accompanied by Grady Hammond, Edith Williams, and Mary Royal. We all are residents in the Judiciary House which is located in China Town of Washington, D.C.

Background Information

Our population is "deemed" independent living. I volunteer as the Acting President and Treasurer for the Resident Council which acts as a liaison between DC Housing and other social service organizations.

The Judiciary House is a Housing Authority property which provides low income housing to the most vulnerable population in the city. The elderly and disabled tenants do not and many times can not understand paperwork. Although the tenants are deemed "capable of independent living" in reality for much of this population, this is not true.

I was approached in late January 2007 by two gentlemen who identified themselves as having good news about Medicare Part C. At this point, I was not aware that they were selling insurance. Initially, I thought they worked with Medicare.

Darnell Keyes and T.C. (Coventry), was sent to my office by the property manager's office. They advised me that they had information about Medicare. They proceeded to explain that Medicare had recently approved Part C which was specifically for Eyes, Dental and Hearing. And as I understood them, this would be in addition, to Medicare Part A, B, and D.

They asked me when could they do an educational presentation to my tenants and advised that they would provide the posters. I advised that I already had the Legal Aid Society Lawyers to assist my tenants with their Healthcare and their Prescription coverage. They advised that they understood and they told me that they were not dealing with Part D for prescription coverage.

I felt confident that these men understood and I treated them like any other health outreach. I provided them with a date and about a week later they gave me the posters. At this point, they did give me some paperwork about Coventry and I again reminded them that Legal Aid had already reviewed and assisted my participating tenants for appropriate insurance and prescription coverage. I posted the posters but, I did not read the information about Coventry.

The Consequences

I arranged for them to do their presentation at two of our tenant meetings. One meeting took place in the Resident Council Office and one meeting took place in our Community Room. I was not ever told that they were selling health insurance or that they intended to change my tenants' health coverage. It was my understanding that they were going to add Medicare Part C to their current coverage.

They did two presentations in the month of February 2007. About three to four weeks later, Mary Royal came to me and advised that her coverage was changed. Then Grady Hammond, Edith Williams, and there were other tenants who complained that they could not get their medications and that their physicians and hospitals did not accept and/or know about this insurance company and calling customer service did not help.

Please Note: This incident created a health crisis for our witness Ms. Edith Williams who has Multiple Sclerosis and had to be treated by an Emergency Room and subsequently she had to pay cash for her medications because they changed her Medicare Part D Drug Coverage. She did not have all of the money and over a period of a week or more she suffered physically and she had to scrape up the money for her medication.

I contacted Jennifer Mezey, Supervising Attorney of the Legal Aid Society of the District of Columbia. Attorney Jennifer Mezey helped Mary Royal, Mr. Grady Hammond, and Edith Williams to disenroll. I know that there are other tenants in my building who needed the assistance of Ms. Mezey to disenroll but they are unable to ask for help and they are still suffering ...

I believe that there is a lack of responsible coverage of care for the seniors, mental, emotional, and sometimes the physically disabled and I feel that there should be measures taken to prevent these types of incidents from occurring.

Conclusion

This statement is also a question ... where is the accountability? Who makes sure/certain that the population who can least afford these types of mistakes are protected? I know of individuals in other states who are having similar problems so this is not a local problem but a national problem.

We barely survived the Medicare Part D problems and in fact, there are citizens who are unable to advocate for themselves who do not understand and are stuck with inadequate healthcare and prescription coverage as a result of the Part D. We seriously need more checks and balances written into the regulations.

Mr. STUPAK. Thank you.

Now that concludes the opening statements of the opening panel here so we will move to questions, we will go for 5 minutes. I will begin.

Ms. Clegg-Boodram, let me ask you this question. You indicated in your testimony you said there are still residents of Judiciary House then you said unable to ask for help to dis-enroll in this Medicare Advantage. Explain that.

Ms. CLEGG-BOODRAM. Because we are a "multi-function community" the disabled refers to people who are mentally-challenged and intellectually challenged and they know something is wrong because when they go to the doctor or all of a sudden their personal care assistant disappears or they go to the pharmacy things are not working. But because of the Privacy Act and many other issues I can't just arbitrarily snatch them and say you need my help and you have got to sit down. Allow me to allow Legal Aid to help you through this. And they will come and you will talk to them and you have to be very patient. There is a whole bunch of stuff that you guys have no clue about.

Mr. STUPAK. That is why we are having this hearing.

Ms. CLEGG-BOODRAM. Right.

Mr. STUPAK. Try to get a clue.

Ms. CLEGG-BOODRAM. I hope you can because it is very serious.

Mr. STUPAK. I agree.

Ms. Healey, is there a SHIP program in Washington, DC or do we rely strictly on Ms. Mezey and Legal Aid?

Ms. HEALEY. There is a SHIP program in DC, yes.

Mr. STUPAK. Ms. Mezey, so you work with SHIP then over here in DC to get these folks dis-enrolled?

Ms. MEZEY. We work with the SHIP program. We collaborate with them but Legal Aid also does this work on our own.

Mr. STUPAK. OK. Very good.

Mr. Harrell, and in your testimony was this—is this the type of problem you have seen in Mississippi? You said you have over a thousand complaints, this, what we see at Judiciary House, is this common and found in Mississippi, also?

Mr. HARRELL. The problem is—the gentleman from the, Mr., I am not going to attempt to pronounce his name, from California, [Mr. Lipshutz's] problems sound very similar to Mississippi's problems and I don't think you can get any more different than California and Mississippi. So that the problems are going to be systematic across the country deemed by other insurance regulators across there. The problems are the same using the business cards, misrepresenting, forging people's names, so it is not a Mississippi problem. It is a national problem from one State to the next, I think the problems are the same.

Mr. STUPAK. Then I guess the point I was trying to ask you, I know you mentioned door-to-door and salesmen, and going to senior housing and you encouraged us to check with our senior groups to see if they are having the problems. I guess the point I am trying to get at is, Ms. Clegg-Boodram said, they do not know how to dis-enroll or how to correct the problem, or unable to ask for help. Do you see that with the people you, as the insurance commissioner you represent?

Mr. HARRELL. Yes, sir. They are not familiar with the program. They do not know who to call and for an example I have got one here that did contact the actually, the gentleman that the lady's brother, and for example on one day he called Humana, stayed on the phone for an hour and a half. Calls the next day, hour and a half, the next day an hour, on and on and on. One day he stayed on the phone from 10:30 to 5:15 on hold. Never spoke to a person. It said hold please when he would call—just on and on for looks like 10 or 12 days. The most time he stayed on hold was 10:30 to 5:15.

So most of them do not know who to ask, most of them, and a lot of them are embarrassed to go ask because they have been taken advantage of and they do not, like I said, they do not know what CMS is. Mississippi has an elected commissioner and that is who they call. And we are not able, due to the jurisdictional limitations, we are not able to give them the help that they deserve and need.

Mr. STUPAK. You indicated that there is a 2-month window period here where these agents come out and they get 10 hours of training and basically what, October to December, is the enrollment period or December to February is the enrollment period, whatever you said. Do those so-called agents who get the 10 hours worth of training, do they become insurance agents, licensed in Mississippi or are they temporary and do not need a license?

Mr. HARRELL. They are a temporary license. They come in and sell, well they do not have a temporary license, they have a real license but they only sell for those 2 to 3 months, then they go back to wherever they came from and they may go to another State. They may go to sell maybe some other product. We do not know where they go, we just see examples of a lot of agents allowing their licenses to lapse and then come back the next year.

Mr. STUPAK. OK. Ms. Healey, when Commissioner Harrell mentioned about this person being on hold from 10:15 to 5:30, you indicated about numbers, direct numbers, the 800 number. Is this what you are trying to express to the committee?

Ms. HEALEY. Exactly. The SHIPs have to call the same number of the plan and 1–800-Medicare so we go through the same process. Even though we have all the information that we need to and we just need to get the plan to do what we need them to do, we are on hold just as long as everybody else.

Mr. STUPAK. OK. Mr. Lipschutz, what recommendations would you make to ensure these abuses that we have heard of this morning actually stop? I know there are guidelines but the guidelines are just simply that, guidelines. There is no enforcement. There is no accountability. You do not have to follow a guideline, right, if you do not wish to, what would you recommend? What would you like this committee to see done?

Mr. LIPSCHUTZ. Our recommendations would range from the specific, including mandatory agent training with the standard curriculum and testing. It would include standardizing appeals processes, including retroactive dis-enrollment and securing special enrollment periods through the Medicare Program, as well as broader recommendations such as achieving payment parity between Medicare Advantage and the original Medicare Program, which we be-

lieve would minimize some of the incentives that are currently driving plans, to neutralize the commission structure, and to rely upon many of the protections that are contained in the Medigap rules that apply to the sale of Medigap products that include insuring that products are suitable for beneficiaries before they are sold, insuring that beneficiaries—or that commissions for sales—are not higher when someone duplicates coverage that they already have or switches out coverage with comparable coverage. So our recommendations, I will refer you to our written testimony for our specific recommendations concerning CMS' new requirements. Again, they are helpful but we have a lot of outstanding questions about how far they will really go to stop the abuses.

Mr. STUPAK. OK. My time is expired.

Mr. Whitfield, for questions, we may go around more than once here with Members because of a very interesting panel. Thank everybody on this panel for being here. Mr. Whitfield.

Mr. WHITFIELD. Thank you. Ms. Clegg-Boodram, how many people actually live in, is it Judiciary House, and what is the total number of people that live there?

Ms. CLEGG-BOODRAM. Judiciary House is a 10-story building with essentially 271 units. Currently, they claim we have about 192 occupied units.

Mr. WHITFIELD. But it is an independent living facility?

Ms. CLEGG-BOODRAM. That is what they say, yes. And some of us are independent.

Mr. WHITFIELD. But there are some people who live there that are not able——

Ms. CLEGG-BOODRAM. Fifty-five percent of my population.

Mr. WHITFIELD. And what is your responsibility there?

Ms. CLEGG-BOODRAM. I am on the resident council. It is a volunteer position. And so essentially I connect them with services when they come and ask.

Mr. WHITFIELD. So Ms. Mezey, you are the attorney for these groups of residents that were defrauded. Is that right?

Mr. MEZEY. Legal Aid in November and December of last year, had come out to Judiciary House to help people with their Medicare Part D enrollment. To make sure they were in appropriate prescription drug plans. After these people had come to Judiciary House and Ms. Clegg-Boodram realized that people had signed-up and wanted to get out, she called me and then we helped them to dis-enroll from the plans.

Mr. WHITFIELD. OK. So they had signed up for Medicare Advantage Program but they had no idea of what that really was.

Ms. MEZEY. Right. As Ms. Clegg-Boodram said during, in February, there were two sessions.

Where the residents signed-up for plans and then when they realized that they did not want to be in these plans anymore we helped them get out of them.

Mr. WHITFIELD. But there also is a DC health insurance assistance program, correct?

Ms. MEZEY. Correct. There is a SHIP here the same way as Ms. Healey's counterpart in DC, and they have also helped a lot of people get out of these plans as well.

Mr. WHITFIELD. So, Ms. Boodram, when, Ms. Clegg-Boodram, when salesmen come to you, you would frequently call Ms. Mezey, and then would you call the health insurance assistance program as well to ask for their thoughts on it or anything like that?

Ms. CLEGG-BOODRAM. No, unfortunately, the health insurance whatever program is not widely publicized. A lot of this information is not available. And my question is to you, sir, is why doesn't CMS do an educational component?

Mr. WHITFIELD. Yes.

Ms. CLEGG-BOODRAM. So that we really understand what the different parts of Medicare or an agent——

Mr. WHITFIELD. So you were not even aware that there was a DC health insurance program.

Ms. CLEGG-BOODRAM. No. I called Legal Aid because I realized there was a problem. There was a contact I have at GW, George Washington University Medical Center.

Mike, who helped me out through some of the part D problems but in the long run I had to call lawyers because I really could not do it.

Mr. WHITFIELD. And, Ms. Mezey, were any legal steps taken against the salesmen who convinced these people to sign-up without their being fully aware of what they were doing?

Ms. MEZEY. We have been focusing at this point, we are mainly focused on getting people out of the plans, which we were able to do through our CMS regional office. And helping Ms. Williams get her prescription drugs, which were cut-off, through these efforts. And as far as I know, to my knowledge, nothing has happened to the salespeople.

Mr. WHITFIELD. Yes. Now, Mr. Harrell, you are with the insurance commission in Mississippi, correct?

Mr. HARRELL. Yes, sir.

Mr. WHITFIELD. So if a person is licensed to sell insurance in Mississippi and they use fraudulent practices, you all have the authority to take their license, would that be correct or not?

Mr. HARRELL. That is in question now. You have the license that the State of Mississippi would issue, but the underlying product, Medicare Advantage, is not something the State of Mississippi regulates. Attorney general lawyers have raised that as an issue for the Department of Insurance, as to how are you taking action against an agent for a product that you do not have any jurisdiction over, period.

Mr. WHITFIELD. So there is a legal question of whether or not you have any jurisdiction, is that correct?

Mr. HARRELL. The department maintains the position that we do, and we have taken licenses and we have multiple open investigations ongoing as we speak.

Mr. WHITFIELD. Ms. Healey, what about in Alabama, has this issue been discussed in Alabama, the authority that Alabama has to take a license?

Ms. HEALEY. Well, I am housed in the Department of Senior Services. We are working with our Department of Insurance but I would defer that question to our Department of Insurance.

Mr. WHITFIELD. Now, Mr. Lipschutz, your organization in California is that a private entity or is that a governmental entity or——

Mr. LIPSCHUTZ. We are independent, private non-profit agency. So we are not funded by the SHIP program and we do not administer them but we work closely with them.

Mr. WHITFIELD. Ms. Healey, I was curious of people who sign-up for Medicare each year, they become eligible to sign up. Do you have any idea what percent would come to your agency for assistance in selecting the right plan?

Ms. HEALEY. I would be giving an estimate but in the information in the Welcome to Medicare packet that CMS sends to the beneficiary, they do have a list of the SHIPs called in the materials.

We do get quite a few beneficiaries aging into Medicare but I do not know the percentage.

Mr. WHITFIELD. OK. My time has expired.

Mr. STUPAK. And thank you. Mr. Burgess for questions.

Mr. BURGESS. Thank you, Mr. Chairman. This is not going to be a question but a statement to you, Mr. Chairman. Are we going to hear at some point from the Inspector General of Health and Human Services? Are we going to hear from the appropriate people at the Department of Justice to find out what is happening with the people who are apparently guilty of malfeasance in the sale of these products? This sounds to me like Medicare fraud, Mr. Chairman. This hearing is all well and good but it seems like this should be pursued at a different level than simply an oversight hearing.

Mr. STUPAK. Well, unfortunately, in the bad piece of legislation that was passed, the standardization of policies, the regulations of insurance agents and that which we usually find in the Medigap and Medicare Supplementals were stricken for at least a couple years under part D here it is more of a State issue there so——

Mr. BURGESS. Well, reclaiming my time, I have an article here from the New York Times dated May 7, 2007, and it talks about individuals who are being signed-up who are deceased. Does anyone on the panel have any direct knowledge of a deceased person being signed-up for one of these plans?

Mr. STUPAK. Congressman, I have read media reports about it.

Mr. BURGESS. Well, again, I would just ask the question, signing-up a deceased person for a Medicare plan sounds to me like Medicare fraud and I am not a lawyer, I am just a simple country doctor but I would think that that would fall into that purview and I do not see how you can suspend the investigation and the prosecution of somebody who is guilty for Medicare fraud simply by passing a statute, even if it was us who passed it.

Mr. STUPAK. I will give the gentleman his time back but that is really consumer fraud. It is not a Federal fraud case to do that.

Mr. BURGESS. I beg to differ. As a practicing physician, if I was guilty of Medicare fraud I was going to jail, and it was Attorney General Janet Reno who made that very clear back in 1990.

Mr. STUPAK. Right. But the way this program was written and that is why it was such a controversial program when it was put forth, the dual-eligibles and the others, the standard frauds that we see as you as a doctor with the Federal Government is much different underneath this legislation and that is why we have the

State insurance commissioners and State folks here because they really have the consumer protection. Unfortunately, it is lacking at the Federal effort and I will be glad to join you in trying to tighten that loophole.

Mr. BURGESS. Well, let me just ask Mr. Harrell then because it was always my understanding in my home State of Texas that when the insurance commissioner had the ultimate trump card. They could pull the license of someone to sell insurance in the State and then you told Mr. Whitfield that you do not think you have that authority in this situation?

Mr. HARRELL. That was an issue that was raised by our attorney general lawyers. It is an issue that is out there. The Department of Insurance still believes that we have the legal jurisdiction over yanking, as you called it, the agent's license. And we would make a referral if we determined if or thought there were criminal activities.

Mr. BURGESS. Well, and I would encourage you to do so and I would hope you would do so if that is indeed the case. Ms. Clegg, let me just ask you, I know when Medicare Part D first started, my office, you are correct, there were some problems and my office was aware of the problems we had in our area. I took each of those problems on as individual casework, if the person who was calling and complaining was willing to sign the appropriate formwork to allow me to intercede on their behalf. I know Washington, DC has a delegate, not a representative, but did you contact your delegate's office? Did you get the delegate's office involved in the individual casework when these problems started to come to light? You alluded that you had some problems with some of the privacy restrictions that prevented you from getting too deeply into a person's medical care and I appreciate that. Obviously, privacy laws are something that we continue to strengthen up here and that is always going to be an issue, but if the person was willing to sign a release at the delegate's office and let their delegate intercede with CMS directly on their behalf, did that happen at Judiciary Center?

Ms. CLEGG-BOODRAM. No, we did do an approach to the delegate's office but we did not get a response. So I just kept moving until I could find someone to help us.

Mr. BURGESS. Well, again anyone has the right to petition their member for help and we were pretty aggressive about it because the pharmacist, some of which I knew from my previous professional life, were not at all shy about calling me and faxing me and telling me the problems they were having so we did take a very aggressive stance and CMS to their credit would deal with those. And I would just offer that as—if you continue to have problems, please, do not overlook that as an avenue because my experience I found that to be a pretty powerful way to intercede on someone's behalf and from again, maybe our experience was different. I have not had the experience that has been discussed here today and to the best of my knowledge it has not come up as a constituent issue back in the district office, but you can bet I will be checking on it later on today. I think the individual Member of Congress' office does have some ability to help dis-enroll, with the dis-enrollment process and working through some of these problems and if we are the ones who caused it then, as has been alleged, then certainly we

are the ones who should be on the front lines of solving it. Just as we have dealt with the passport issue here recently. Thank you, Mr. Chairman, for your indulgence. I will yield back.

Mr. STUPAK. Thank you, Mr. Burgess.

Ms. CLEGG-BOODRAM. May I speak?

Mr. STUPAK. I have to go to Mr. Murphy. I think we are going to go another round. I am certainly going to give you an opportunity and your residents if they want to say a few words.

Mr. Murphy, 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman. I want to ask a couple of folks, maybe Ms. Williams, you can help me with this. I am trying to get a sense of how you were presented information on these plans. So, for example, when someone was talking to you about purchasing a Medicare Advantage plan, I am correct there, that is what someone offered you, right? Did they offer a comparison for example of Medicare Advantage or something else, do you remember?

Ms. WILLIAMS. Well, if I can answer this correctly. First, I was having trouble with another insurance company. OK. And when I heard about Advantage and what they had to offer and I went with them because I thought it was better then I found out that it wasn't what I thought it was. When they interviewed me I gave them my Medicaid and Medicare card. I asked them would I need this and they said no, I didn't need that anymore, that I would be covered with them.

Mr. MURPHY. Can you, and this is really helpful and thank you so much, if you could try and recall to the best of your ability did they mention specifically what the Medicare Advantage plan would cover that the Medicare and Medicaid wouldn't cover?

Ms. WILLIAMS. They said that it would cover dental, eye, eye doctor and something else and I asked them what about my medicine? And they said that is why I didn't need the Medicaid and Medicare because they would cover it.

Mr. MURPHY. So dental, eye and medicine, and then when you started with your Medicare Advantage plan did you find that they did or did not cover dental and eye and medicine?

Ms. WILLIAMS. Well, I didn't take it that far to find out.

Mr. MURPHY. OK.

Ms. WILLIAMS. Only as far as my medicine, I got sick.

Mr. MURPHY. I appreciate it. I am trying to find out. I am so sorry this happened to you.

Ms. MEZEY. Congressman, can I explain what happened to Ms. Williams?

Mr. MURPHY. Yes.

Ms. MEZEY. OK. Ms. Williams was previously in a Medicare Advantage plan that also had prescription drug coverage. So when Ms. Williams signed-up with the Advantra Freedom plan which did not have drug coverage and this was not made clear to her, she was in the hospital, she came out of the hospital and had to take steroids and antibiotics and those drugs were not covered.

Mr. MURPHY. And I am trying to find out all of these elements and thank you, it helps me to know this, Ms. Williams, and I am sorry this is upsetting for her. I am trying to understand what these folks said to you and it really helps us a lot to know that.

Is there anybody else who can give us information in terms of the kind of information that was said on these sales pitches in particular? Ms. Royal, could you let us know a couple things?

Ms. ROYAL. Yes. I was the first person who informed Brenda about the problems I was having. I had to go to the hospital for a procedure. They had me down there as Medicare HMO. I said I have regular Medicare and Medicaid. And so I could not get my procedure done and so when I got home that evening I had got the card from Advantage before I got any other information and it said doctor co-payment $10, emergency room $50, and so I had called customer service. I said I can't afford to pay $10 for each doctor's appointment that I have I said because I go to the doctor sometimes four times in a month. And so she said well the reason I enter us in it, she said well you can write us a letter and stating that I no longer have to be in the program.

So I said what about my Medicare and Medicaid? She said I would no longer have Medicaid and Medicare . That would be discontinued and I would their insurance. I said well I don't want your insurance I said because I prefer to have my Medicaid and Medicare because it said that I may not have the same doctor and be able to go to the same hospital. I said well I have about five different doctors. I said I cannot afford to try and find another doctor to train him and I said and have different hospital because I went to Providence [Hospital]. Providence told me that they did not carry that type of insurance.

Mr. MURPHY. And just to be clear, and this is all what a salesperson was telling you with Medicare?

Ms. ROYAL. They told me that they didn't even mention that I had to change doctors.

Mr. MURPHY. OK.

Ms. ROYAL. They didn't say that.

Mr. MURPHY. That was never told to you——

Ms. ROYAL. Medicaid would take care of my eyes, my dental and ears, nose and throat, which Medicare do not handle. But I get all of that from my Medicare and my Medicaid.

Mr. MURPHY. OK. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you. A few more questions here for you.

Ms. ROYAL. Oh, excuse me, I did have to show them my Medicaid and my Medicare card.

Mr. STUPAK. Ms. Healey, Ms. Royal was just talking about Medicare and Medicaid and underneath the MMA Act of 2005 the dual-eligibles are no longer, it doesn't exist. Would you explain that a little bit the dual-eligibles and how it is underneath the new program because there is so much confusion out there and if you would explain that.

Ms. HEALEY. The dual-eligibles? There are several different types of dual-eligibles. If you have Medicare and you may have what is called a qualified Medicare beneficiary where your co-pays and your co-insurance would be taken care of, the next level would be what is called a SLMB, Specified Medicare Low, I believe the acronym is wrong, and then QIs, and each one is a different level but the QMBs are the full duals and that is where Medicare and Medicaid covers most of their cost, all of their costs actually.

Mr. STUPAK. I guess the point I was trying to make and it is easy for us to ramble off those acronyms but for people like Ms. Royal and others it is very, very difficult and they don't understand the changes that took place in 2005, therefore, their coverage is much different then what it was before.

Mr. Harrell, Mr. Burgess and I were talking a little bit about it, about the law and the agents. You indicated you have jurisdiction over the agents but do you have jurisdiction over the policies that are being presented in your State of Mississippi or is that a subject still open to interpretation?

Mr. HARRELL. The position is that we don't have jurisdiction over the product itself which would be the policies' marketing.

Mr. STUPAK. Just the agents then?

Mr. HARRELL. Yes, sir.

Mr. STUPAK. Mr. Lipschutz, you indicated that one of the things we have to do is to commission structure, take a closer look at the commission structure. I get the impression that Medicare Advantage are profit-driven policies?

Mr. LIPSCHUTZ. Well, they are profit-driven policies for the companies but they also try to maximize enrollment into their plans by using commission structures that tend to pay more in commissions for enrollment into Medicare Advantage plans than other plans and it is not uncommon for plans to pay three, four, five, six times as much in commissions, each commission in a Medicare Advantage plan than they pay for a standard——

Mr. STUPAK. Give me an example of a commission for a Medicare Advantage plan versus a different plan.

Mr. LIPSCHUTZ. Well, one example would be say a company that offers both a stand alone part D prescription drug product and a Medicare Advantage plan will typically offer say $50 for each enrollment into a stand-alone part D product and it will offer $250 or more for each enrollment into a Medicare Advantage product. That creates an incentive on the part of the agent to steer people towards those Medicare Advantage products regardless of whether or not that is actually the best option for an individual.

Mr. STUPAK. What responsibility, we talked a little bit about agents here and their fees and commissions, but what responsibility does the insurance carrier itself, the parent company, have? Here are two people like Ms. Royal and Ms. Williams and Mr. Hammonds, and others.

Mr. LIPSCHUTZ. It is my understanding that the companies are free to set their own commission structures. A CMS marketing guideline says that companies can set commission structures commensurate with the level of involvement that is entailed when trying to describe a product to an individual. So in theory the Medicare Advantage product is more complex than the stand-alone part D product the company can pay more or a greater commission. But there are no standards that require an agent to actually explain the additional complexity of a particular plan. It is my understanding that it's a CMS position that they do not have the ability to regulate commissions that are paid to insurance agents.

Mr. STUPAK. And have you or Mr. Harrell or Ms. Healey, have you—gone back to the insurance carriers, the parent company and say look what your agents are doing? You have a responsibility

here if not legal at least moral and ethical to make sure that your policies are being presented accurately to individuals. Have you contacted anyone like that?

Mr. LIPSCHUTZ. We have contacted some companies and some companies have contacted us in response to complaints that we have made about agent activity.

Mr. STUPAK. Mr. Harrell.

Mr. HARRELL. We have done the same thing in Mississippi working with the respective carriers, working with CMS, working with Social Security Administration and we have two on-going marked conduct examinations of two of the carriers.

Mr. STUPAK. Ms. Healey.

Ms. HEALEY. We have done the same thing, in fact, we worked with some agents to talk about the difference between a full dual and someone who just receives only Medicare.

Mr. STUPAK. What I have seen thus far from CMS is maybe some voluntary guidelines. Do you think voluntary guidelines work or do we need more? Anyone, Mr. Harrell, Mr. Lipschutz, Ms. Healey, Mr. Harrell?

Mr. HARRELL. I don't think it has worked up to now. Same as some of the same problems that we are seeing today are the same problems that the Department of Insurance saw in the late 1980s and early 1990s with Medigap products and it hasn't worked to date and I don't think it is going to work.

Mr. STUPAK. Ms. Healey.

Ms. HEALEY. We are moving forward with our toolkit because we are going to focus on prevention. Two of the things we have already developed is a form that we want the beneficiary to fill out, did you check to make sure that your doctor is going to accept this? Did you contact SHIP to work with us? We also have a form that we can, that SHIP can hand the agent and they will need to initial that this plan is going to take them out of original Medicare so they are aware of what they are going to be facing and try to make an informed decision because we feel that the seniors are failing to ask enough questions and they are not verifying the information and they are not checking with a trusted resource such as SHIP before they make that decision because the agents who are doing this are basically predators.

Mr. STUPAK. Sure. Mr. Lipschutz, did you want to add anything?

Mr. LIPSCHUTZ. I would like to highlight a statistic I came across the other day. It is my understanding that nationwide there are roughly 12 to 14,000 SHIP counselors, including volunteers. That is compared to what some industry estimates put at 200,000 agents selling Medicare products across the country. Whereas insurance agents are specifically trying to steer people towards particular plans the SHIP programs are not permitted to do so and instead it is their mission to provide unbiased counseling about individual's options so that people can make informed decisions about their choice.

Mr. STUPAK. Thanks. My time has expired. Ms. Clegg-Boodram, looked like you were wanting to say something there. Was there something you want to say?

Ms. CLEGG-BOODRAM. These individuals never made it clear that they were an insurance company, No. 1. Number 2, when they

talked to our people they knew that most of our people did not understand what they were talking about. Ms. Williams and Mr. Grady Hammonds and Ms. Royal are probably three of the most proactive individuals in our community. So that is the level and it is not fair. And I have one last little, little question, OK?

Mr. STUPAK. Sure.

Ms. CLEGG-BOODRAN. When you guys designed this program I think you all realized that it had some problems because it feels like it was designed to fail. OK. That is No. 1. I mean my body is falling apart but parts of my mind still work. Then, how could this program, and any rule written into it, supersede the laws of this country so that someone couldn't be prosecuted for Medicare fraud? I have a problem with that. So when you guys are doing your legislative duties or whatever, you guys got really good lawyers because they are making the dollars and I think this whole problem is a dollar thing. And it has nothing to do with the people of this country. And it is getting old. Thank you very much.

Mr. STUPAK. Thank you for your testimony and this program was controversial when it was brought forth and it passed by a very close vote, and but it did pass. In this country when it passes, it becomes law. We have to administer it whether you support the program or not the best as possibly can and we have a couple more panels here and that is why your testimony is important to us here today to understand the problems being faced by folks out there.

Mr. Whitfield, questions please?

Mr. WHITFIELD. I don't have anymore questions. I do have one comment before Mr. Walden I understand has questions. Ms. Clegg-Boodram, I want you to know that CMS will be testifying on a later panel and they have a responsibility for managing the entire Medicare Program, and Medicaid as well at the Federal level. But I can assure you that anyone that defrauds a person relating to Medicare can be prosecuted. So this Medicare, and we will have them talk about that but we do appreciate your time very much today.

Mr. STUPAK. Mr. Walden.

Mr. WALDEN. Thank you, Mr. Chairman. Thank you, Mr. Whitfield. I apologize for having to come and go here but some other meetings I had to attend to but I am very concerned about what I heard in your testimony and obviously it is our obligation to not only learn about what went wrong but how to make sure it doesn't go wrong again. And how to make sure that people who have been harmed are unharmed, which is not a word but I think it gets the meaning of the problem here.

Mr. Harrell, how effective do you think the new practices such as post enrollment call-back can be. I mean I have heard from some that say, OK, the agent comes in and makes the sale but then the company calls back and says here is what you were sold. Are you sure this is what works for you.

Mr. HARRELL. The problem is when they call back, the insured is still not going to understand it. That's the problem that I think Ms. Boodram referenced a while ago with the three witnesses she brought here today. They were, without putting words in their mouth, they were at the top of the list in terms of the most active. Who's out there protecting the ones who don't know who to call?

They don't know what the agents are selling them. They don't know who CMS is or the carrier when they call-back, so I don't see the call-back in some of the more despicable cases. I don't see the call-back working.

Mr. WALDEN. OK. So how would you fix this then? Would you just ban the sale of these products altogether?

Mr. HARRELL. For the informed person I don't think the product is a bad situation, for some people it is a good product. If you can somehow just like the Congress did with the Medigap product, if you give the State regulators the jurisdiction over the product and the agent I think with that joint effort that Congress did in the 1990s along with NAIC, was able to solve the problem. You don't see those problems in Medigap now that you see in Medicare Advantage due to the policing of it from the State regulators who are in every State who have been able to solve that. When you go out and penalize the agent and the company that is when you are going to start seeing some reaction from the carriers.

Mr. WALDEN. Are you seeing any of these problems with the Medicare Part D?

Mr. HARRELL. No, sir.

Mr. WALDEN. And are those products sold by agents as well?

Mr. HARRELL. I mean you usually see problems with any insurance product, in Mississippi we are very familiar with the insurance issues the last couple years but we are not seeing the same volume you are going to get a problem on any insurance product, but the volume of what we are seeing, the largest volume of complaints we are seeing, and we are a very rural State, is involving Medicare Advantage once you get past Hurricane Katrina issues.

Those are the two biggest problems we are seeing.

Mr. WALDEN. Why is it you are not seeing a problem with Medicare D? That is a very complicated process I can assure you having my wife's parents sign-up and go through that I retreated immediately out of the room and told my staff, we have got to hold some hearings, some meetings out, in the district to educate people.

Mr. HARRELL. I don't know exactly, I am very familiar with that. My own parents call me about Medicare Advantage, what is this? And I quickly got them in touch with our consumer services director.

Mr. WALDEN. Right.

Mr. HARRELL. And had her explain all of the nuances and differences similar to what Ms. Healey does. I wasn't capable of doing that and any time you are representing your parents, I am also a lawyer by trade, it gets to be dangerous. But what I have seen I don't know why when we are still complaints but we are not seeing anywhere near the volume of the complaints we are seeing on Advantage.

Mr. WALDEN. And when you talk about the volume in the Medigap plans, can you give me some perspective here of how many complaints you get overall versus complaints out of Medigap? What is that volume figure you are referencing?

Mr. HARRELL. I didn't bring those stats with me. Our office keeps the stats of what kind of complaints we get but I will be glad to provide them.

Mr. WALDEN. Is it twice as many as you get on other plans?

Mr. HARRELL. The Medicare Advantage is the leader as it relates to all complaints that we are getting now.

Mr. WALDEN. Among health and among these——

Mr. HARRELL. Among all types of insurance.

Mr. WALDEN. All types. So does that include property, casualty, auto?

Mr. HARRELL. It even includes Katrina claims.

Mr. WALDEN. OK. And so it is No. 1.

Mr. HARRELL. Yes, sir.

Mr. WALDEN. In Mississippi. Is that the same in California from your perspective, Mr. Lipschutz?

Mr. LIPSCHUTZ. I think in California the State Department of Insurance hasn't registered as many complaints as other State insurance departments, in part because of the way different SHIP programs are organized in different States. In some States SHIP programs are administered through the Department of Aging, whereas in some States it is administered through the Department of Insurance. And I think in States where the SHIP program is administered through the Department of Insurance it is much more likely that complaints will get registered and it is a much more streamlined process. So while the complaint volume to the Department of Insurance might not be as high in California as some of these other States, that does not mean that the volume of problems are not in fact happening.

Mr. WALDEN. OK. I understand what you are saying. My time is about to expire. I want to thank all of you for your testimony today and we obviously are going to pursue this with vigor and certainly look to CMS to see how they plan to address this issue as well. Thank you, Mr. Chairman.

Mr. STUPAK. Mr. Burgess, any questions?

Mr. BURGESS. Let me just ask Mr. Harrell a follow-up to what your discussion with Mr. Walden. You said penalizing the agent and the company was the best way to get this problem solved. Did I understand that correctly?

Mr. HARRELL. In our opinion, yes, sir.

Mr. BURGESS. And right now there is a discrepancy with how you are able to respond to someone who has a problem with Medigap as opposed to someone who is in a Medicare Advantage Program, is that correct?

Mr. HARRELL. Yes, sir.

Mr. BURGESS. And what is the nature of that discrepancy?

Mr. HARRELL. Looking at it with the Department of Insurance does not have jurisdiction over the product that is being sold in Medicare Advantage due to the standardization that Congress passed that relates to Medigap. If we could tie the two together, link the company and the agent because the agent is representing the company, he is not representing me.

Mr. BURGESS. OK. Is the plan licensed by the State?

Mr. HARRELL. The insurance company is, yes, sir.

Mr. BURGESS. And you still have jurisdiction over that, is that not correct?

Mr. HARRELL. On the company itself we do but not the underlying product that is being marketed.

Mr. BURGESS. But if it is amalgamated to whomever and they are selling a Medicare Advantage plan in your State you could simply pull all of their license for all of their products, could you not?

Mr. HARRELL. That is in question. Our lawyers are advising us that they don't think we have jurisdiction over the product itself. Now whether we can or cannot take the license is something that we have not, we have looked at it but also that would also harm all the other individuals who sold good products.

Mr. BURGESS. Sure, sure it would be a drastic step, but it would certainly be a way of getting the company's attention.

Mr. HARRELL. Amongst the other thousands of policyholders who were not victimized, yes, sir.

Mr. BURGESS. Well, let me ask you this. If you had another company with another policy that wasn't Medicare Advantage and you discovered a problem with it what would be the trajectory that you would follow there?

Mr. HARRELL. It depends on what the situation would be. Examine the company to find out what the problem was, what the violations and how to fix them. And then take disciplinary action against the company.

Mr. BURGESS. And in your opinion what is it that prevents you from doing that for the Medicare Advantage purchasers in your State who feel that they have been harmed?

Mr. HARRELL. Our lawyers have looked at it and had discussions with CMS. It is their opinion that we do not have the underlying jurisdiction to take action against the carrier as relates to the product being marketed.

Mr. BURGESS. Well, I think we are going to hear from CMS later on this morning. I will be interested in their response to that as well but clearly if that is an area where you don't feel you have the power to advocate on behalf of the people in your State, that is something that I think needs to be corrected. And, Mr. Chairman, I will just for the good of the order, I did follow-up with my constituent service department back home. We currently have no Medicare Advantage cases that are pending. We have two Medicare Part D that were just resolved that were apparently long-term cases where people were trying to dis-enroll and weren't allowed to do that. But again the individual Member's office has considerable ability to deal with CMS and for those of you who are having difficulty I would not overlook that as an avenue to get some immediate help for the recipients who are in the greatest amount of need. And with that, Mr. Chairman, I will yield back.

Mr. STUPAK. I thank you, Mr. Burgess. Every week my staff gives a report and Medicare Advantage is one of those that shows up every week in my district and I have half of the geographic size in the State of Michigan and the problem we see is once you recognize a problem with Medicare Advantage and you want to dis-enroll, the length of time it takes and the hoops you have to go through for our constituents is very, very difficult, to dis-enroll once you realize there is a problem there.

Mr. BURGESS. But if the gentleman will yield, that and that is exactly the place where the congressional office can make a difference. Two cases that I referred to were long-standing cases and we had them resolved within one, 4 weeks, and one, 5 weeks. I

grant you that is a long period of time but when someone has been fighting it for a year they are grateful to have that sort of attention.

Mr. STUPAK. Sure. And on behalf of Ms. Norton, the delegate from Washington, DC, she advises that if you would vote to make DC full voting rights in the Congress, she could move more expeditiously to help her constituents. She is a very effective voice here, right. Mr. Murphy, did you have any further questions?

Mr. MURPHY. Yes, Mr. Chairman, just real quickly.

Mr. STUPAK. Sure.

Mr. MURPHY. Mr. Harrell, are these the issues that the insurance commissioners through other States have prepared any sort of report on, these problems with Medicare Advantage, to your knowledge?

Mr. HARRELL. I believe the National Association of Insurance Commissioners is working on that. You have two commissioners on another panel later today and I think they can update you as well. I know that the southeastern zone of the insurance commissioners have been working on this together trying to solve the problem. We have written our entire congressional delegation on this issue.

Mr. MURPHY. OK. I certainly hope that they will make that available to the chairman. Also, how have insurance companies responded to your requests about complaints from people selling these plans in this way?

Mr. HARRELL. On a one-on-one basis they have been very cooperative working with us trying to solve the problems. They have also been trying to work with the Social Security Administration trying to get the bank drafts stopped, trying to dry-up the checks, working with CMS. It is a very difficult problem because you have got two very large governmental agencies working together, hopefully, and a large insurance company trying to work together but on a one-on-one basis they have been, but that is just one-on-one of the ones who are contacting the Department of Insurance. I know to contact CMS, many don't know who they are and may not know to contact their Senator or their Representative because they don't know that it is not an insurance product. In fact, when we have written our congressional delegation, we have even spoken to some of our congressional staffers and some of them were not sure why the people were calling them either initially. Now they do now because of all the publicity that has been out there in the last year.

Mr. MURPHY. When they have identified that that there is some problems in terms of agents, perhaps, less than scrupulous behavior in terms of selling or promising plans there are a couple of things I want to know. One is while people were looking to switch plans back were there gaps in their coverage and did anybody offer anything during that time to help with payments or medications or hospital or anything, or were these people left completely out in the dark.

Mr. HARRELL. It is my understanding—I defer to some other panel—some of them were left in some gap periods because they had cancelled one and trying to get dis-enrolled in the other.

Mr. MURPHY. How do we keep track of agents that are involved in fraudulent behavior then? How do you keep track of them? Is

there a national database? How do we know in the future if these people are trying to sell other——

Mr. HARRELL. The National Association of Insurance Commissioners has formulated a national database for an agent. So if an agent in Pennsylvania has his license revoked and he moves to Mississippi, when we run his name through the system it will reveal that Pennsylvania Department of Insurance took action regarding Mr. Smith.

Mr. MURPHY. And then here is another issue here. When we read now and then about people being involved in unscrupulous activity with regard to sales tactics with insurance plans what is unique to this issue, the Medicare Advantage or the Medicare issues that is not just a matter of people doing bad things. But what is there unique to this that is allowing this to occur that we need to change?

Mr. HARRELL. Well, my personal opinion is you look at the victims here, the insureds, they are all elderly. Some of them are in good mental shape, some of them in good physical shape, a lot of them are not. If you go into a nursing home and start enrolling individuals, you are going to have some who do not need to be in a position of making that decision. And we have seen a lot of them where they would have a power of attorney, be it either brother or sister or another loved one, that is a power of attorney. That person is supposed to be there but for some reason they are not. I don't know why the agent would have gone when the power of attorney person is not there. We are seeing instances of those and some of the issues we have talked about today are, if you give the States authority to enforce it, right now that is in question, do the State regulators have that authority? That is what we are trained for, that is what we have been doing for over a hundred years, not me personally, but that is what the insurance forum is across the country are doing. All of them have specially-trained staff. In Mississippi our SHIP program is not even part of the Mississippi Department of Insurance and my figures don't even include what the SHIP program has gathered complaints on.

Mr. MURPHY. Ms. Healey or Mr. Lipschutz, either of you have any comments on this in terms of the questions I just raised about other things specific to this Medicare plan that allows these fraudulent salespeople to operate here?

Mr. LIPSCHUTZ. I would say part of the reason is due to the complexity of the Medicare Advantage Program, the sheer number of plans that are now available, the differentiation between the plan types, the great flexibility the plans have to design their benefits and cost-sharing structures that can sometimes leave people paying more for certain benefits if they are in such a plan than they would in original Medicare.

Mr. MURPHY. Did any of you know is there any side-by-side comparison of here is what is in Medicare, here is Medicaid, here is what is Medicaid Advantage, here is the preferred plans, any side-by-side clear comparisons so that people can either look at to see what is in this and what is not and how much is it going to cost me? I haven't been able to find any and so I find, no wonder people can be victimized.

Mr. LIPSCHUTZ. I think some SHIP programs do piece together their own side-by-side comparisons of various plans. I would also ask the Congressman to direct the question toward CMS because there may be some prohibitions against plans actually comparing benefits against one another. The one of our outstanding issues when it comes to particularly Private Fee-for-Service plans is that we believe that those that are targeting marketing towards dual-eligibiles should be able to clearly show how the benefits they provide are, in fact, better than State Medicaid benefits, if at all.

Mr. MURPHY. Thank you. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you. That concludes questions of this panel and I want to thank this panel once again for putting and bringing forth and educating Members as to the problems faced with a Medicare Advantage. Thank you all for coming and you are dismissed. And we will have our second panel come forward.

Our second panel of witnessess will be Mr. Francis Soistman, executive vice president of health plan operations at Coventry Health Care, Incorporated, Mr. Gary Bailey, vice president of Medicare Operational Performance at WellCare Health Plans, Incorporated, and Ms. Peggy Olson with Healthwise Insurance Planning, LLC. Welcome, and as you know it is a policy of this subcommittee to take all testimony under oath. Please be advised that witnesses have a right under the rules of the House to be advised by counsel during testimony. Do any of our three witnesses wish to be represented by counsel here today? They all indicate no. Then if so, I am going to ask you to stand and raise your right hand and take the oath.

[Witnesses sworn]

Mr. STUPAK. Let the record reflect all witnesses replied in the affirmative. You are now under oath. We will start with our opening statements.

Mr. Soistman, do you want to start, please.

STATEMENT OF FRANCIS SOISTMAN, EXECUTIVE VICE PRESIDENT, GOVERNMENT AND INDIVIDUAL PLANS, EXECUTIVE VICE PRESIDENT, HEALTH PLAN OPERATIONS, COVENTRY HEALTH CARE, INCORPORATED

Mr. SOISTMAN. Chairman Stupak, Ranking Member Whitfield and member of the subcommittee, thank you for inviting me here today. I am Fran Soistman, executive vice president of Coventry Health Care, a national health insurance company headquartered in Bethesda, Maryland. Our Medicare programs provide part D prescription drug coverage to 700,000 beneficiaries and serves more than 200,000 beneficiaries through a variety of Medicare Advantage plans. We understand the committee's concerns about marketing activities of independent agents and we appreciate the opportunity to discuss these matters with you.

I want to make three points today. Number 1, putting beneficiaries first is a core value for Coventry and we have a very good track record in doing just that. Number 2, while we have faced some unanticipated problems with the conduct of some independent agents we have taken steps to put this right. And No. 3, we remain committed to working with CMS, State regulators and our industry to insure fair and appropriate marketing practices.

As a leader in serving Medicare beneficiaries for more than a dozen years we have a solid track record. In marketing our HMO and PPO plans through our internal sales force and then our part D plans through national distribution partners we had great success and encountered few complaints about agent marketing practices.

When we began offering Private Fee-for-Service plans for 2007 enrollment we ran into some unexpected challenges with the marketing activities of certain independent brokers and agents. The situation at Judiciary House where an agent misrepresented himself and misrepresented our product is an unfortunate example of these activities. This was a deplorable situation and I want to extend my personal and Coventry's deepest apologies to Mr. Hammonds, Ms. Royal and Ms. Williams. This kind of conduct is unacceptable.

Coventry has terminated both agents and the agency. We have taken a number of steps over the past 8 months to deter sales to dual-eligibles, protect beneficiaries, and enhance agent training and accountability. First, in January we sent two field communications to independent agents emphasizing that our Private Fee-for-Service plans are likely not suitable for dual-eligibles and reiterating special marketing guidelines for, excuse me, for institutionalized settings.

Second, to further deter agents from selling Private Fee-for-Service plans to dual-eligibles, we proposed eliminating commissions on such sales. CMS advised that our proposal would not satisfy their non-discrimination rules so instead we stopped paying upfront commissions on these sales. We have already seen significant reductions as a result.

Third, we began a successful program to make verification calls to all enrollees in Mississippi to confirm that they understand and intend to sign-up for our Private Fee-for-Service plans. We are moving to extend this program across the country.

Fourth, we are implementing stricter guidelines for marketing our products in subsidized housing facilities. Fifth, we raised the bar for agents requiring they pass a test to ensure their grasp of our products and the do's and don'ts of marketing. Sixth, agents are now required to re-train and re-test prior to selling products for the 2008 enrollment year. Seventh, we have enhanced our broker quality-management program to include new performance metrics and an expanded special investigations unit that allow us to evaluate agent practices and take action when necessary.

Coventry remains committed to working with CMS, State regulators and our industry to protect Medicare beneficiaries. As the committee knows on June 15, CMS, Coventry and six other leading companies announced a temporary suspension of Private Fee-for-Service marketing activities. This was done to strengthen consumer protections for early implementation of CMS' new marketing guidelines for 2008.

We continue to work constructively with regulators in a number of States including Mississippi, Georgia and Oklahoma. Finally, we are working with AHIP to identify helpful industry level measures such as a national registry of sanctioned brokers.

In conclusion, Mr. Chairman, we have no tolerance for improper agent conduct and we are committed to doing whatever it takes to ensure appropriate marketing practices by everyone who sells a Coventry product. This is good for our customers. It is good for us. We have an excellent reputation in this industry. We value that reputation and we intend to keep it.

Thank you.

[The prepared statement of Mr. Soistman follows:]

Testimony on

Medicare Advantage Marketing and Sales

by

Fran Soistman
Executive Vice President
Coventry Health Care, Inc.

Before the
U.S. House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

June 26, 2007

Introduction

Chairman Stupak, Ranking Member Whitfield, and members of the Subcommittee, thank you for inviting me here today. I am Fran Soistman, executive vice president of Coventry Health Care. I have responsibility for Coventry's Medicare, Medicaid, and individual insurance operations. Coventry has more than a decade of experience in delivering excellent service to hundreds of thousands of Medicare recipients across the country. We are committed to the long-term success of the Medicare Advantage and Part D programs.

Coventry Health Care is a national health insurance company headquartered in Bethesda, Maryland. We operate health plans and insurance companies and offer a full range of risk and fee-based managed care products to individuals, employers, and government entities, including Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP). We are proud to provide high quality health benefits to more than 4 million people through our commercial products and our participation in government programs. In the Medicare program, we offer Part D Prescription Drug Plans that currently cover 700,000 beneficiaries and Medicare Advantage plans that provide 123,000 beneficiaries with Private Fee-For-Service (PFFS) coverage and 88,000 with Coordinated Care HMO/PPO coverage.

We share the legitimate concerns that have been raised about the sale and marketing of Medicare Advantage PFFS plans and, in particular, the conduct of certain independent brokers and agents. We take these concerns seriously. The vast majority of our members are very satisfied with our plans, but, from our perspective, any situation involving unscrupulous marketing practices is one too many. That is why Coventry has

no tolerance for inappropriate marketing practices by brokers and agents, and we are committed to enforcing that policy with vigilance. This approach is good for our members, good for health care providers, good for our distribution partners, and it's good for us. Improper marketing activities by independent agents and brokers undermine our mission and harm every participant in the health care system – from the beneficiaries who do not receive a health care plan that meets their needs; to the health care providers who shoulder extra burdens when a patient's plan does not cover expenses that otherwise would have been covered under traditional Medicare and Medicaid; to the tens of thousands of agents and brokers who do act professionally and ethically in advising people about the vast array of available insurance products.

Coventry has taken a leading role in identifying challenges and developing solutions to ensure that Medicare beneficiaries are getting access to appropriate health plans as well as the information they need to make the best decisions for their individual circumstances. This is a top priority, and we work with Congress, state and federal regulators, our industry association, and others to protect Medicare beneficiaries.

Coventry's Participation in Medicare

Through more than twelve years of serving Medicare beneficiaries, we have learned a great deal about how to reach consumers who could benefit from our products and give them the information they need to pick a plan that is right for them. As we have expanded the choices we are able to offer, we have adjusted the ways we make products available. The health care system is dynamic, and we are continually looking for ways to improve.

Prior to the launch of PFFS plans and Part D prescription drug coverage in the past two years, Coventry's participation in Medicare was limited to HMO and PPO coverage in five markets. Because of the limited geographical area in which these programs were offered, Coventry was able to rely primarily on our internal sales force to inform beneficiaries about our products and assist them with the application process. With implementation of the lock-in requirement in 2005, we discovered that we needed to add a limited number of independent agents in these markets to reach beneficiaries in a timely manner. We have served nearly 100,000 Medicare beneficiaries successfully under these programs, with few complaints about broker-agent marketing practices.

Having built a solid foundation with the HMO and PPO programs, in 2006, we began to offer a Medicare Part D prescription drug program to Medicare beneficiaries as well. Given the national scope of Part D, we realized that our own sales force was not intended to market a product for national distribution and that we needed a more effective way to reach people across the country, so we partnered with nationally recognized distribution organizations. We had great success with our entry into the Part D field, becoming the sixth largest PDP in the nation. And again, there were few complaints about broker-agent marketing practices.

PFFS Plans

More recently, we decided to begin offering PFFS plans. Although these plans are not right for everyone, we think they offer a valuable health care choice for many. First, they make health care more accessible to beneficiaries in rural and other underserved areas where Medicare health plans were not available in the past. Second,

PFFS plans improve patient care by offering care coordination and disease management services for conditions that commonly affect the elderly or the disabled. Third, like other types of Medicare Advantage plans, our PFFS plans provide many extra benefits that are not available in the Medicare fee-for-service program, including, for example, dental, hearing and vision benefits. According to CMS, Medicare Advantage plans are providing enrollees with, on average, savings of $1,032 annually – through improved benefits and lower out-of-pocket costs – compared to what they would pay in the Medicare fee-for-service program.

In evaluating how we could make the new PFFS plans available nationally, we concluded that we again needed to use multiple distribution partners, but we knew that several of our Part D partners were not available. The need for a national distribution system was particularly acute because the limited sales period in the Medicare Advantage program has created a compressed window in which beneficiaries are required to make decisions. Most PFFS products are sold during an intensive six-week Annual Election Period, from November 15 through December 31, each year, with an additional opportunity to switch to a different plan from January 1 through March 31. This short sales window creates a need for a national distribution capacity using agents and brokers.

In modifying the distribution model from the Part D program to include new relationships with other distribution partners, we encountered unexpected challenges in ensuring that independent brokers and agents met our stringent marketing standards.

One striking example of that kind of misconduct is a subject of today's hearing. It involved an independent agent, who in February 2007 marketed our PFFS policies to

beneficiaries at Judiciary House in Washington, D.C. by misrepresenting himself and misrepresenting our product. This was a deplorable situation.

Let me be very clear: We abhor the actions that the independent agent took at Judiciary House, and I want to extend my personal, as well as Coventry's, deepest apologies to Mr. Grady Hammonds, Ms. Mary Royal, and Ms. Edith Williams. This never should have happened. It is unacceptable. And we do not tolerate this kind of conduct.

We have terminated the agent and the agency with which he was affiliated. That agency was in fact already the subject of internal investigations begun this spring by our Special Investigations Unit regarding separate improper agent conduct.

Our Response to Sales and Marketing Issues

Over the course of the rollout of our new PFFS product over the past eight months, we realized that issues were developing with regard to agent-related marketing practices, and we took a number of steps to address the situation.

First, within a month after the first enrollment effective date, we sent two field communications (attached to my testimony) to the independent brokers and agents marketing and selling our plans to underscore key guidelines for marketing to beneficiaries who are dually eligible for Medicare and Medicaid and to beneficiaries in institutionalized settings – populations where we saw greater risk for agent misconduct. The first sales communication plainly stated our belief that our PFFS plans may not be suitable for dual eligibles. The second sales communication acknowledged the even "greater responsibility" to ensure appropriate marketing practices in institutionalized

settings and reiterated specific instructions, such as forbidding door-to-door marketing. These memos are examples of our practice of communicating directly to agents to reinforce our policies and CMS' guidelines.

Second, we have taken additional proactive measures to address concerns about the marketing of PFFS plans to dual eligibles. We know that our PFFS plans are not best suited for this population, so we requested permission from CMS to eliminate or substantially reduce the commissions we pay to agents who sell PFFS plans to dual eligibles. CMS shared our concern but felt constrained to not grant this request because of its nondiscrimination rules. On our own initiative, we did eliminate up front commission payments for sales of PFFS to dual eligibles and now pay for these sales only on the back-end, which can be up to a year later. This change has already made an important difference, significantly reducing the number of PFFS plans our agents sell to dual eligibles.

Third, in collaboration with the state Department of Insurance and Medicare Patrol, we instituted a program in Mississippi to call enrollees and verify their intent to sign up for our PFFS plan. After a beneficiary decides to enroll in a PFFS plan, we call to make sure the beneficiary is aware that he or she has signed up to enroll in one of our PFFS plans, is educated about the plan, and is familiar with the benefit structure. As a result of this verification program, dual eligibles often have chosen to disenroll from our PFFS program, after concluding that it was not right for them. We are now starting to extend this verification program across the country.

Fourth, we have other proactive policies to communicate individually with enrollees. For example, when Coventry terminates an agent for cause, we follow up with every member that the terminated agent was responsible for enrolling and give them the option of disenrolling.

Fifth, we have increased the rigor of the process for contracting with new independent agents. Originally, we required attestation that an agent had read our online training materials. In February, we strengthened the requirement to include passing a test to prove understanding of our products and the dos and don'ts of marketing for Coventry.

Sixth, we are committed to continually improving our programs and policies for training brokers and agents and certifying that they are qualified to market our products. Prior to selling Coventry's Medicare plans, we require that each agent must:

(1) be licensed in the state where selling;

(2) execute the appropriate agent contract with Coventry;

(3) complete the online training and written exam with a passing grade; and

(4) not be excluded from any federal or state program, including the Medicare and Medicaid programs. (Coventry checks the exclusion lists of the Office of Inspector General for Health and Human Services and the Government Services Administration prior to contracting with any agent.)

Each agent is required to re-train and re-test prior to selling products for the 2008 enrollment season. In addition, any broker or agent who has not completed a sale within the past 60-90 days is required to complete a re-training program.

Seventh, in response to the issues identified at Judiciary House, we are developing and implementing new marketing guidelines that provide strict standards for conducting marketing activities in subsidized housing facilities.

Eighth, we monitor the ongoing performance of those who market our plans not only through direct contact with agents, but also through contact with Field Management Organizations, which recruit agents. We conduct quarterly meetings and weekly calls with the Field Management Organizations to keep regular tabs on broker-agent conduct, complaints, and other business issues.

Ninth, Coventry has established a dedicated broker services unit, as well as a Broker Quality Management Program, which is under our Medicare Compliance Department. Key components of these programs are data analysis and feedback into agent training, a special investigations unit for complaint management, and proactive outreach to state agencies.

Tenth, in situations where all of these training and oversight mechanisms have not ensured appropriate agent conduct, we do not hesitate to terminate independent agents or agencies.

Working With CMS, State Regulators, and the Industry

In addition to these unilateral actions, we are also working with CMS, the states, and our industry association, AHIP, to develop additional solutions.

To protect the best interests of beneficiaries and safeguard against future agent-related problems, Coventry, together with six other leading Medicare Advantage plans and CMS, announced that we are temporarily suspending marketing of our PFFS plans to individuals and, at the same time, strengthening consumer protections by expediting the early implementation of CMS' new marketing guidelines for 2008. This action will facilitate the immediate implementation of additional safeguards to protect Medicare beneficiaries. CMS set forth a number of steps that all seven companies must take – several of which we had already started doing (discussed above), and the rest of which we will promptly undertake.

In fact, Coventry has a solid history of working with CMS to provide beneficiaries with high quality, affordable health care choices that best meet their needs. We are proud of our track record in serving hundreds of thousands of Medicare beneficiaries across the nation. We have played a leadership role in addressing these issues since they first came to light in January, and we remain committed to fixing any lingering problems so beneficiaries can continue to enjoy a wide range of choices in Medicare to meet their health care needs.

We have also worked constructively with regulators in a number of states, including Oklahoma, Mississippi, North Dakota and Georgia, among others. In Mississippi, for example – the state in which we have enrolled the largest number of beneficiaries in our PFFS plans – once we identified issues regarding agent practices I

personally reached out to Insurance Commissioner George Dale; we worked with his staff to address problems; and, within the past three weeks, I have met with Commissioner Dale to review our progress in resolving issues in Mississippi to his satisfaction. And in Oklahoma, we received a commendation for our efforts, which I have attached to my written statement.

Finally, Coventry is working with AHIP to identify industry-level measures – consistent with a set of principles adopted by AHIP in May 2007 – that are designed to protect beneficiaries and to ensure that brokers, agents, and plan marketing staff meet new qualifications and requirements. For example, Coventry supports efforts currently underway to prevent problem agents from simply transferring from plan to plan by establishing a national registry of sanctioned brokers, with appropriate safeguards and appeals to protect against unfair accusations.

Conclusion

Thank you for this opportunity to testify. We do not tolerate improper conduct, and we are committed to do whatever it takes to ensure sound and appropriate marketing practices by anyone who markets or sells a Coventry product. This is good for our customers, and it is good for us. We have an excellent reputation in this industry as a responsible and upright company, we value that reputation enormously, and we intend to keep it.

Exhibit 1

Advantra Freedom

Memo

To: Distribution Partners

From: Mike Burke

CC: J. Stelben

Date: January 19, 2007

Re: Private Fee For Service Dual Eligible Enrollment

As discussed on Thursday January 18th, Coventry Health Care believes that our Private Fee For Service Advantra Freedom products may not be the best health care coverage solution for Medicare beneficiaries who have both Medicare and Medicaid coverage (dual eligible.)

There are several reasons that have contributed to our conclusion:

- Most dual eligibles will have limited financial exposure when enrolling in plans designed specifically for their situations. Our Advantra Freedom products will in many cases increase their financial exposure for covered services in the form of increased co-pays or coinsurance.
- Coordination of benefits with most states is often arduous and in some cases, state Medicaid departments prohibit coordination of benefits with Medicare Advantage Plans, thereby further increasing a dual eligible's potential financial exposure as referenced above.
- Dual eligible residents of nursing homes are especially challenged in that they may not be able to properly evaluate the positive or negative impacts to their coverage when enrolling in Advantra Freedom.
- Our analysis of Advantra Freedom's benefit structure to that of a dual eligible's needs has concluded that in most cases we will be increasing their out of pocket cost for covered health care services (i.e. co-pays and coinsurance).

Coventry believes that we have designed and introduced PFFS products that are a good fit and value for the majority of Medicare beneficiaries. We all must work together to ensure that we do everything possible to educate Medicare beneficiaries on their choices and enroll them in products that best fit their individual needs. Agents should not sign up dual eligible individuals unless the dual eligible has verified with their local SHIP (State Health Insurance Assistance Program) or Medicaid office that the plan is beneficial to the dual eligible.

Coventry's primary interest is in providing Medicare beneficiaries with the appropriate products that meet their health care benefit needs. We expect you to represent our company consistent with these values and in accordance with all CMS requirements. We thank you in advance for your support and cooperation.

Attached you will find additional information regarding enrolling members in a nursing home or institutional setting.

Exhibit 2

COVENTRY
Health Care

Field Communication

To: All Distribution Partners
From: Mike Burke, Vice President of Medicare
Date: 01/17/07
Category: New Business
Field Communication FC 24

Subject: Enrolling members in a Nursing Home or Institutional setting

Institutionalized beneficiaries or beneficiaries in long term care or assisted living facilities have equal rights to enroll in a Medicare Advantage PFFS plan. However, with their enrollment comes greater responsibility to ensure the application was appropriately and legally sold in accordance with CMS marketing requirements.

All Marketing and Enrollment rules apply, as discussed in the Coventry Agent Training Material, when marketing to this population. In addition to the training, please be aware of the following:

- Marketing should occur only in common areas of the Nursing facility and not in areas where care is being rendered.
- Door to door solicitation is not allowed in any circumstance in any setting.
- An agent should never meet with a beneficiary in their room, home, or apartment unless the beneficiary has previously agreed to meet with the agent in on of these settings.
- It is required that paperwork for Legal Guardianship or Legal Power of Attorney be provided when signing up members who are not competent to make their own decisions. In most instances it is not the social worker that has Legal Guardianship or Power of Attorney but a family member. It is the agent's responsibility to ensure that the agent doesn't sign up members that are not competent to make their decisions with out obtaining permission and signature of the Legal Guardian or legal POA.
- Ensure appropriate education occurs with each beneficiary. Education cannot occur though the social worker or any other employee at the facility. Materials and copies of the applications need to be left behind with each beneficiary or their POA or legal guardian. Under no circumstance is a Medicare beneficiary required to sign any document to obtain marketing materials.
- In most instances it is not beneficial to a dual eligible beneficiary to sign up for Coventry's PFFS product. Agents should not sign up dual eligibles if the dual eligible beneficiary has not verified with their local SHIP or Medicaid office that the plan is beneficial to the dual eligible beneficiary.

Coventry's primary interest is in providing Medicare beneficiaries with the appropriate products that meet their health care benefit needs. We expect you to represent our company consistent with these values and in accordance with all CMS requirements. We thank you in advance for your support and cooperation.

Exhibit 3

GOVERNOR
BRAD HENRY

INSURANCE COMMISSIONER
KIM HOLLAND

June 1, 2007

OKLAHOMA INSURANCE DEPARTMENT
STATE OF OKLAHOMA

Coventry Health & Lie Insurance Company
Attn: Michael Dobson
4300 Cox Road
Glen Allen, Virginia 23060

JUN 07 2007

IN RE: ADVANTRA FREEDOM
HOWARD COOKSEY; INQUIRER
OID FILE NUMBER: 200000147

Dear Mr. Dobson:

Thank you for your response of May 25, 20007 regarding the above inquiry.

We felt you and your company needed to be congratulated. Coventry Health is the very first company advising of seeing a need for additional and/or retraining of agents regarding the Medicare Marketing Standards of Conduct and emphasis on the Medicare regulations governing a company. We can only hope that other companies will see that additional training/retraining might possibly be necessary for their agents in field considering the amount of confusion that has occurred since the new drug plans were made available.

It is this department's main concern to take care of all consumers in our state. However, Commissioner Holland is very concerned with the welfare of our senior citizens and makes every effort to ensure they are not taken advantage of in any way.

Again, you are to be commended for this step forward in an effort to keep abreast of the availability of health and supplement plans and the requirements needed to follow rules and regulations.

Sincerely,

Martha Hall

MARTHA HALL
Analyst
Consumer Assistance/Claims Division
(405) 521-2991

MH/

Mr. STUPAK. Thank you.

Ms. Olson, your opening statement, please, for 5 minutes.

STATEMENT OF PEGGY OLSON, HEALTHWISE INSURANCE PLANNING, LLC

Ms. OLSON. My name is Peggy Olson. I am honored to have been asked to testify before the subcommittee. I am a licensed health insurance agent from Portland, OR, and I specialize in the sale of Medicare-related health insurance products including Medicare Advantage plans. I have been in the insurance business for 25 years and I have counseled seniors since 1989.

I am very aware of the publicity surrounding agents selling Medicare Advantage plans. I make absolutely no excuses for those individuals or their egregious violations of the Medicare marketing rules. However, I do not think the outrageous behavior of a dishonest few is in any way reflective of my entire industry.

The sale of senior products is a labor of love. This is not a quick way to get rich. I have never been offered a trip to Las Vegas.

The Medicare eligible population has unique needs. Clients are frequently suffering from debilitating or chronic medical conditions. Many have trouble with functional literacy or comprehension. Selling any Medicare-related product if it is done properly is a very labor-intensive process that requires patience, compassion and specialized knowledge.

I have an example in here of a client I worked with recently who it took a long, long time to get her problems straightened-out. For this nice lady, I will receive $4 per month in commission for the entire time she stays on the contract.

The standard I use for advising my clients is to treat them as I would my own parents and this is the standard that most of my professional colleagues use too. Most licensed producers who sell Medicare Advantage plans spend a lot of time advising their clients, answering questions and helping to select the best possible plan for them.

I would hate to see the subcommittee take any actions that would limit the ability of people to access the services of a licensed, ethical health insurance producer. One of the main ways we can make sure that all producers selling Medicare-related products do so in the most ethical manner is through education. My passion for education is a large part of what led me to become involved with the National Association of Health Underwriters, which is my industry's professional trade association. Since joining I have worked with HCFA, on Medigap standardization and to create agent training programs for the sale of Medicare managed care.

NAHU has been committed to senior product education but I wanted to make sure that all of you were aware of the project we have undertaken in cooperation with America's health insurance plans to make sure the producers have access to high-quality, consistent training.

Our program has been reviewed by CMS and approved for Continuing Education Credit in almost every State, except Oregon. And we are actively promoting the course to both NAHU members and non-members. The program is currently being updated and expanded to include more training on Private Fee-for-Service plans

and will be available in a more universal format. It is our understanding this will be the standard for education for producers whether they are independent agents or employees of insurance carriers.

The recent voluntary suspension of Medicare Advantage Fee-for-Service product sales accentuates the need for this type of comprehensive training. It is our understanding that all carriers will utilize this uniform training and its required exam to be certain that all agents are trained with the same information.

I truly appreciate this opportunity to appear before the subcommittee today and hope that I can help.

[The prepared statement of Ms. Olson follows:]

Testimony for the

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing Regarding

Predatory Sales Practices in Medicare Advantage

On
June 26, 2007

Submitted by

Peggy Olson
Healthwise Insurance Planning, LLC
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June 26, 2007

Good morning. My name is Peggy Olson, and I am very honored to have been asked to testify before the Subcommittee today. I am a licensed health insurance agent from Portland, Oregon, and I specialize in the sale of Medicare-related health insurance products, including Medicare Advantage products. I have been in the insurance business for 25 years, and I have been counseling seniors about Medicare-related health insurance products since 1989.

First of all, I would like to commend the Subcommittee for taking up this important issue, which is extremely close to my heart. I am well aware of recent publicity that has documented the highly unethical behavior of some individuals selling Medicare Advantage plans. I make absolutely no excuses for those individuals and their egregious violations of the Medicare marketing rules. However, I do not think the outrageous behavior of a dishonest few is in any way reflective of my entire industry.

The sale of "senior products" is really a labor of love. I speak not just for myself, but for my thousands of professional colleagues from all over the country who have built up their businesses focusing on this niche market, when I tell you that this isn't in any way a "get rich quick" means of making a living. The Medicare-eligible population has very unique needs. Clients are frequently suffering from debilitating and/or chronic medical conditions. Many have trouble with functional literacy and/or comprehension as a result

of either health issues or educational background. Most are simply deliberative by nature. Selling any Medicare-related insurance product, if done correctly, is a very labor-intensive process that requires great patience, compassion and specialized knowledge of the many facets of the Medicare system.

Just to give you a real-life example, I recently worked with a client who is 83 years old. Her husband had died recently and his employer was astounded to find out that neither of them had ever enrolled in Part B of Medicare. Open enrollment for Part B is from January 1st to March 31st each year, and then the Part B coverage becomes effective the following July 1st. After a lot of discussion and explanation, I was able to enroll her in a "bridge" plan to cover her Part B benefits until July 1st and finished her enrollment in a Medicare Advantage Plan last week. This whole procedure took more than 10 total hours of meetings, phone calls and paperwork. For this, I will receive $4 in commission per month for the length of time she stays on the plan.

The standard I use for advising my senior clients is to treat them as I would my own parents. This is the standard that the vast majority of my professional colleagues use as well. Most licensed producers who sell Medicare Advantage plans spend countless hours advising their clients, answering questions and helping to select the best possible plan options based on their clients' budgets and personal preferences. I would hate to see the Subcommittee undertake any actions that would limit the ability of seniors to access the services of licensed, ethical health insurance producers.

I would also hate to see the Subcommittee do anything to limit plan options for seniors. Medicare Advantage may not be the right choice for every senior, but there are many Medicare beneficiaries who are very happily insured under these plans. Eighty percent of my clients have chosen to use the Medicare Advantage plans because they are easy to understand, offer excellent benefits and, at least in Oregon and Southwest Washington, are relatively inexpensive.

I think it is critical that all Americans, including Medicare beneficiaries, have a wide range of health plan choices available to them. And it is just as important that they have access to a licensed and ethical health insurance professional who can help them pick the policy that best suits their individual needs.

One of the main ways we can make sure that all producers selling Medicare-related products are able to advise their clients in the most ethical manner is through education. As I have said already, Medicare is a unique market that necessitates special sales rules. It is critical that anyone selling any type of Medicare product, be it Medicare Advantage, Part D or a Medigap plan, be thoroughly trained.

My passion for proper producer education is in large part of what led me to become involved with my industry's professional trade association 25 years ago. Since 1997, I have been a member of the National Association of Health Underwriters' (NAHU) national Medicare Advisory Group, and I served as its chair in 1998. I have also worked with CMS and its precursor, HCFA, on creating agent training programs for the sales of

Medicare managed care products and have served as the president of my state association, the Oregon Association of Health Underwriters.

My association has always been committed to senior product education, but I want to make sure that all of the Subcommittee members are aware of the project we have undertaken in the last year in cooperation with America's Health Insurance Plans (AHIP) to make sure that producers have access to high-quality and consistent training.

To ensure that NAHU members are equipped with the most up-to-date and accurate information on marketing Medicare plans, during the past year NAHU and AHIP established a four-part education program on Medicare, Medicare Part D and Medicare Advantage. The NAHU/AHIP course teaches the marketing rules and responsibilities of each program and, like all of NAHU's many education programs, it covers and encourages ethical professionalism and includes a required exam to document competency. My fellow Advisory Group members and I reviewed the course content over the past year and I participated in the training program last fall. This program has been approved for continuing-education credit in almost every state, and we are actively promoting the course to both NAHU members and non-members.

We learned in development of the course that its effectiveness would depend on its consistent use by carriers operating in the Medicare Advantage market. The program is currently being updated and expanded to include more training on private-fee-for-service plans and will be available in a more universal format. It is our understanding this will be

the standard for education for producers who market these products, whether they are independent agents or employees of insurance carriers. This has been underway for a number of months, and the recent voluntary suspension of Medicare Advantage fee-for-service product sales accentuates the need for this type of comprehensive training. It is our understanding that all carriers will utilize this uniform training and its required exam to be certain that all agents are trained with the same information. We expect to be able to announce major enhancements to our program that will greatly expand its outreach in the coming weeks.

I truly appreciate this opportunity to appear before the Subcommittee today. If you would like any additional information, I can be reached at either (503) 788-5680 or olsonmm@yahoo.com. If any of the Subcommittee members have questions, I would be happy to answer them.

Mr. STUPAK. Thank you and thank you for your testimony.
Mr. Bailey.

STATEMENT OF GARY BAILEY, VICE PRESIDENT, MEDICARE OPERATIONAL PERFORMANCE, WELLCARE HEALTH PLANS, INCORPORATED

Mr. BAILEY. Mr. Chairman, Ranking Member Whitfield and other members of the committee, I appreciate the opportunity to testify about the sales practices of Medicare Advantage Programs. I am Gary Bailey, vice president, Medicare Operational Performance for WellCare Health Plans. At WellCare I am responsible for monitoring and improving our Medicare Advantage and prescription drug programs. Previously, I spent over 30 year at CMS working to improve the operations of the Medicare Program and services delivered to beneficiaries. Today I am proud to be working at WellCare, a company committed to providing high quality products and services to Medicare beneficiaries.

WellCare is striving to have a best-in-class compliance program. We have a zero tolerance policy for inappropriate marketing. WellCare is a leading provider of managed-care services with a long-standing commitment to Medicare/Medicaid. Founded in 1985, our team of over 3,000 associates currently serves over 2.2 million Medicare/Medicaid members nationwide. We offer Medicare Advantage plans in 40 States and DC.

Today I will speak about WellCare's efforts to protect beneficiaries in the marketing of Medicare Advantage plans. I will provide this committee with specific recommendations on how to improve this program. WellCare's corporate ethics and compliance program is called the Trust Program. We have enhanced the Trust Program with additional measures in the oversight of independent sales agents who market our Medicare Advantage products.

These measures include we conduct a thorough pre-screening of all agents. We verify the agent as licensed. We conduct extensive criminal background checks. We have extensive agent training, re-training and testing. If an agent does not pass with 100 percent or if they are not trained or re-trained, they are suspended from selling WellCare's products.

We maintain a field management program. We conduct ride-alongs with our agents. We also look at dis-enrollment rates to see if there are any inappropriate trends. We call each and every member after they enroll in our plan to measure their satisfaction, to ensure that they fully understand their new plan and that they are fully informed.

We have developed a strict code of conduct. Every agent agrees to the code of conduct before they can market our products.

We have recently started a secret shopper program. We have an outside, independent organization that monitors our marketing efforts to give us feedback from the member and to ensure broker compliance. When any compliance issue is identified agents are immediately investigated and if appropriate are terminated. Over the last 7 months we have terminated 18 sales agents for marketing conduct violations.

But there is more to do. We recently announced additional efforts to strengthen our compliance program. These include implementa-

tion of an in-bound telephone enrollment verification process. This system will ensure that prospective enrollees understand the plan while they are meeting with a licensed agent. We will find this out in real time.

The program will be in addition to our 100 percent out-bound call-back program already in place for new members. Also, since we are recording the call we can monitor the agent's behavior at the point of sale.

On June 15, we announced our decision to join six other Medicare Advantage organizations in pledging to strengthen consumer protections for Medicare beneficiaries. The pledge implements CMS' 2008 marketing rules in 2007. This pledge includes a temporary suspension of the marketing of our Private Fee-for-Service plans until we implement these new rules.

Our Trust Program's compliance process works. For example, in monitoring Medicare Advantage enrollment applications we proactively discovered an agent in Georgia that had submitted fraudulent applications. Working with the Georgia Department of Insurance and others, aggressive action was taken against this agent. This agent and his accomplice were subsequently arrested.

In California we learned of improper marketing by an agent that translated approved marketing materials into Chinese and then distributed them to Medicare beneficiaries who do not speak English. We terminated this agent. Following this we immediately undertook a national agent re-training program and initiated a program of making calls to 100 percent of our members to verify their understanding of our plans.

But we support even more improvements. First, we believe there should be a uniform national training program for all agents who sell Medicare Advantage products. Second, we believe a national database should be developed now to share information about those agents and brokers who have been sanctioned by a State or terminated by a health plan. We do not want to be associated with an agent or broker who has been terminated by another plan because of their non-compliance with State or Federal rules.

Third, we believe all plans should conduct the in-bound telephone enrollment and verification process I described. If the national database had been established we would not have hired an independent agent selling for another plan whose license had already been suspended in Mississippi. This agent then moved and was selling Medicare Advantage plans in Alabama. We were one of the plans who unknowingly had this agent selling for us. We then learned he had lost his license. We investigated and terminated him within 72 hours. If we had had a national database he would never have been allowed to sell our products or any other plan's products.

We appreciate the committee's attention to this important program and thank you for the opportunity to testify and I look forward to answering your questions.

[The prepared statement of Mr. Bailey follows:]

STATEMENT OF GARY BAILEY

Good afternoon, Chairman Stupak, Ranking Member Whitfield and members of the Committee. I am Gary Bailey, Vice President, Medicare Operational Perform-

ance for WellCare Health Plans. In that role, I am responsible for monitoring and improving WellCare's operations and performance in our Medicare health plans, including both the Medicare Advantage (MA) plans and Medicare Prescription Drug Benefit plans (PDP). Previously, I was Deputy Director for Plan Policy and Operations in the Center for Beneficiary Choices at the Centers for Medicare & Medicaid Services (CMS). During my tenure at CMS, I was responsible for the administration of Medicare Advantage plans and the Medicare Prescription Drug Benefit. I appreciate this opportunity to testify about sales practices in the Medicare Advantage program, what we at WellCare have done to contribute to industry improvement, and what more can be done to ensure the program works well for Medicare beneficiaries.

In my 32 years of Federal Government service at CMS, I consistently focused on improving the Medicare program. During my tenure at WellCare, I have been extremely impressed with WellCare's commitment to serving the needs of Medicare beneficiaries, the organization's responsiveness to rapidly changing Medicare program dynamics, and our commitment to strong corporate compliance. WellCare is a company that prides itself on continuous improvement, and I have seen this improvement first hand in our approach to Medicare Advantage sales and oversight.

WellCare understands the challenges and the rules governing marketing practices in the Medicare Advantage program, particularly for new Private Fee for Service (PFFS) products that have expanded so rapidly. Health plans and their independent sales agents must abide by appropriate marketing and sales practices for these products so that beneficiaries understand the important differences between PFFS and traditional Medicare or other options, so they can select a plan that best fits their health care needs. At WellCare, we have a zero tolerance policy for non-compliance with our marketing guidelines. We will—and we have—promptly terminated contracts of non-compliant sales agents. It is our company's ethic to do more than merely "follow-the-rules"—we have NO tolerance for any unethical behavior.

In my testimony today, I will provide information about: WellCare's government-sponsored health care plans, specifically our Medicare Advantage PFFS plans; CMS's recent audit of WellCare's PFFS plans; our recently announced decision to join six other leading health plans in pledging to strengthen consumer protections for Medicare beneficiaries; and WellCare's zero-tolerance of inappropriate marketing. Finally, I will provide our recommendations about how further improvements can be made to marketing and oversight of Medicare Advantage plans.

I. About WellCare Health Plans

WellCare is a leading provider of managed care services dedicated exclusively to government sponsored healthcare programs, such as Medicare and Medicaid. WellCare operates a variety of Medicaid and Medicare plans, including health plans for families, children, and the aged, blind, and disabled as well as prescription drug plans. Founded in 1985, our team of over 3,000 associates serves more than 2.2 million members nationwide. We currently operate networked managed care programs in eight states, and we are the fifth largest vendor to CMS for the nationwide PDP program.

In order to better serve the Medicare population, WellCare continues to expand its range of Medicare products. In 2006, WellCare laid the foundation for the January 2007 nationwide launch of our Medicare Advantage PFFS plans that feature an open network and additional benefits for members. We operate our open-network MA plans through three life and health insurance subsidiaries under the WellCare name. We contract with licensed, independent sales agents across 39 states and offer these MA plans in 793 counties in 39 states and Washington, D.C. As of March 31, 2007, WellCare has enrolled over 32,000 members in our Medicare Advantage PFFS plans.

II. CMS Audit of WellCare

As you may know, there was a report in the New York Times about a CMS audit conducted on WellCare's private fee-for-service operations. The routine audit consisted of documentation review, interviews with WellCare staff and sampling of various records. Preliminary findings were issued during the exit conference in mid-March and formal findings were subsequently delivered to WellCare.

As a result of the CMS audit, WellCare has improved several marketing processes, two of these, the "secret shopper" program and the telephonic enrollment system, will go a long way towards addressing the concerns put forth by CMS. In addition to those improvements, WellCare has implemented mandatory broker re-training and re-testing, the translation of additional materials into multiple languages, and additional outreach and coordination with advocacy groups and state agencies.

WellCare appreciated the opportunity to have CMS come on-site within the first 10 weeks of our launch of the Medicare Advantage private-fee-for-service program to provide early identification of concerns and improvement opportunities. We welcome input and communication from others on issues and concerns. We will investigate and take swift action when we suspect any abusive practices.

III. OUR DECISION TO JOIN SIX OTHER LEADING MEDICARE ADVANTAGE HEALTH PLANS IN PLEDGING TO STRENGTHEN CONSUMER PROTECTIONS FOR MEDICARE BENEFICIARIES

Based upon our concerns about misleading marketing practices by independent agents, WellCare has helped lead the drive toward industry improvements. We are working with CMS, America's Health Insurance Plans (AHIP), the National Association of Insurance Commissioners (NAIC) and other health plans to develop consistent compliance and oversight standards for independent sales agents.

On June 15, WellCare announced its decision to join six other leading Medicare Advantage health plans in pledging to strengthen consumer protections for Medicare beneficiaries. This pledge includes the accelerated implementation of the 2008 CMS Call Letter, the CMS marketing guidance provided to MA PFFS plans on May 25th as well as the development of best practices for compliance oversight of independent sales agents. To allow time for these activities, the pledge includes a temporary suspension of the marketing of our PFFS plans.

Under the voluntary pledge of compliance with CMS, a plan may not market PFFS plans until CMS certifies that the plan has the additional systems and management controls in place to meet all the additional requirements specified in the May 25, 2007 guidance and 2008 Call Letter issued by CMS. While the full range of updated requirements will be in effect for all sponsors of PFFS plans beginning October 1, 2007, WellCare and the six other MA health plans have agreed to accelerate the adoption of these new requirements. CMS will require the following protections before PFFS marketing can resume:

- All materials, including advertisements, enrollment materials, and materials used at sales presentations must include model disclaimer language provided by CMS in its guidance;
- All representatives selling the product must pass a written test that demonstrates their thorough familiarity with both the Medicare program and the product they are selling;
- A provider outreach and education program must be in place to ensure that providers have reasonable access to the plan terms and conditions of payment, and that provider relations staff are readily accessible to assist providers with questions concerning the plan;
- Outbound education and verification calls will be made to all beneficiaries requesting enrollment to ensure that they understand the plan rules;
- A list of planned marketing and sales events must be provided to CMS that includes events sponsored by delegated brokers and agents as well as those sponsored by the plan; and
- At CMS's request, plan sponsors must provide a complete list of all representatives marketing a PFFS product and authorize CMS to make that list available to State Insurance Departments upon request.

Even before these new CMS requirements, WellCare had previously announced enhancements to our compliance program for our PFFS products, including an inbound telephone enrollment and verification process and a "secret shopper" program using an independent organization to anonymously monitor field marketing activity. These enhancements are in addition to extensive compliance efforts that were already in place for our independent sales agents.

III. WELLCARE'S CURRENT APPROACH TO THE MARKETING OF MEDICARE ADVANTAGE PLANS

WellCare vigorously enforces a zero-tolerance policy for the violation of all laws, rules, and policies. I will address both the Federal and WellCare controls in turn.

A. Federal Controls on the Marketing of Medicare Advantage Plans

As a rule, each WellCare employee is personally responsible for compliance with all Federal, state, and local laws and regulations. All employees and representatives of WellCare must become and remain knowledgeable on the legal and regulatory requirements applicable to their respective positions, duties, and contractual requirements. Additionally, WellCare has created an environment enabling all people who work and are under contract with WellCare to exercise this individual responsibility.

The marketing of Medicare Advantage plans is controlled by Federal regulations and CMS guidance. Federal regulations prohibit the distribution of any marketing materials or election forms to prospective beneficiaries unless approved by CMS. In conducting marketing activities, MA organizations may not: (i) provide cash or other monetary rebates as an inducement for enrollment; (ii) engage in any discriminatory activity, including targeted marketing to Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas; (iii) solicit Medicare beneficiaries door-to-door; or, (iv) engage in activities that could mislead or confuse Medicare beneficiaries or misrepresent the MA organization. Importantly, Federal rules also require an MA organization to establish and maintain a system for confirming that enrolled beneficiaries have in fact enrolled in the MA plan and that beneficiaries understand the rules applicable under the plan.

In addition to regulations, CMS has released numerous guidance documents that reflect CMS's current interpretation of the requirements and related provisions of the Medicare Advantage and Medicare Prescription Drug Plan rules. As I mentioned, on May 25, 2007, CMS issued additional guidance specifically to MA PFFS plans outlining CMS's new requirements for PFFS marketing. Finally, the CMS 2008 Call Letter outlines in detail the information that health plans need to ensure compliance with CMS policies and program requirements.

B. WellCare Health Plans Compliance Programs for Medicare Advantage Plans

In addition to the Federal regulations and marketing guidance, WellCare Health Plans has implemented even stronger oversight policies. These are based upon our corporate ethics and compliance program, known as the Trust Program, that was adopted in 2002. All people associated with WellCare must accept the individual responsibility and duty to conduct WellCare's business in an ethical and compliant manner, consistently adhering to the standards of conduct embodied in the Trust Program.

1. The Trust Program

The Trust Program is the foundation for WellCare's operations, unifying our longstanding corporate ethics and compliance policies under a comprehensive program with the goal of establishing a culture of integrity and trust within WellCare. The Trust Program promotes prevention, detection, and the resolution of conduct that does not conform to applicable Federal or state laws or our high standards of business ethics. The Trust Program applies to WellCare, our Board of Directors, employees, and our business partners. The Trust Program provides guidance and oversight to ensure that all work at WellCare is performed in an ethical and legal manner.

The Trust Program, however, cannot substitute for an individual's personal sense of honesty, integrity and fairness. We strongly encourage all people within the WellCare community to rely on their common sense in recognizing right from wrong using the Trust Program to ensure that we observe high ethical standards.

2. Additional Compliance Measures

To augment the Trust Program, we recently announced enhanced compliance measures designed to protect the rights of Medicare beneficiaries. These enhancements will increase the oversight of independent sales agents who market the company's MA products. Our recent improvements include two new components for oversight of MA independent sales agents. Because independent sales agents market more than health plans, WellCare firmly believes these improvements are necessary to ensure that the quality and professionalism of WellCare's sales practices remains best-in-class.

The first improvement is an inbound telephone enrollment and verification process. This system will allow prospective enrollees an additional opportunity to verify their understanding of plan benefits, acknowledge that they received all the information needed to make an informed decision before joining a Medicare Advantage program, and confirm their voluntary election to select the plan terms. The phone call verification will be digitally voice recorded at the point of enrollment for all Medicare Advantage beneficiaries. With this new enrollment process, WellCare will implement a real-time verification and quality assurance process. The inbound verification program will be in addition to the 100 percent outbound callback program already in place for new members.

The second new component is the launch of a "secret shopper" program where WellCare will use an independent organization to anonymously monitor the compliance of Medicare Advantage independent sales agents. This national program began its rollout just before the announced voluntary suspension of marketing. Once WellCare meets the benchmarks outlined in the agreement with CMS, and resumes marketing, the program will continue its phased nationwide rollout. All results of WellCare's secret shopper program will be reported directly by the independent organization to WellCare's Corporate Compliance department, generally on a same-

day or next-day basis. Like our other compliance and consumer protection measures, the secret shopper program aims at ensuing seniors are fully informed about their PFFS benefits and treated appropriately by independent agents. It also will help us to identify inappropriate agent activity and aid in our ongoing efforts in improving agent education.

In addition, WellCare is working with America's Health Insurance Plans (AHIP) on new principles, standards and practices to further protect Medicare beneficiaries. In short, these new measures will tolerate nothing less than strict adherence to a code of conduct that appropriately educates and protects our members. We are confident that with these new enhancements, our overall compliance strategy will continue to be best-in-class.

Other enhancements to WellCare's compliance program will build upon the extensive activities already in place to oversee independent sales agents for Medicare Advantage private fee-for-service products, including:

- Confirmation of agent's state licensure;
- Extensive criminal background screening;
- Mandatory training and testing on product benefits and marketing guidelines;
- Mandatory contract terms, incorporating a sales agent code of conduct;
- On-site monitoring of agents by field sales management;
- Post-enrollment outreach calls to 100 percent of new members;
- Mandatory re-training and re-testing to refresh knowledge of plan terms and marketing guidelines;
- Secret Shopper program;
- Developing an inbound enrollment verification process;
- Rapid resolution of any identified compliance issues; and,
- Zero tolerance for verified infractions.

3. Sales Agent Code of Conduct

As a leading provider of Medicare products, WellCare has established a reputation for providing quality health plans at affordable rates for beneficiaries. In an effort to ensure all independent sales agents contracted with WellCare are representing our plans with the highest degree of integrity, we also require every sales agent to abide by the "WellCare Sales Agent Code of Conduct." This code of conduct requires the following:

Respect the beneficiary: Agents must provide guidance with the beneficiary's best interest in mind, be respectful of the beneficiaries' wishes and understand their unique health care needs. Sales agents should be available for any questions or concerns before and after the sale.

Provide full disclosure: Agents must present all plan options completely with full disclosure of any plan limitations and compare WellCare plans to the beneficiary's current coverage to ensure they understand differences in features, benefits, costs, and access to providers.

Follow proper marketing guidelines: Agents must follow approved marketing methods for setting appointments and conducting sales sessions as outlined by CMS regulations. Agents cannot solicit individuals via door-to-door sales, phone calls or unsolicited email and cannot solicit or enroll members where health care services are dispensed.

Use approved materials: Agents must use only WellCare and CMS approved materials and agents must not alter the materials in any way. WellCare has developed all the sales and marketing material needed to present plan information to the beneficiary and makes these materials available in multiple languages.

Proper use of sales tactics: Agents must never use high pressure sales tactics to influence a beneficiary's decision to enroll. Agents must allow the beneficiary time to review and understand the information and offer them independent sources of information such as the CMS web site: www.cms.hhs.gov.

Representation: Agents must always represent themselves and WellCare appropriately to ensure that beneficiaries understand that they represent WellCare but are not an employee of WellCare, Medicare, Social Security, or any other government entity.

Use enrollment forms correctly: Agents must not back-date, falsify, or alter any enrollment document or form, and applications must be submitted so that information on the original copy matches exactly with the copy that was left with the prospective member. Completed enrollment forms must be mailed or faxed to WellCare within 24 hours of the date the beneficiary signed the form.

Do not discriminate: To ensure fairness, agents must not discriminate against potential enrollees on the basis of health status, ethnicity, or any other improper criteria. If an agent believes a beneficiary lacks understanding of the program or is of questionable competence, he or she must observe proper procedure by having the

member's authorized representative present at the time of enrollment and approve the member's decision.

Comply with oversight standards: WellCare has rigorous compliance standards for all independent sales agents. Agents must know and understand these standards.

4. WellCare Oversight

To ensure compliance with all marketing guidelines and the Code of Conduct, all Sales Agents are informed and understand that WellCare undertakes the following initiatives:

- Deployment of a secret shopper service to pose as potential beneficiaries to experience the sales process/presentation;
- Revocation of selling privileges for sales agents who do not complete the mandatory training and score 100 percent on the required testing;
- Follow-up calls to all beneficiaries enrolled by any terminated sales agent to confirm the beneficiary's enrollment decision or to facilitate disenrollment;
- Monitoring of sales data for potential issues and to educate or even terminate agents based on the findings, with emphasis on proactive resolution of issues;
- Monitor a confidential compliance Hot Line where members, associates and government regulators can report concerns about potential marketing misconduct; and
- As our inbound enrollment verification process is implemented nationwide for PFFS, all agents will need to complete any sales activities through this process.

The focus of our oversight is to ensure that each Medicare beneficiary receives high quality, professional interaction in their sales experience. Medicare beneficiaries must fully understand their health plan benefits, coverage limitations, and policies to make an informed choice about the health care coverage that best suits their needs. Ensuring a positive sales experience is in everyone's best interest. If a product or service is not good for a beneficiary, then it is not good for WellCare, either.

C. Recent Examples of WellCare's Zero Tolerance Policy

Through WellCare's compliance programs, 18 independent sales agents have been terminated for marketing conduct violations across the country because WellCare has a zero-tolerance for agent misconduct. However, we are never satisfied with our past performance, and we continue to improve our internal compliance measures.

The New York Times report I mentioned was critical of WellCare's private fee-for-service operations, and I'd like to set the record straight. In January 2007, WellCare learned of improper marketing efforts by a California licensed, independent sales agent who was not an employee. This agent translated approved marketing materials into Chinese and aggressively distributed them to a group of Medicare beneficiaries who did not speak English. WellCare immediately analyzed the selling history of this agent to reveal that the agent used inappropriate sales tactics and that the materials he was using were not approved. As a result, WellCare immediately terminated its contract with the sales agent.

Because WellCare takes its responsibilities under the Medicare program seriously, we moved quickly and aggressively. First, WellCare staff commenced mandatory retraining for the insurance agency that contracted with the terminated agent to reinforce the agency's understanding of the Medicare marketing guidelines and WellCare's expectations. Second, WellCare initiated mandatory retraining and testing on a national basis for all licensed independent sales agents under contract with WellCare for its Medicare Advantage products. If sales agents do not complete this follow-on training and score 100 percent on the required retesting, their selling privileges with WellCare will be revoked. Third, WellCare initiated mandatory new member call-backs to 100 percent of new Medicare Advantage enrollees to confirm that their sales experience was positive and that they understand their benefits. WellCare also placed follow-up calls to the beneficiaries enrolled by the terminated agent to confirm their enrollment decision or facilitate disenrollment.

Another recent action occurred with a sales agent in Georgia. In early December 2006, through our monitoring of enrollment applications, we learned that an agent submitted several Medicare Advantage applications for deceased persons. That day, an investigation was initiated and within two days, the agent in question was terminated. We conducted an analysis of and contacted all of the fired agent's enrollees. Through the investigation, we learned that the terminated agent participated in several prohibited marketing activities in violation of Federal regulations, CMS guidelines, and WellCare policies. Accordingly, WellCare informed the Georgia Department of Insurance and Federal authorities of the agent's actions, and we cooperated with them on their investigation. In the spring, the fired agent was escorted from his home in handcuffs by Georgia law enforcement authorities. He and his accomplice are now behind bars.

V. WELLCARE'S RECOMMENDATIONS TO FURTHER IMPROVE MARKETING PRACTICES

WellCare is extremely proud of our Medicare Advantage offerings. The plans offer beneficiaries new choices to broaden the ways in which beneficiaries can receive high quality health care. We are confident that Federal regulations combined with our vigilant internal compliance efforts and commitment by the industry will help ensure the highest standards of integrity. Nonetheless, through the operation of our zero-tolerance policy as well as our recent dialogue with CMS, as evidenced by our new compliance pledge to further strengthen consumer protections, we recognize there is room for improvement. We offer the following recommendations for your consideration:

Development of a mandatory national standardized Medicare training program for all agents selling Medicare products. While plans conduct such training and specific training will always be needed for company-specific benefits and products, consumer protection can be enhanced by ensuring all agents marketing PFFS products are trained with a uniform set of education materials and directed to cover with Medicare beneficiaries a set of mandatory topics and disclaimers. This will provide a platform for excellence in education of consumers and streamline investigation of any compliance issues with agents. This issue is currently under discussion with AHIP and CMS;

Use of an inbound telephone enrollment and verification process that would provide the opportunity to ensure that enrollees fully understand the benefits and features of the plan. Again, this proposal would serve to enhance consumer education and help plans to quickly identify any compliance or training issues with independent agents. It would ensure that no person who did not have an adequate understanding of the PFFS product would be enrolled in the program;

Creation of a national database to provide and share information about agents and brokers that have been sanctioned by a state or terminated by a health plan. While most agents are ethical and professional in their marketing of our products, a national database would allow plans to track and quickly report any issues with a small subset of roque agents—who sometimes seek to sell in other states when their bad behavior is discovered in one state. Again, this issue is currently under discussion with AHIP, NAIC and CMS;

Early implementation of the CMS 2008 Call Letter. This effort is now underway for those plans, like WellCare, taking the voluntary compliance pledge;

Additional provider outreach and education, including fixing the "Common Working File;" and

Industry-wide adoption of secret shopper programs.

While all of the issues mentioned above should be adopted, I want to stress the importance of two of them—inbound verification and a national database. As the Committee is aware, there was an independent agent whose license was suspended in Mississippi, but he continued selling MA plans in another state. WellCare was one of the plans who unwittingly had this agent selling our products in Alabama because Alabama was not aware the agent had been suspended in Mississippi, and he passed all other background checks. We became aware of the Mississippi suspension only through word of mouth during our general outreach effort to the Mississippi Medicaid Agency and the Department of Insurance. When they identified this agent as a problem in Mississippi, we immediately sought to determine if he was selling our products in any other states. He was, we undertook an investigation, and within 72 hours had terminated our relationship with him. We began contacting the members in Alabama he had signed up and worked to disenroll those who were not satisfied with our product.

Luckily, we found this agent, but it was very much due to our aggressive oversight. It is our belief, though, that with inbound verification and a national database, this agent and others like him could be stopped much sooner. Inbound verification would have stopped this agent from enrolling individuals in the first place if they expressed concerns about the agent. We also could more quickly and proactively investigate such agents. And we could quickly report to the central database any termination of an agent to protect other Medicare beneficiaries who may be approached by the same agent marketing for a different company.

In conclusion, we believe the most effective action to undertake on behalf of Medicare beneficiaries is to improve communication channels and provide effective confirmation of allegations of abusive marketing practices. By fostering cooperation at the Federal, state, health plan, and agent or agency levels in communicating and resolving complaints, we can take swift action against those who defraud Medicare beneficiaries.

WellCare is proud to be an industry leader in good compliance. We started with a best-in-class compliance program five years ago and have added enhancements

along the way as we continuously seek to improve the quality of our products, our operations, and the practices of the independent sales agents that market our products.

Thank you again for this opportunity to testify about our perspectives on these important issues. Please be assured that WellCare remains deeply committed to the long-term success of the Medicare Advantage program. We appreciate the critical oversight that the Committee provides over this valuable program and look forward to continuing to work with you to meet future challenges in the Medicare and Medicaid health programs.

Mr. STUPAK. Thank you. We will start with the questions.

Mr. Soistman, Mr. Bailey talked about a national registry for agents, would you be in favor of that?

Mr. SOISTMAN. Mr. Chairman, we would be very much in favor of that.

Mr. STUPAK. OK. Would you be in favor of putting that registry on the Internet so senior citizens would have access to it so they could see if these agents were in fact registered and licensed in good standing?

Mr. SOISTMAN. We think the, Mr. Chairman, we think that information should be available to the public at large and obviously to State regulators provided it is kept timely and it is reliable. I think it could be a very useful tool in the process.

Mr. STUPAK. You have all mentioned the abuses we have heard about on Medicare Advantage. Strike that, I don't want to go there.

Mr. Bailey, let me ask you this question. Your company is on a corrective action plan by CMS right now, is that correct?

Mr. BAILEY. Yes, sir, that is correct.

Mr. STUPAK. What led to that? Why did you have to go on this corrective action plan?

Mr. BAILEY. OK. We were notified by CMS that they were going to do an audit, a full review of our Private-Fee-For-Service plan in March. They visited us on March 12. It was a good opportunity for us. The program was only 10 weeks old and we would rather find out if there were any issues that needed to be corrected sooner than later. So they spent the week with us. We had an informal debriefing at the end of that week on March 16. They actually issued a requirement report to us on April 19.

Mr. STUPAK. Your private plan had only been out there for what, 10 days you said?

Mr. BAILEY. Actually, for 10 weeks. And it is not unusual——

Mr. STUPAK. Was there a lot of complaints then?

Mr. BAILEY. I think there were probably two reasons they decided to visit us. One, it is not uncommon for the agency to visit new plans when they are in start-up mode just to provide technical assistance, but also I think they had received a number of complaints about brokers in general and wanted to visit us and make sure we were doing all that we could do to prevent that from happening. So I think that is the two contributing factors.

Mr. STUPAK. Were the complaints on what you call on the inbound verification call? Is that what the complaints were based on?

Mr. BAILEY. Actually, what they really asked us to do after spending a week with us in terms of corrective action, they wanted to make sure we were managing the broker community as effectively as we could.

Mr. STUPAK. Now a broker community now, that would be agents?

Mr. BAILEY. That would be the agents. Primarily the agent or brokers on this one. They wanted to make sure that, in fact, they wanted to see the results of the calls that we were making, as I had mentioned earlier, we began to make in February before the CMS audit occurred, calls to our Private Fee-for-Service applicants before they were enrolled to gauge the satisfaction of their sales experience.

Mr. STUPAK. Now that is that in-bound verification call, right?

Mr. BAILEY. Actually that is another thing.

Mr. STUPAK. OK.

Mr. BAILEY. There are three different levels of calls. What we do for Medicare Private Fee-for-Service as a result of some of the abuses that we had heard of earlier where that the agent in San Francisco had illegally translated the marketing materials, we realized at that point we need to reach out to the beneficiaries before they were enrolled, before they were into the system, so we implemented a 100 percent call-back on Private Fee-for-Service enrollees. So that is call No. 1.

We would call them and we ask them about their satisfaction of the sales experience. We wouldn't want to do that at the time the broker was there so we waited about a week after is we call them up, go down some of the benefits of the program, some of their understanding, but more importantly how did the sales satisfaction go. So that is the first call.

The second call that we have been doing on all members for our programs are the out-bound calls within 2 weeks of effective enrollment we call them and we discuss with them their understanding of the benefits. We want to make sure that we have the correct address, they understand their benefits and how to access them.

The in-bound telephone and verification call is something relatively new now. Some other major plans are using it. But what we want to do there at the time of a sales transaction, this may have occurred to several folks in this room or up there, with other products. At the time of the sales transaction, before the sale is actually consummated, the agent will make a call, in this case to an enrollment verification specialist working at WellCare, and they will talk to the representative for several minutes to provide some of the beneficiary's information. But more importantly, we ask the beneficiary to take the phone, if they wouldn't mind, and the enrollment verification specialist goes through a pretty detailed questionnaire. We do not ask about broker performance but you understand the deeming concept and how that works, the provider must accept this. Do you understand that if it is a Medicare Advantage plan and we go down a list.

Mr. STUPAK. Does CMS approve these scripts that you are like any other outward communications?

Mr. BAILEY. Absolutely. That script like any other outward communication that CMS has been approved.

Mr. STUPAK. Go to exhibit No. 8. So CMS approved these communications, halftime, extra points, we are urging your agents to sign-up people. You get $100 bonus for every application and you can possibly win a Panasonic 42-inch, plasma HDTV.

Mr. BAILEY. I don't think since this wasn't a communication to the members that CMS would have had to approve it, but I recall this.

Mr. STUPAK. But wouldn't this go to your members, your agents, your brokers, your independent brokers.

Mr. BAILEY. The agents.

Mr. STUPAK. OK. The independent brokers and——

Mr. BAILEY. The CMS approveal, I believe, is required on communications going to the members.

Mr. STUPAK. To members you mean the people you sign-up, in other words.

Mr. BAILEY. We don't do this. We have actually stopped any type of effective incentives January 1, when we began to offer our product. I remember this specifically. We were very concerned about the agents making sure they got their applications of the members to us quickly. Because if not you can run into some date lag so we don't want that, so we actually put incentive out if, in fact, this was to promote them getting their applications into us quickly and not gathering them and sending them all at once.

Mr. STUPAK. But they wouldn't get paid a commission unless they got their application in, right?

Mr. BAILEY. This is true but from the beneficiaries, we wanted to minimize the amount of time from when the beneficiary said I would like to join to when we were able to fulfill the member, the member kit and providing the ID card.

Mr. STUPAK. So you are telling us you had to do this to get them to turn in their applications quicker?

Mr. BAILEY. No, I think at the time we just wanted to just have a double-check to make sure they got them as quickly as possible. Again, we don't do this anymore but at the time the program was relatively new for us, we just didn't have any track records as to how long it would take to get those in. And now we seem to have a pretty good flow of applications and we are not really concerned about this.

Mr. STUPAK. I find that hard to believe that you have to do these kind of incentives to get them to get your application in early. I would think they would get their application in because their commission runs on it, right?

Mr. BAILEY. In terms of what some of the folks have said about things that you have done and what you have learned from them, I think that situations like this that you have raised have driven us to supporting the implementation of the in-bound enrollment verification system. Because, in effect, what you have done there if it is successful encounter between the representative from the plan and the agent and the beneficiary it all transpires over the telephone. It is done telephonically.

Mr. STUPAK. These sort of invites agents to play rather quick and loose with the facts in order to get your points to get your chance to win that plasma TV that retails at, according to your flyer here, $1,439.99. I mean this would be more encouraging to sign people up not to get your applications in quickly. Well, I got to get it in by the deadline if you want to qualify for the contest but and you don't do this anymore?

Mr. BAILEY. No, we don't do that anymore and that, as I said there was some things in the administration of the program that you learn from and you move forward so no we don't.

Mr. STUPAK. OK.

Mr. Whitfield, for questions, please.

Mr. WHITFIELD. Ms. Olson, I represent a rural district and a lot of people like these Medicare Advantage Programs and from your experience as a person selling them, what are the positives about these Medicare Advantage Programs? Why do people like them?

Ms. OLSON. There are a number of reasons. First of all, let me state I do not sell Private Fee-for-Service plans because they don't work very well where I am.

Mr. WHITFIELD. OK.

Ms. OLSON. Medicare Advantage plans are relatively easy to understand. There are co-payments, some of them offer both in-plan and out-of-plan benefits, usually they offer vision benefits, some alternative care benefits, depending on where you are, and the price is reasonable. And you know, pretty much, from month to month as opposed to a Medicare Supplement or a Medigap plan exactly what your out-of-pocket is going to be.

Mr. WHITFIELD. OK. Now, let me ask you, do you represent a lot of different insurance companies?

Ms. OLSON. I use to. I got it down to about seven companies now for my Medicare people.

Mr. WHITFIELD. All right. So you have seven companies that you represent.

Ms. OLSON. Yes, sir.

Mr. WHITFIELD. Are you an agent or a broker or a consultant?

Ms. OLSON. I am an agent and a consultant.

Mr. WHITFIELD. And, Mr. Soistman, your company has a Medicare Advantage Program that it put together and you were selling it, is that correct?

Mr. SOISTMAN. Yes, Congressman, we have multiple Medicare Advantage Programs.

Mr. WHITFIELD. OK. And what percent of your sales force would be actual employees of your company as opposed to independent brokers or independent agents?

Mr. SOISTMAN. Well, our Medicare Advantage plans that are health plan based, we call them coordinated care plans, they are in five markets, and they are limited by the number of counties. So they are not even statewide in those five markets and there are approximately 35 employees who are responsible for selling.

Mr. WHITFIELD. So those are in-house employees and then you have contracts with other agents that can sell them as well.

Mr. SOISTMAN. That is correct.

Mr. WHITFIELD. OK. And, Mr. Bailey, what about how many agents do you have in-house selling these programs?

Mr. BAILEY. I don't have those numbers at my fingertip and I can absolutely get those but I am thinking probably in-house could be 15 to 20 percent, 25 percent of the total agent population.

Mr. WHITFIELD. OK. Now, Mr. Soistman, unfortunately your company was the one involved with Judiciary House and the salesman that sold those Medicare Advantage Programs at Judiciary

House from your analysis and review of that case what did they do wrong?

Mr. SOISTMAN. Well, Congressman, they did a number of things wrong. First, just so the committee understands these are independent agents. They weren't employees of the company. What we have been able to piece together through out internal investigation is that as the previous panel indicated, the agents did call on Judiciary House on two occasions in February. They, apparently, made statements representing that they were from Medicare and that they were there to talk about the new part C programs. So clearly they were misrepresenting themselves. They were misrepresenting the purpose of their visit and, clearly, misrepresented the products that they were marketing. As far as we can tell, they were indeed promoting our Advance for Freedom Private Fee-for-Service plan. We know these agents represent other companies so don't know exactly——

Mr. WHITFIELD. But they both had licenses to sell in the District?

Mr. SOISTMAN. The agent in particular that was identified as having signed the applications was licensed, he indeed was licensed.

Mr. WHITFIELD. And has he lost his license in the District?

Mr. SOISTMAN. He has lost his license and the agency that he is affiliated with was terminated as well.

Mr. WHITFIELD. But it would be possible——

Mr. SOISTMAN. I am sorry, let me correct that.

Mr. WHITFIELD. OK.

Mr. SOISTMAN. He has been terminated, losing his license is not something that we really can affect other than report any agent who has violated the contract and has done something of a significant nature including fraud, we would report them to the State Department of Insurance.

Mr. WHITFIELD. But if he went to Mississippi, say, and wanted to sell insurance in Mississippi on his application would he have to state or would they ask the question have you been terminated in another jurisdiction or do you know?

Mr. SOISTMAN. I would imagine that in most States that is a requirement if you have ever lost your license you have to report that. The States, I think, are somewhat limited in terms of the availability of that information though.

Mr. WHITFIELD. Now, Ms. Clegg-Boodram, mentioned in her testimony that when the Federal law passed that allowed Medicare Advantage Programs to be sold that in essence CMS was prohibited from bringing any Medicare fraud charges against anyone. Now, you understand as an insurance company selling Medicare products you can be prosecuted for fraud by CMS, is that correct?

Mr. SOISTMAN. Well, we can certainly, CMS has the authority to take multiple actions, corrective actions, sanctions, et cetera, if we are violating our agreement or not living up to the agreement.

Mr. WHITFIELD. So that is quite clear that that is still in place which we think is certainly helpful and I see my time has expired.

Mr. STUPAK. Thank you, Mr. Whitfield.

Mr. Walden.

Mr. WALDEN. Thank you very much, Mr. Chairman. I want to welcome our panelists. I appreciate your testimony as well.

Mr. Bailey, I want to go to you on this extra points sales promotional flyer that went out to the agents. At the very bottom it says WellCare reserves the right at its sole discretion to determine eligibility for this program on a case-by-case basis and may disqualify agents if they violated any of these provisions, the producer agreement, CMS Marketing Guidelines, or the law. So this flyer would aggressively, well, it is designed to get agents to go out and sell your product first of all, which isn't an offense I don't think.

I have been in the broadcast business for 20 years and we are always trying to find ways to incent agents but we don't incent them to violate the law or other practices of ethical business behavior, so my question is given that last line there, were there agents that you encountered that went too far in WellCare, and if so were there case-by-case situations where policies were not appropriate had been issued and were subsequently reviewed and terminated?

Mr. BAILEY. Let me try to answer that question the best that I can. We have terminated 18 agents in the last 7 months.

Mr. WALDEN. Eighteen agents.

Mr. BAILEY. Eighteen agents. When an agent is terminated in terms of the downstream effect what we do is we then reach out to talk to all of the enrollees of that particular agent just to make sure that they were fully informed as to what the plan was at the time of enrollment.

Mr. WALDEN. And let me stop you on that point because in the prior panel I asked about the call-back notion which is a little different then this but it is basically the same, you are checking back and the answer I got was generally that that is not an effective technique because some of these people don't know whether they are in the right plan or not.

Mr. BAILEY. All right. Well, several comments. With regard to the calls that we made we actually have a compliance staff with WellCare that will make these particular calls and we will basically advise them, of what happened with the agent we found that he had provided misleading information, and we just want to make sure were you satisfied with the presentation, do you feel fully informed. And several of those individuals for whatever reason whether because of the fact we have told them about the agent or have had second thoughts, have wanted to dis-enroll and we have worked with CMS and the regional office the SHIP, whomever to dis-enroll those people.

In terms of the previous person's comment, I can understand that. I think that having an out-bound telephone verification system, an out-bound call process, 2 to 3 weeks after they enroll which what we do is great but it doesn't go the whole way. We think it needs to be done in conjunction with the in-bound telephone verification enrollment system. And that is when the beneficiary actually is at the conclusion of the appointment with the licensed agent the broker asks if he may use the beneficiary's phone and they call an enrollment specialist in the plan. The enrollment specialist goes down a very detailed questionnaire to try to tease out the fact that the beneficiary isn't fully informed and if any of these answers appear not to be the fact that—not to be the matter, actually, we actually will end it at that point. But what we will do is say please, give the call back to the broker, the telephone back to the broker

and we will explain at this particular point we don't think the person is fully informed. It is not good to have someone that is not fully informed in our plan.

Mr. WALDEN. So are you doing that now with each enrollment?

Mr. BAILEY. Well, actually we were ready to roll this out.

Mr. WALDEN. OK.

Mr. BAILEY. And then we participated and we let the enrollment freeze.

Mr. WALDEN. Right.

Mr. BAILEY. This was absolutely directed towards brokers so while this halt is here, and we are determining other ways to strengthen our broker management processes, we are actually looking at this again to strengthen. But, yes, we are ready to roll this out and we are excited about this.

Mr. WALDEN. OK. Mr. Soistman, is your company looking at a similar sort of proposal?

Mr. SOISTMAN. On the post verification process?

Mr. WALDEN. Or the in-bound, as the agent is sitting there counseling somebody if they say it is, I have been on those solicitation calls, not insurance but like to my alma mater and if you agree to give they say, OK, now I have got to put my supervisor on the line and they confirm that I have agreed to give. It sounds like that sort of process is what Mr. Bailey's company is looking at. Is that something that would work for yours?

Mr. SOISTMAN. Congressman, we have some concerns about that process. More specifically, we are concerned that there may be a feeling of intimidation to have the agent and the Medicare beneficiary going through that process together and we really feel that it would be best when the agent leaves to then confirm and we can ask a series of questions and do it in a way that is far less intimidating.

Mr. WALDEN. Well, let me because my time is about expired. I was troubled by some of the comments from the last panel of the delays in being able to get a live body on the line to get an answer. And my frustration level is pretty short when it comes to trying to get consumer help. And I am curious, maybe Ms. Olson, can you tackle that one for me? What needs to happen there that seems like a real abuse.

Ms. OLSON. If I was queen of CMS or whatever——

Mr. WALDEN. Well, if you have got the answer we may convene that.

Ms. OLSON. We need a lot more very well-trained customer service people, poly-lingual, if possible. I tell my people if they are calling Medicare, 1–800-MEDICAR, have a cup of coffee there. Be ready, it is going to take some time.

Mr. WALDEN. Right.

Ms. OLSON. And be prepared. The Medicare Advantage plans and the prescription drug plans have caused huge numbers of questions. In Multnomah County, OR, we have 47 different Medicare Advantage plans available. That is absurd. If I was running things I would standardize the Medicare Advantage plans and that was spoken of earlier. I think that makes sense the same way we did with the Medicare Supplements a number of years ago and I was involved in that. This population in particular, spends a lot of time

on the phone and they are very deliberative and they have a lot of questions. And if an agent can't answer them properly, first of all that agent shouldn't be selling the product. Second of all those people need to have instant access to somebody who can answer their questions.

Mr. WALDEN. And is that the responsibility of Medicare or Medicare and the plans?

Ms. OLSON. It could be the State SHEBA programs. It could be the insurance plans.

Mr. WALDEN. Does anybody track how long you wait on the call, and does that matter to anybody?

Ms. OLSON. Yes, I do.

Mr. WALDEN. Who, but I mean as a consumer, do I know I have been on, I think, phone companies that sort of thing, they tell you how long you have waited but there internally they are regulated on that, too, by their regulators. Does anybody regulate you all on that from the plans, do you regulate it?

Mr. SOISTMAN. I am happy to field that question.

Mr. BAILEY. Yes, we have. We do have performance measures and metrics on the quality and of the phone calls that we make with members. I don't have them all at my fingertips. One is the average speed of answer.

Mr. WALDEN. Got it.

Mr. BAILEY. Another one is the waiting time. I am not sure exactly——

Mr. WALDEN. Are those data published anywhere for consumers to know about?

Mr. BAILEY. I believe, we share those with CMS. I can verify that.

Mr. WALDEN. OK. They are going to be on our next panel, I guess, so thank you. Thank you. I have way over-extended my time. Thank you very much.

Mr. STUPAK. Let me follow that up, will you provide those numbers to us, the waiting time and quality there? If you provide them to CMS could you provide them this committee?

Mr. BAILEY. Absolutely. And what is very interesting is the person that runs our call center is extremely proud of those because we always exceed the CMS metrics, so when I tell him that the committee has asked for this, you will get it post haste, sir.

Mr. STUPAK. OK. This is not your agents waiting but your clients waiting.

Mr. BAILEY. No, at WellCare employee we have a call center that this year we will probably handle 10 million calls and we are proud of what they do and he will be very proud to submit the data and probably come on a plane and walk you through it. I know him very well.

Mr. STUPAK. OK. And the last panel told us we would almost need a direct line to Starbucks just to stay awake on the phone.

Mr. Soistman, can you also provide those waiting time for us?

Mr. SOISTMAN. Mr. Chairman, it would be my please to do that.

Mr. STUPAK. OK. Thanks. Thanks, Mr. Walden.

Mr. Burgess, for questions.

Mr. BURGESS. Thank you, Mr. Chairman. I can assure you that I was monitoring the time that Mr. Walden went over.

Let me ask our witness from Coventry, Mr. Soistman, you heard the testimony from the previous panel on the problems that the young lady with multiple sclerosis had when she went to the emergency room with the Coventry plan. Now, if you proactively do these phone calls back to the people who signed-up for the program, a lot of times they aren't going to know that they have a problem with the product that they have purchased until they go to use it. So what, do you have any quality assurance mechanism in place at your company that makes certain that at the point of utilization that the beneficiary who enrolled in the plan understands what they got what they understood they were getting? Because it seemed to be a real disconnect there regardless of how she was signed-up and whether or not it was, in fact, proper to sign her up, the disconnect between what the beneficiary thought they had and what they actually had?

Mr. SOISTMAN. Congressman, let me begin by answering it this way that the product that Ms. Williams and Ms. Royal both were enrolled in was not really the right product given their Medicaid status, the Medicare/Medicaid status. And that is getting to the root cause which we took steps in early January.

Mr. BURGESS. Well, let me just ask you this. Do you think proactively you have gone back and now identified all of those potential problems and corrected the defects in plan coverage that might have been given to a dual-eligible?

Mr. SOISTMAN. I don't think we have corrected all of the defects meaning that there are still individuals enrolled who are dual-eligibles into these plans. We have reached out to all of the dual-eligibles who were associated with agents who misrepresented the product to make sure that they knew they had an opportunity to switch plans if they so choose.

Mr. BURGESS. Was that only with a telephone call because again we heard testimony from the last panel that maybe a telephone call may not be a sufficient way to conduct that interview?

Mr. SOISTMAN. Presently, our process is by telephone. If we are not able to reach the beneficiary by telephone we then provide a letter.

Mr. BURGESS. I don't want to ask this question but I have to. You don't outsource that calling, do you?

Mr. SOISTMAN. No, Congressman.

Mr. BURGESS. This is someone who speaks English at least, we heard about the problem of needing multiple, somebody who is poly-lingual but at least the person who is calling them back is calling from an American call center?

Mr. SOISTMAN. It is and I am pleased to say, Congressman, that we built that call center in your home State of Texas.

Mr. BURGESS. Then I know they are getting good service. I appreciate that. Well, how—for any of the three up there—do you account for the predatory practices actually beginning in the first place? What was the driver there? I mean you are talking about, Ms. Olson, you are talking about $4 a beneficiary, is that enough to drive the kind of practices that we are seeing that caused people to go door-to-door to sell these policies?

Ms. OLSON. Well, $4 per month per client. And, of course, that is one plan I am selling. I have one plan that I sell where I don't

get paid anything per month. But I think the initial rules were not as clear as they could have been and I think in the big rush to get particularly the Medicare Advantage with prescription drug plans up and a number of us talked about this before it happened, that we would see a rush towards people signing-up as many clients as they possibly could, either on the agent level or on the company side.

Mr. BURGESS. Let me ask you this. We heard testimony from the panelists who were the State insurance commissioners or deputy commissioners and I have in the evidence binder under tab 10 I have a letter from the Department of Insurance from the State of North Dakota, Mr. Poolman, and the opening paragraph, or the second paragraph, as part of MMA 2003, the regulation of Medicare Advantage plans and the companies marketing them was given to CMS. And the letter goes on to state that maybe that is not the best way to deal with that. Does anyone on the panel here agree or disagree with that statement that, perhaps, this authority should be given back to the State commissioners or do you feel that the State commissioners lack the authority that they need to be able to adequately provide the oversight?

Ms. OLSON. Well, since my license or one of my licenses is and my real license is through the State of Oregon, I mean I have real license elsewhere but the State of Oregon can take away my license. And at that point I would lose my errors and omissions insurance and in theory could not get my license back again.

Mr. BURGESS. So the amount of regulatory authority that the State commissioner at least in Oregon possesses should be adequate for oversight to prevent this problem from happening?

Ms. OLSON. On the agents' side, I would think.

Mr. BURGESS. Mr. Bailey, you alluded to the fact that there was an agent arrested in Georgia, is that correct?

Mr. BAILEY. Yes, we had a situation where we have a process in place to check the validity of the applications when they come in and the system showed us that some of the applicants, in fact, were deceased. We conducted a quick investigation. We terminated the broker. We contacted the Georgia Department of Insurance and they conducted their own study. We helped them on the study and they actually, that agent and his accomplice were arrested, not sure of the disposition now, but they were arrested.

Mr. BURGESS. Did that State insurance commissioner, let me—did they have the authority to do what they needed to do under the laws as it is written?

Mr. BAILEY. I have not personally spoken to the commissioner. I can assume that they probably have revoked this gentleman's license and the fact, and actually he was incarcerated for some period of time. What we have found in terms of, it wasn't so much a case of do we need additional regulation, it was more from what we have seen over the last 25 or 26 weeks since we have been in the program, it is more an instance of communication and coordination. We have reached out to a lot of DOIs to share information with them. A lot of the DOIs have reached out to us to share information with us just like the case for Mississippi where they advised us of the gentleman that was working without—well, they had suspended his license. What we have found we need to bridge

the coordination, the communication gap, we need some tools. We need some help. And we think the national database where anyone can go in and put information in, and anyone even an insurance commissioner can check not only what is happening outside of his or her State boundaries, but also within the State. We think that coupled with something else that I want to mention also, which was a national, mandatory standardized training program for any agent that is going to sell Medicare products. We have a lot of companies selling Medicare products. We probably all have what we consider to be good training materials. We would like to see something up to the next level, work under the auspices of CMS and have this out and have——

Mr. BURGESS. Does that function not already get taken care of by the individual States in their Department of Insurance?

Mr. BAILEY. I am sure that training of the agents is absolutely essential to the States' requirements but we are talking about a consistent and mandatory training to at least guarantee that every agent has a certain level of Medicare across the country and that is what——

Mr. BURGESS. Well, shouldn't you as a company demand that of any agent that sells policies on your behalf?

Mr. BAILEY. We provide our own training not only on Medicare but also on our particular products. But we would like to make sure that we are just taking advantage of any best practices and taking advantage of the expertise of CMS in helping to develop this training program and then making it mandatory.

Mr. BURGESS. OK. Thank you. And, Mr. Chairman, I see that I have used all of the additional time that Mr. Walden used.

Mr. STUPAK. And let us go another round I think if you have some more questions we can go a little bit more with this panel.

Ms. Olson, you are an independent or representing the independent insurance agents, correct?

Ms. OLSON. And I am an independent insurance agent.

Mr. STUPAK. So you sell more than just Medicare Advantage policies all kinds, home, casualty, life, the whole thing.

Ms. OLSON. Oh no, health insurance, life insurance.

Mr. STUPAK. OK.

Ms. OLSON. Long-term care.

Mr. STUPAK. So what is the benefit of having an insurance agent acting as the middle person, if you will, between an insurance company and a consumer?

Ms. OLSON. There are a number of reasons. First of all, we know those products very well. In some cases I designed the products that I am now selling, when I was working for the insurance companies. So I know the products and that is why I finally cut it down to about seven products.

Mr. STUPAK. Seven products or seven companies?

Ms. OLSON. Seven companies.

Mr. STUPAK. OK.

Ms. OLSON. I take the time, I can also translate what the paper says into a real life situation for them. I also make sure that all of my clients know that no matter what the problem is if they have a problem with their health insurance, they call me. I have trained most of the agents in our State about Medicare so I get a lot of re-

ferrals from other agents. And I know most of the people who work for the insurance companies I use.

Mr. STUPAK. Where is the breakdown here, Medicare Advantage and last year we have had all these reports and that is the reason we are having these hearing.

Ms. OLSON. Right.

Mr. STUPAK. I hear the company saying it is those darn agents. On you, on behalf of the agents saying no, the companies aren't doing it right. Where is the breakdown here? When you, when the last panel, Mr. Harrell, says they have had more complaints on Medicare Advantage then they do on Hurricane Katrina claims in Mississippi so where is the breakdown?

Ms. OLSON. That is outrageous. We need to have the standardized training. Standardized training for all agents who are selling Medicare-related products. And that is what the National Association Health Underwriters and the American Health Insurance plans has put together. CMS has already approved it to be used.

Mr. STUPAK. Well, it is a guideline. What CMS is suggesting so far has been guidelines. Where is the enforcement of a guideline? What happens if you violate the guidelines?

Ms. OLSON. Refuse to appoint agents who have not taken that training.

Mr. STUPAK. All right. And then the company should pay for the training then I take it?

Ms. OLSON. Not necessarily.

Mr. STUPAK. You want CMS to pay for the training?

Ms. OLSON. No, I would pay for it.

Mr. STUPAK. OK.

Ms. OLSON. I have paid for it.

Mr. STUPAK. Well, all right. Let me ask you this, one policy you said you received no money, then one policy you said you received $4 a month and you spent a lot of time. You said you have never been to Vegas.

Ms. OLSON. Well, I have been to Vegas, but I haven't been paid to go to Vegas.

Mr. STUPAK. Then maybe that is where you make a living because I see one policy with no money and another one $4 a month. To even qualify for that plasma TV at $1,400 you would have to, at $4 a month, you would have to go 360 months and that is 30 years. If you sell it to a person who is 62 you have to make sure they live to 92. Is that right?

Ms. OLSON. Exactly. Right.

Mr. STUPAK. So doesn't these incentives like tab No. 8 about the plasma TV, isn't it really incentives for agents to cut corners to get that commission to move things along faster?

Ms. OLSON. I certainly hope not.

Mr. STUPAK. But isn't that the purpose of it really?

Ms. OLSON. I am sure it can be interpreted that way.

Mr. STUPAK. Well, do you really think that it is the gift of deadlines. No, I didn't think so either. The seven companies you sell for do you get prizes? Do you qualify for prizes and trips?

Ms. OLSON. Sometimes they are available I just never get there.

Mr. STUPAK. OK.

Ms. OLSON. I don't do enough business with one company to qualify for something like that.

Mr. STUPAK. Well, what other suggestions are there other then—let me ask you this. CMS rules currently allow cross-selling. Would you support a rule banning cross-selling?

Ms. OLSON. Cross-selling?

Mr. STUPAK. Of policies met, I go from Mr. Bailey's to Mr. Soistman's, I am cross-selling two different insurance products.

Ms. OLSON. Well, only during enrollment or if you moved out of the service area could you do that.

Mr. STUPAK. Well, I don't know. That is why we are trying to see if this cross-selling is a good idea or not. It is two different products.

Ms. OLSON. You mean to voluntarily move a client's insurance so that you get like the big first year commission or bonus?

Mr. STUPAK. Commission, yes.

Ms. OLSON. Well, that is extremely unethical.

Mr. STUPAK. Well, so you wouldn't——

Ms. OLSON. Not if it wasn't right for the client.

Mr. STUPAK. If we banned it that would be OK?

Ms. OLSON. For me it would be fine.

Mr. STUPAK. OK. Because it is that first year where you make your money, right?

Ms. OLSON. Not necessarily. If you are just going to make $4 a month for the life of the contract you just want them to live a long time.

Mr. STUPAK. Sure, but aren't some of them set-up that if you switch over in the first year there is a pretty good bonus? You are not aware of that?

Ms. OLSON. It has to be the right thing for the client.

Mr. STUPAK. Right, I realize all that. I am saying what is the reward for doing it in cross-selling? Isn't that the benefit, you get a——

Ms. OLSON. It can be very definitely.

Mr. STUPAK. OK. Thank you.

Mr. Whitfield, questions?

Mr. WHITFIELD. Just one other question.

Ms. Olson, obviously there are some unscrupulous sellers out there and that has been demonstrated quite clearly. But you are a professional in Oregon and you have a reputation of selling health insurance plans for people and I am sure you have experienced some situations where you sold a plan that turned out not to be the right plan and a person came back and you have to deal with that to dis-enroll and so forth. So as a person who is in the community and a part of that community, I mean you have every incentive to be sure that they get the right plan, don't you?

Ms. OLSON. Absolutely.

Mr. WHITFIELD. I would think it would be a major headache to sell somebody the wrong plan and they don't have the coverage, I mean they would be pretty upset.

Ms. OLSON. Very definitely. It saves me a lot of time to do it right the first time.

Mr. WHITFIELD. Right. And what we have to be sure of from our next panel is that CMS is providing the tools to make sure that everyone has the incentive to do it right the first time, so, thank you.

Mr. STUPAK. Nothing? All right. Then we will move on to our third panel. Thank this panel for their time and efforts and testimony today and answers. Thank you.

Our third panel is Ms. Abby Block, director of the Center for Beneficiary Choices at the CMS Centers for Medicare and Medicaid Services, the Honorable Kim Holland, commissioner at Oklahoma Insurance Department, and Mr. Jim Poolman, commissioner at the North Dakota Insurance Department. We will have those witnesses come forward in a minute here.

It is the policy of this subcommittee to take all testimony under oath. Please be advised, witnesses have the right under the rules of the House to be advised by counsel during testimony. Do any of our witnesses wish to have counsel present during their testimony? Ms. Block? No. Ms. Holland? Mr. Poolman? OK.

All right. Then I will have you rise and raise your right hand and take the oath, please.

[Witnesses sworn]

Mr. STUPAK. Let the record reflect the witnesses have indicated in the affirmative. They are now under oath. We will start with opening statements. We will start with Ms. Block, if you would please for your opening statement.

STATEMENT OF ABBY BLOCK, DIRECTOR, CENTER FOR BENEFICIARY CHOICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. BLOCK. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss oversight issues related to Medicare Advantage organizations, particularly with regard to marketing.

As you know, Medicare Advantage offers an affordable, high-value choice in comprehensive health care coverage for all Medicare beneficiaries. I am also pleased to report that this year beneficiaries selecting an MA plan are receiving on average $1,032 per year in benefits over and above what original Medicare provides.

Enrollment in growth in one type of MA plan, the Private Fee-for-Service plan, has increased precipitously since the Medicare Prescription Drug Improvement and Modernization Act of 2003. In fact, more than 500,000 beneficiaries have enrolled in Private Fee-for-Service plans from August 2006 to February 2007.

However, specific features of the Private Fee-for-Service product are unfamiliar to many beneficiaries and providers and, therefore, a certain level of confusion with this product is coming to light as more people enroll. Responding to emergent concerns, CMS is building on lessons learned and information gathered during 2006, to strengthen its oversight of Private Fee-for-Service plans, and all Medicare organizations in 2007 and forward into 2008, ensuring beneficiaries' protections begins early. Before a plan sponsor is allowed to participate in the MA program it must submit an application and secure CMS approval. CMS conducts a comprehensive review of all applications to verify compliance with a broad range of important protections. Any deficiencies in these areas must be

cured before a plan is able to go to the next step of benefit and bid review.

Second, upon successful completion of the application or renewal process, plans submit benefit packages and bids for CMS review and negotiation. Through the bid review process CMS assesses MA benefit packages to ensure that they are not discriminatory against certain classes of beneficiaries. In the CMS actuarially equivalence test on the benefit packages and cautionary arrangements reviews, benefit packages must be valued as equal to or better than Medicare Fee-for-Service.

Once plans have secured application and bid approval, CMS continually collects and analyzes performance data submitted by plans' internal systems and beneficiaries. The recently released 2008 call letter to plans serve as a central guidance document to help plans implement new CMS policies and procedures. Baseline measures for performance measures outlined in the call letter will be used for the MA plan report card available this fall, in time for the next open enrollment period. And, by the way, we monitor, and those report cards will include information on wait times at call centers, at plan call centers. All of that is very carefully monitored and there are requirements in place. CMS' monitoring of the performance metrics is supplemented by routine and targeted audits of MA plans which is outlined in more detail in my written testimony.

In addition to regularly scheduled audits, a new contract, a risk assessment tool, will be available in the fall of 2008, and will be used to identify organizations and program areas representing the greatest compliance risks to Medicare beneficiaries and the Government in order to focus audits in the highest risk areas.

On May 21, 2007, to further support compliance efforts, CMS issued a proposed rule strengthening its current oversight requirements and penalties for Medicare Advantage plans and part D prescription drug plans. Among other things, CMS proposed new steps to help expose potential fraud or misconduct through mandatory self-reporting of compliance violations as well as modifications to the current rules to expedite our ability to take compliance actions, including non-renewal of contracts.

On May 25, 2007, CMS released guidelines that include specific policies for Private Fee-for-Service MA plans designed to protect beneficiaries from inappropriate sales tactics. Those guidelines say that Medicare Advantage organizations must monitor the activities of employees and contractors engaged in the marketing of plans to potential enrollees to ensure that their activities comply with applicable Medicare and other Federal health care laws.

We are working with State insurance department officials and the National Association of Insurance Commissioners to address problems with marketing. Part of this effort includes a Memorandum of Understanding that allows States and CMS to share information more easily.

As an update to the number in my written testimony, I am happy to say that to date 27 States, Puerto Rico, and the District of Columbia, have signed the MOU. These agreements are critically important because State insurance departments, indeed, retain jurisdiction over licensed brokers and agents in their States. And CMS requires that plans use only licensed agents.

Therefore, States can act on information they receive from CMS or any source to control any inappropriate or illegal marketing practices of their licensees.

We are particularly concerned about reports of marketing schemes designed to confuse, mislead or defraud beneficiaries and have taken very vigorous action to address these issues. Ninety-eight Medicare Advantage plans are on a corrective action plan to fix identified problems and allow enhanced monitoring of their conduct.

In a further step to target marketing violations, CMS recently announced that seven health care organizations have agreed to voluntarily suspend the marketing of Private Fee-for-Service plans. CMS will certify that a given plan is ready to resume marketing when the plan has demonstrated to us that it has the systems and management controls in place to meet all of the conditions specified in the CMS marketing guidance I mentioned earlier.

Again, this guidance includes strong measures such as verification of the beneficiaries intent to enroll, documented training of marketing agents and brokers, and inclusion of a clear disclaimer statement in all Private Fee-for-Service marketing materials that tells beneficiaries what a Private Fee-for-Service plan is and what it is not.

We are putting in place a rigorous process to review organizations' actions to determine when CMS can certify that the plan is ready to resume marketing. Violations after plans resume marketing will be subject to the full range of available penalties which include suspension of enrollment, suspension of payment for new enrollees, civil monetary penalties, and termination of the plan's participation in the Medicare Program.

This voluntary suspension action is meaningful and precedent-setting and indicates how important good practices are to both CMS and the industry. The organizations included in the voluntary suspension represent 90 percent of Private Fee-for-Service enrollment. Their willingness to forego significant enrollment opportunities indicates their determination to work with CMS to root out problems and do the right thing for beneficiaries.

CMS has also developed Standard Operating Procedures to implement our long-standing policy that any beneficiary who believes he or she was enrolled in a plan without consent, or through misinformation may contact 1–800-MEDICAR to request prospective disenrollment assistance, or work through a CMS regional office to request assistance with retroactively dis-enrolling from the plan, and returning to original Medicare, if desired. CMS is committed to taking whatever steps are necessary to ensure that people with Medicare are not misled or harmed by MA plans or their agents. As evidenced by our recent actions, we are putting beneficiaries first and we will continue to do so.

Thank you and I look forward to taking any questions.

[The prepared statement of Ms. Block follows:]

Statement of
Abby L. Block
Before the
Energy and Commerce
Subcommittee on Oversight and Investigations
On
Marketing of Medicare Advantage Plans

June 26, 2007

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss oversight issues related to Medicare Advantage (MA) organizations, particularly with regard to marketing.

First, I would like to emphasize that the MA program is providing an affordable, high value choice for all Medicare beneficiaries. Enrollment is at an all-time high and plans are available in every State across the country, including rural areas. In 2007, beneficiaries in all fifty States have access to MA plan options. Almost one in five beneficiaries (8.3 million) has elected private plan coverage for 2007. Of these enrollees, 93 percent are in MA plans, with the remainder in other private Medicare plan options such as cost contract plans or PACE plans.

I am also pleased to report that this year, beneficiaries selecting a MA plan are receiving, on average, $1,032 per year in benefits over and above what original Medicare provides.

Enrollment growth in one type of MA plan – the private fee-for-service (PFFS) plan – has increased significantly since the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). More than 500,000 beneficiaries have entered PFFS plans from August 2006 to February 2007. However, specific features of the PFFS product are unfamiliar to many

beneficiaries and providers, and therefore, a certain level of confusion with this product is coming to light as more people enroll. Responding to emerging beneficiary and provider concerns, CMS is building on lessons learned and information gathered during 2006 to strengthen its oversight of PFFS plans and all MA organizations in 2007 and forward into 2008.

CMS oversight protocols include a rigorous application and bid review process, which helps ensure that beneficiaries in private plans have adequate access to the health care services they need, and are not discriminated against in any way. During the benefit year, CMS continuously monitors plan performance and tracks complaints. In the marketing area specifically, CMS has strengthened oversight through expanded partnerships with the States, and acts to quickly resolve complaints received through 1-800-Medicare and our Regional Office casework system.

Application and Bid Review Process

Before a plan sponsor is allowed to participate in the MA program, it must submit an application and secure CMS approval. CMS conducts a comprehensive review of all applications to verify compliance with a broad range of important protections. Plans must submit licensure, formulary (for plans providing prescription drug benefits), and service delivery information for CMS review prior to being accepted for the following contract year. Any deficiencies in these areas must be cured before a plan is able to go to the next step of benefit and bid review. CMS establishes a single point of contact (Account Manager) for each plan sponsor, who coordinates all communications with the plan. Account Managers also work with plans after they have been accepted into the MA program to help resolve any compliance issues that may arise.

Upon successful completion of the application / renewal process, plans submit benefit packages and bids for CMS review and negotiation. Through the bid review process, CMS assesses MA benefit packages to assure they are not discriminatory against certain classes of beneficiaries. After assuring that all Part A and Part B covered benefits are included in the plan's benefit design and that any supplemental benefits are allowable, CMS conducts an actuarial equivalence test on the benefit packages and reviews the cost sharing arrangements. Plan benefit packages must be actuarially valued as equal to or better than fee-for-service Medicare. MA plans are free to structure their cost-sharing in ways different than fee-for-service Medicare, provided that it is at least actuarially equivalent to fee-for-service Medicare and any differences in benefit design are not discriminatory. The cost-sharing review and subsequent negotiations are used to identify and improve benefit packages that seem to be outliers. CMS employed twelve specific benefit-related criteria to identify and address (through negotiation) outlier benefit designs for 2007.

In addition to the benefit review, the CMS Office of the Actuary reviews the pricing of the bids to assure that the pricing is supported on an actuarial basis, and reasonably and equitably reflects the plan's estimated revenue requirements for providing the benefits. By statute PFFS and MSA plans are exempt from some of the baseline measures for performance data, but the 2008 Call Letter strongly encourages PFFS plans to voluntarily provide this data for inclusion in the report cards. A plan's revenue requirements (as reflected in the bid) for a given county typically differ from the county's benchmark, which is the maximum amount Medicare will pay a plan for delivering the Parts A and B covered benefits, determined by CMS under a statutory formula. (For most plans, benchmarks are based on county capitation rates that were used to pay plans

before the bidding system began in 2006.) Generally, a plan's overall benchmark is the average of county rates weighted by projected plan enrollment in each county. In most cases, the benchmark exceeds the plan's bid. The plans are required to use 75 percent of the difference between the benchmark and the bid to provide extra supplemental benefits, buy-down Part B and D premiums, or reduce cost sharing amounts. The remaining 25 percent reverts to the Federal Treasury. Plans that bid above the benchmark must charge a premium in addition to the Medicare Part B premium for Medicare covered services. CMS annually reviews its bid submission and evaluation tools and its review and negotiation processes, making refinements to continuously drive MA plan offerings toward higher value for beneficiaries.

Performance Monitoring and Compliance Actions

Once plans have secured application and bid approval, CMS continually collects and analyzes performance data submitted by plans, internal systems, and beneficiaries. The recently-released 2008 Call Letter to plans serves as a central guidance document to help plans implement new CMS policies and procedures and improve compliance with critical program requirements. In the Call Letter, CMS identified baseline measures for performance data that will be used for report cards in the upcoming open enrollment period. We are tracking plan performance on those measures and contacting those organizations where we are seeing early patterns or potential problems. By statute, PFFS plans and MS plans are exempt from some of the foregoing requirements.

CMS shares key plan performance metrics of MA Plans with Part D coverage with beneficiaries on the Medicare Prescription Drug Plan Finder feature of the www.medicare.gov web site.

CMS is also improving ways of collecting performance data and refining our performance measures for the development of comparative materials such as plan report cards, so that people with Medicare can better evaluate their health care plan options. As CMS expands its web-based and other resources, we expect sponsoring organizations to provide comparative, in-depth plan information so people can choose the health plans that best meet their needs. Looking forward, new areas for measurement may include, but are not limited to: medication therapy management (MTM) services, prescription drug utilization, patient safety, disenrollment rates, and member satisfaction. This Fall, CMS will release an MA Plan Report Card to help patients compare all private plans with or without drug coverage to better inform choices for the next enrollment period.

CMS monitoring across the performance metrics is supplemented by routine and targeted audits of MA plans. In the auditing process CMS first reviews aspects of plans where data is not submitted, verifies contractor self-reported data to be credible and accurate, investigates irregularities or outliers identified in self-reported data and documents to external auditing agencies (e.g. OIG, GAO, and CFO auditors) that CMS had adequate internal controls. The audit is conducted by a cross-functional team including CMS central and regional office staff to ensure the necessary expertise for the selected audit areas and provides independence and unbiased objectivity. CMS established a three year comprehensive regularly scheduled audit cycle for MA plans. The cycle consists of yearly randomized desk audits and one mandatory on-site audit. The yearly audits should cover approximately one-third of the 14 program audit areas. All 14 audit areas must be covered within the three year period. More targeted audits will take place as a result of questionable findings through contractor management activities, such as data

analysis or analysis of appeals, grievance and complaint data.

CMS has strengthened its methods for identifying companies for compliance audits and making more efficient use of the resources available for ensuring compliance. A new contractor risk assessment methodology identifies organizations and program areas representing the greatest compliance risks to Medicare beneficiaries and the government. CMS will direct its resources to those high risk contracts. We envision that this approach to oversight will include a mostly centralized data-driven program, fueled by data provided by contractors and beneficiaries. While receipt and analysis of data is critical to this oversight strategy, regularly scheduled and focused/targeted program compliance and program integrity audits will ensure program compliance and document the Agency's program oversight responsibilities. CMS anticipates the risk assessment tool will be ready for implementation in January 2008.

Further, CMS is now working with a contractor to augment the internal agency resources available for health plan compliance audits. Among other things, the contractor is conducting "secret shopping" of sales events across the country. Such information will enable CMS to learn firsthand what is happening in the sales marketplace and to identify organizations for compliance intervention that are not meeting CMS marketing and enrollment requirements.

On May 21, 2007, to further support compliance efforts, CMS issued a proposed rule strengthening its current oversight requirements and penalties for Medicare Advantage plans and Part D prescription drug plans. In the proposed rule, CMS proposes clarifications to existing regulatory protocols, including:

- New steps to help expose potential fraud or misconduct through mandatory self-reporting of compliance violations; and
- Changes to streamline the process relating to intermediate sanctions and contract determinations (including terminations and non-renewals) and to better clarify the process for imposing civil monetary penalties.

These revisions will help strengthen the existing range of compliance actions available to CMS when plans violate program requirements and fail to meet required performance metrics.

Oversight of Plan Marketing and Sales Tactics

As mentioned earlier, PFFS plans are a new product with a rapidly growing market. The structure of these plans have generated misunderstandings on the part of both beneficiaries and providers, in addition to some very legitimate complaints concerning the marketing tactics certain PFFS plans have used. One of the reasons PFFS plans can be confusing, for example, is that they do not usually follow the health plan model that most consumers are familiar with, which includes a defined network of providers. CMS recognizes these issues and has acted swiftly to address confusion as well as deliberately misleading marketing practices.

CMS Marketing Guidelines explicitly address compensation of individuals involved in marketing, for example, stating that compensation must be in line with the industry standard for services provided and that compensation is to be withheld or withdrawn if an enrollee chooses to disenroll from a plan in an unreasonably short timeframe. On May 25, 2007, CMS released guidelines that include specific policies for PFFS MA plans designed to protect beneficiaries from inappropriate sales tactics. Medicare Advantage organizations must monitor the activities

of employees and contractors engaged in marketing of plans to potential enrollees to ensure that their activities comply with applicable Medicare and other Federal healthcare laws.

CMS requires that MA plans cooperate with reasonable requests from a State that is investigating a marketing agent and ensure that terminations for cause are reported to the appropriate State entity, if the State has such a requirement. CMS also is working with State insurance department officials and the National Association of Insurance Commissioners (NAIC) to address problems with marketing. Part of this effort includes a Memorandum of Understanding (MOU) that allows States and CMS to share information more easily. For example, CMS can immediately share specific agent/broker complaints with State Departments of Insurance. States are able to share with CMS their findings from Market Conduct reports. To date, 26 States and Puerto Rico have signed the MOU. The terms of the MOU are effective on a State-by-State basis as soon the MOU is signed. The MOU has already facilitated action in some States to address complaints about marketing. CMS, NAIC and the States are working together to complete a full implementation of the MOU, which will provide a national structure for sharing information consistently.

We are particularly concerned about reports of marketing schemes designed to confuse, mislead or defraud beneficiaries. These schemes violate CMS' marketing guidelines, and we have taken vigorous action to address such violations. CMS enforcement responses to marketing violations range from corrective action plans (CAP), to suspension of marketing, suspension of enrollment, civil monetary penalties, or even termination of a plan from the program. For example, this year alone CMS has fined plans more than $400,000 in civil monetary penalties for failing to provide

information to beneficiaries in a timely manner.

In a further step to target marketing violations, CMS recently announced that seven health care organizations have agreed to voluntarily suspend the marketing of their PFFS plans. This suspension for a given plan will be lifted only when CMS verifies that the plan has the systems and management controls in place to meet all of the conditions specified in the aforementioned 2008 Call Letter and the May 25, 2007 guidance issued by CMS. The guidance included strong measures such as verification of the beneficiary's intent to enroll for all PFFS non-employer group applications and documented training of marketing agents/brokers. We are putting into place a rigorous process to review each organization's actions to determine when the plan is ready to resume marketing. We are developing metrics and performance criteria to review the organizations. The measures are categorized by marketing material compliance, sales agent/broker communication, training and licensure, provider outreach and education, enrollment verification, coordination with States, beneficiary and provider complaints, and review of outstanding CAPs if applicable. The review process will include reporting progress on performance metrics as well as file sampling and on-site audits by CMS staff. The companies included in the voluntary suspension are: United Healthcare, Humana, Wellcare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee. Organizations that fail to adhere to the voluntary suspension will be subject to a full range of available penalties, which can include suspension of enrollment, suspension of payment for new enrollees, civil-monetary penalties, and termination of the plan's involvement in the Medicare program. This action is meaningful and precedent setting and indicates how important good practices are to both CMS and the industry.

There are multiple election periods under which plans are able to enroll beneficiaries year-round. For example, special election periods (SEPs) exist for beneficiaries who meet certain criteria, such as full dual eligible, residence change, low income subsidy, institutionalized, etc. Plans may enroll beneficiaries who qualify for SEPs throughout the year. Additionally, a new limited open enrollment period gives beneficiaries enrolled in Original Medicare one opportunity to enroll in an MA plan that does not include Medicare prescription drug coverage (MA-only) at any time during the year.) The most significant source of new enrollment throughout the year is the Initial Enrollment Period (IEP). Beneficiaries newly eligible for Medicare have a seven month IEP during which they are able to enroll in any Medicare plan. This election period starts three months before the end of the month the beneficiary turns age 65 and ends three months after the month the beneficiary turns age 65. For beneficiaries who are eligible for Medicare due to disability, the period is three months before and after the month of cash disability benefits. An average of 208,000 beneficiaries become eligible for Medicare each month or 2.5 million annually. The organizations that signed the voluntary pledge, representing 90 percent of PFFS enrollment, are willing to forgo significant enrollment opportunities which indicate their determination to work with CMS to root out problems and do the right thing for beneficiaries.

In addition to placing organizations on CAPs for marketing violations and encouraging voluntary agreements to suspend marketing activities, CMS has taken additional steps to ensure that beneficiaries are protected. For example, we have developed Standard Operating Procedures to implement our long-standing policy that any beneficiary, who believes he or she was enrolled in a plan without consent or through misinformation, may contact 1-800-MEDICARE to request

prospective disenrollment assistance from the plan, or the CMS Regional Office to request assistance with retroactively disenrolling from the plan and returning to Original Medicare, if desired.

CMS has in place a Complaints Tracking Module (CTM), which is a central repository of Medicare Part C and Part D-related complaints received in the Regional Office, Central Office, or through 1-800-MEDICARE. The CTM was designed to capture and track Medicare Part C and Part D complaints as a means of immediate and longitudinal oversight for the MA program and the Medicare Drug Benefit. The majority of complaints are received by 1-800-MEDICARE call centers and are uploaded into CTM daily. Other complaints are received via phone, fax, and email and are manually entered into CTM by CMS Central Office staff, Regional Office staff, or the Medicare Drug Integrity Contractors (MEDICs). Complaints are assigned to various categories and subcategories, including but not limited to enrollment, disenrollment, benefits, access, pricing, co-insurance, marketing, fraud, waste, abuse, and customer service.

Conclusion

CMS is committed to taking whatever steps are necessary to ensure that people with Medicare are not misled or harmed by MA plans or their agents. As evidenced by our recent proposed rule to strengthen our compliance tools, our recent guidance specifying rigorous requirements around PFFS marketing, and our announcement of voluntary marketing suspensions for seven PFFS plans, CMS is putting beneficiaries first, and we will continue to do so. Mr. Chairman, thank you again for this opportunity to testify and I would be happy to answer any of your questions.

Mr. STUPAK. Ms. Holland, opening statement, please.

STATEMENT OF KIM HOLLAND, COMMISSIONER, OKLAHOMA INSURANCE DEPARTMENT

Ms. HOLLAND. Thank you, Mr. Chairman, distinguished members. My name is Kim Holland and I am the Oklahoma State insurance commissioner. I appreciate the opportunity to speak to you today about an issue for which I care deeply, the safety and security of our citizens promised by the availability of quality insurance products and services. I want people to want to be insured.

Since the roll-out of Medicare Part D the Oklahoma Insurance Department has responded to an unacceptable number of complaints caused by the inappropriate and sometimes fraudulent marketing of Medicare Part C and part D products by certain insurance companies and their agents. We have received hundreds of complaints from confused, unhappy and frightened citizens who have been misled or deceived during a sale.

The creation of new and affordable programs under Medicare Part C and D means that many of our Nation's seniors no longer have to choose between a meal or their medication. But it is this reality of pressing demand for coverage and a growing supply of available plans, 54 in Oklahoma alone, that necessitates adequate regulatory oversight. Yet, the MMA's preemption of State's authority to oversee the licensure, market conduct and financial solvency of Medicare Part D, agents and carriers, and the marketing practices of Medicare Advantage insurers has allowed insurers to exploit this exemption from regulatory oversight.

Our seniors are plagued by aggressive and frequently misleading advertising, agent high-pressure sales tactics, and a lack of responsiveness if not outright neglect from their insurance companies. A letter I received just this month from a senior caregiver offers a poignant illustration of the problems. I quote directly from her correspondence. "WellCare employees are stationed on every other corner in the neighborhood. They are approaching people in the street including our residents to sign them up for WellCare services. They do this in a very aggressive manner. They do this without establishing the care needs of the current providers of the patients." She writes that 90 percent of their residents suffer from chronic illnesses and that their ability to form competent judgments is impaired. She also writes that she sent a letter expressing her concerns to WellCare in October 2006, and has received no response. She told me personally that WellCare is not facilitating dis-enrollment in a timely manner, that patient care is being denied, and that her CMS regional offices manager did not know how to address the problem.

We recently completed a targeted market conduct examination of Humana, one of America's largest providers of Medicare Advantage plans in response to an escalation in number and nature of unresolved complaints involving the sales tactics of agents selling their products. When finally completed the examination exposed chronic and blatant disregard for State regulation and for senior policyholders and the inadequacy of Federal oversight. That examination focused on the current limits of our authority regarding Medicare

Advantage and part D products, insurers' obligation to properly license their sales agents.

However, the full scope of market conduct oversight customarily performed for the benefit of insurance consumers goes well-beyond licensing. Insurance departments monitor compliance of an insurer's handling of complaints, claims practices, marketing and sales materials and advertising, producer licensing as well as appointed agent training and conduct, underwriting and rating practices, policyholder service, and company operations and management. Our rigorous examination standards ensure that consumer protections are kept at the forefront of an insurer's enterprise, equally balanced with their profit motives.

Our inability to assert this balance has resulted in a travesty of security for Medicare beneficiaries. Since my recent testimony to the Senate, I have met with Humana executives who outlined new processes and heightened compliance oversight of their Medicare business stream. Well, we are still in disciplinary discussions with the company and will continue to monitor their activities closely. I am somewhat encouraged by their actions to devote increased resources to assist and protect their Medicare plan policyholders.

However, the problems identified with Humana are certainly not unique to them but rather a glaring example of what is occurring on a regular basis as companies pursue market share in an unregulated environment. Insurance departments across the Nation are receiving complaints of a similar nature from seniors, their families and caregivers against many insurers, including other dominant players such as WellCare, Coventry, Secure Horizons and Pyramid Life.

While I applaud CMS for their recent efforts to compel insurer's to refrain from marketing activities while they attempt to address the issues I raised in my Senate testimony, their efforts are simply no substitute for the 136 years of State-based insurance regulation that has resulted in our sophisticated and expansive and incomparable understanding of insurance company financials, operations and marketing.

Congressmen, we put this expertise to use everyday acting promptly and judiciously on behalf of the industry and the consuming public. Given our seniors chronic and continuing complaints against insurers why are State insurance departments vast resources being denied those in need to their continued peril?

I opened my remarks by telling you that I want people to want to be insured. It is a challenging proposition but an important goal in insuring the financial security of Oklahomans and the future prosperity of my State. But I can tell you that my progress is severely impeded when my public is fearful that their insurer or their insurance product is bad. When they begin to question whether going without coverage is safer and less costly then simply going without.

Today I ask again that Congress un-encumber me from the unproductive, unnecessary and dangerous preemptions that expose my citizens to the neglect and abuse I have described, and let me do my job. I am not interested in territorial squabbling or finger-pointing. I am interested in working together for the benefit of my folks back home. If government cannot protect our most vulnerable,

our children, our frail, our disadvantaged and our elderly, of what use are we? Let us do our job.

Thank you very much.

[The prepared statement of Ms. Holland follows:]

STATEMENT OF KIM HOLLAND

Good morning Mister Chairman and members of the Committee. My name is Kim Holland and I am the Oklahoma State Insurance Commissioner, an elective office I have held since January 2005. I appreciate the opportunity to speak to you today about an issue for which I care deeply: the safety and security of our citizens promised by the availability of quality insurance products and services. I want people to want to be insured.

The primary obligation of my agency is to protect our insurance consuming public. I, and my staff of over 150 dedicated individuals, take this obligation very seriously. Our office fields over 60,000 calls to our consumer assistance division each and every year, plus an additional 12,000 calls to our federally funded SHIP program. We license and regulate the activities of over 80,000 agents, monitor the financial solvency and market conduct of over 1,600 insurance companies and my twelve member law enforcement team responds to more than 700 insurance fraud and abuse allegations each year. We act swiftly and aggressively on behalf of all policyholders against any carrier, agent or broker that has acted unlawfully or otherwise not delivered on their promise to policyholders.

Since the roll-out of Medicare Part D in November of 2005, the Oklahoma Insurance Department has responded to an unacceptable number of complaints caused by the inappropriate and sometimes fraudulent marketing of Medicare Part C and Part D products by certain insurance companies and their sales producers. We have received hundreds of complaints from confused, unhappy and frightened citizens who have been mislead or deceived during a sale.

The passage of the Medicare Modernization Act has made access to affordable medications possible for 20 percent of Oklahoma's population, a large measure of whom depend solely on social security for their livelihood. The creation of new and affordable programs under Medicare Parts C and D means that many of our Nation's seniors no longer have to choose between a meal or their medication. But it is this reality—a pressing demand for coverage and a growing supply of available plans (54 in Oklahoma alone!)—that necessitates adequate regulatory oversight.

Yet the MMA's preemption of states' authority to oversee the licensure, market conduct and financial solvency of Medicare Part D agents and carriers and the marketing practices of Medicare Advantage insurers has allowed them to exploit this exemption from regulatory oversight. Our seniors are plagued by aggressive and frequently misleading advertising, agent high pressure sales tactics, and a lack of responsiveness if not outright neglect from their insurance company. A letter I received just this month from a senior care-giver offers a poignant illustration of the problems. I quote directly from her correspondence: "WellCare employees are stationed on every other corner in the neighborhood. They are approaching people in the street, including our residents, to sign them up for WellCare Services. They do this is a very aggressive manner. They do this without establishing the care needs or the current providers of the patients". She writes that 90 percent of their residents suffer from chronic illness and that their ability to form competent judgments is impaired. She also writes that she sent a letter expressing her concerns to Well Care in October of 2006 and has received no response. She told me personally that her CMS regional office's regional manager did not know how to adequately address the problem. While the sales activities have relented somewhat, she says that WellCare is not facilitating disenrollment in a timely manner and patient care is being denied.

As you are aware, we recently completed a targeted market conduct examination of Humana, one of America's largest providers of Medicare Advantage plans, in response to an escalation in number and nature of unresolved complaints involving the sales tactics of agents selling their products. When finally completed, the examination exposed chronic and blatant disregard for state regulation and for senior policyholders, and the inadequacy of Federal oversight.

That examination focused on the current limits of our authority regarding Medicare Advantage and Part D products—insurers' obligation to properly license their sales agents. However, the full scope of market conduct oversight customarily performed for the benefit of insurance consumers goes well beyond licensing. Insurance Departments monitor compliance of an insurer's handling of complaints; claims practices; marketing and sales materials and advertising; producer licensing as well

as appointed agent training and conduct; underwriting and rating practices; policyholder service; and company operations and management. Our rigorous examination standards ensure that consumer protections are kept at the forefront of an insurers' enterprise—equally balanced with their profit motives. Our inability to assert this balance has resulted in a travesty of security for Medicare beneficiaries.

Since the presentation of my testimony in May, I have met with Humana executives who outlined new processes and heightened compliance oversight of their Medicare business stream. While we are still in disciplinary discussions with the company and will continue to monitor their activities closely, I am somewhat encouraged by their actions to devote increased resources to assist and protect their Medicare plan policyholders.

However, the problems identified with Humana are certainly not unique to them, but rather a glaring example of what is occurring on a regular basis as companies pursue market share in an unregulated environment. Insurance Departments across the Nation are receiving complaints of a similar nature from seniors, their families and caregivers against many insurers, including other dominant players WellCare, Coventry, Pacificare and Pyramid Life.

While I applaud CMS for their recent efforts to compel insurers to refrain from marketing activities while they attempt to address the issues I raised during my testimony to the Senate Special Committee on Aging, their efforts are simply no substitute for the 136 years of state based insurance regulation that has resulted in our sophisticated and expansive and incomparable understanding of insurance company financials, operations and marketing. Congressmen, we put this expertise to use every day, acting quickly and appropriately on behalf of the industry and the consuming public. Given our seniors' chronic and continuing complaints against insurers, why are State Insurance Department's experience, assistance and protections being denied those in need at their continued peril.

I opened my remarks telling you I want people to want to be insured. It's a challenging proposition, but an important goal in ensuring the financial security of Oklahomans and the future prosperity of Oklahoma. But I can tell you that my progress is severely impeded when my public is fearful that their insurer or their insurance product is bad; when they begin to question whether going without coverage is safer and lest costly than simply going without.

So today I ask again, that Congress unencumber me from the unproductive, unnecessary, and dangerous preemptions that expose my citizens to the neglect and abuse I have described and let me do my job. Allow me to fully deploy the substantial and immediate resources of my office to protect the interests of all policy-holders, regardless of their age and regardless of the private health plan they purchase. I am not interested in territorial squabbling or finger-pointing. I am interested in working together for the benefit of my folks back home. If government cannot protect our most vulnerable—our children, our frail, our disadvantaged, our elderly—of what use are we? Let's do our job. Thank you.

Mr. STUPAK. Thank you for your testimony.

Mr. Poolman, the North Dakota insurance commissioner, your opening statement please, sir.

STATEMENT OF JIM POOLMAN, COMMISSIONER, NORTH DAKOTA INSURANCE DEPARTMENT

Mr. POOLMAN. Thank you, Mr. Chairman, and good afternoon and good afternoon, Mr. Whitfield, and members of the committee. I am pleased to appear before you today and truly appreciate the opportunity to articulate my concerns about MMA and specifically abuse in the Medicare Advantage plan marketing. And thanks also for, hopefully, taking action. My name is Jim Poolman. I am the elected commissioner in the State of North Dakota. I took office in January 2001, and given that length of tenure in office of seeing firsthand the implementation of the Medicare Modernization Act, I sit before you today to urge you to restore the regulatory authority over these programs and consider using the current Medigap insurance regulatory model as the model going forward.

And I do want to say that I believe in Medicare Modernization Act and I believe in what you folks have done to get prescription drugs under part D to the citizens across the country. I have about 105,000 out of 640,000 that are eligible for Medicare. Not, what I am trying to tell you is the North Dakota experience that we have gone through in the implementation of Medicare Modernization.

From the earliest days of the roll-out we saw widespread confusion and frustration on the part of seniors in North Dakota. As the roll-out progressed it became increasingly clear that the Centers for Medicaid and Medicare Services was ill-equipped to adequately address the conflicts that arose for this vulnerable population. For example, our contact with customer service staff at Medicare is typically unproductive. Not only do they lack the answers or information we need but they are also inadequately trained and on occasion CMS staff members have simply hung-up the phone on beneficiaries or those folks in our SHIP program who are trying to help beneficiaries.

Companies and agents have capitalized on the confusion associated with the new products by using aggressive sales practices that in my estimation are misleading at best, and fraudulent at worst. I have examples of tactics ranging from agents refusing the leave people's homes or giving them misleading information to actually sending money to an insurance company on behalf of that potential policyholder that was not their money. We even have seniors who were switched from traditional Medicare to an MA plan simply because they signed their name on the entrance of a mass enrollment event.

In addition, we have an example of a woman who was switched from one plan to another plan without consent only to find that she does lack coverage but the company she was switched to had no record of her enrollment. The back story is incredible. CMS confused her with another person of the same name who may have switched plans. This woman has made multiple complaints to CMS and to the company and still her situation is not resolved. She is paying for her drugs out-of-pocket on a very limited Social Security check. That is not the goal of Congress when setting-up MMA.

Even though CMS has long been aware of the conflicts and bugs in the system they have not been resolved and they are worse. Instead of becoming more responsive, CMS has adopted a "do not call us" attitude. That requires us to spend countless hours on the telephone with them only to be referred to the company, specifically, for help.

The ramifications of this situation are varied. From a State senior health insurance counseling program standpoint my staff has fielded over 3,800 client contacts. And of those contacts, 75 percent of them are dealt with enrollments or dis-enrollments of Medicare Advantage plans. The data tells us this, nine out of 10 clients that contact our SHIP program were the result of some type of problem with the Medicare Modernization Act, either part D or Medicare Advantage. Only one out of ten client contacts are basic Medicare/Medigap, prescription assistance, long-term care, Medicaid questions that are SHIP staff or SHIP counselors were answering prior to MMA. Three out of four problem-type calls involved Medicare Advantage plans that are related to enrollments or dis-enrollments,

strongly suggested inappropriate sales and/or inefficient administration of the policies. By comparison, one out of three problem calls involving part D plans are related to enrollments or dis-enrollments.

From our perspective the situation in untenable, it becomes difficult to do the good work that we desire to help our senior population. As insurance commissioner my main duty is to protect insurance consumers. However, under the current circumstances seniors in North Dakota are being shortchanged by CMS and the current MMA. Clearly, these companies need more rigorous oversight and CMS is not prepared or seemingly unable to do the job. With all due respect, I find it highly unlikely based on our experience during this situation that CMS will be able to do better as Ms. Norwalk suggests in a recent press release.

Today I again urge you to restore and expand State insurance regulatory oversight over these programs and consider the regulation of Medicare Supplement insurance as a potential model. By adopting the Medigap model consumers will still have a variety of plans to choose from that will be standardized. Competition will remain strong as in the current Medigap market of which I believe in. State regulators would be able to adequately safeguard consumers.

The bottom line is if State insurance regulatory is restored all of the stories you have heard about abuse of marketing tactics would be prohibited by State law, monitoring questions by State insurance regulators, and controlled by State-based insurance regulation. By restoring State authority you, in fact, untie my hands and allow me to take whatever steps appropriate to safeguard the seniors in my State.

Mr. Chairman and members of the subcommittee thank you again for holding this hearing and this issue is one that affects not only seniors in my State but obviously all of your States. And I hope that the information that I have shared with you and that the information that we will share in a give and take on questions will be helpful. Together, Mr. Chairman, we can work together to fill in the gaps that will protect seniors across the country.

[The prepared statement of Mr. Poolman follows:]

House Energy and Commerce Subcommittee on Oversight for 06/26/07
Commissioner Jim Poolman

Good afternoon Mr. Chairman and members of the Committee. I am pleased to appear before you today and truly appreciate the opportunity to articulate my concerns about the marketing of Medicare Advantage (MA) plans. Thanks also for your interest in taking action to address the marketing abuses that we are currently seeing. I am Jim Poolman and am the elected insurance commissioner for North Dakota. I took office in January 2000 and given the length of my tenure in office, I have seen firsthand the ramifications of the implementation of the Medicare Modernization Act (MMA). I sit before you today to urge you to restore state regulatory authority over these programs and consider using the current Medigap insurance as a regulatory model.

As early as January 2006, I called for changes to simplify the Medicare Part D program.[1] I also addressed these concerns in letters to Centers for Medicare and Medicaid Services (CMS) and Congressman Pomeroy and Senators Conrad and Dorgan.[2] We are now into the second year of the implementation of the MMA of 2003, and I continue to see significant problems causing us grave concern.

From the earliest days of the rollout, we saw widespread confusion and frustration on the part of seniors in North Dakota. As the rollout progressed, it became increasingly clear that the Centers for Medicare and Medicaid Services (CMS) was ill-equipped to adequately address the conflicts that arose for this vulnerable population. For example, our contact with customer service staff at Medicare is typically unproductive. Not only do they lack the answers or information we need, but they also are inadequately trained. On occasion, CMS staff members have simply hung up the phone.

Companies and agents have capitalized on the confusion associated with the new products by using aggressive sales practices that in my estimation are misleading at best and at

[1] Exhibit 1 - North Dakota Insurance Department press release, "Poolman: Changes Needed to Simplify Medicare Part D Program" – 01/27/06
[2] Exhibit 2 – Commissioner Poolman: Correspondence—CMS, Rep. Pomeroy, Sen. Conrad, Sen. Dorgan – 01/27/06

worst, fraudulent. I have examples of tactics ranging from agents refusing to leave someone's home or giving misleading information to actually sending money to an insurance company on behalf of the potential policyholder. We even have seniors who were switched from traditional Medicare to an MA plan simply because they signed their name at a mass enrollment event.[3]

We have experienced many administrative delays at CMS and the Social Security Administration (SSA). I surmise this is because of inadequate data systems. The result is inaccurate records regarding the product a person is enrolled in or regarding the premiums being deducted from their accounts. We have examples of people where premiums are being withdrawn from their account for plans they are not even enrolled in.

In addition, we have an example of a woman who was switched from one plan to another without consent only to find that not only does she lack coverage, but the company she was switched to had no record of her enrollment. The back story is incredible - CMS confused her with another person with the same name, who may have switched plans. This woman has made multiple complaints to CMS and the company and still her situation is not resolved. She is paying for her drugs out-of-pocket on a very limited Social Security check.

Even though CMS has long been aware of the conflicts and "bugs" in their system, they have not been resolved—they are worse. Instead of becoming more responsive, CMS has adopted a "Don't call us" attitude [4] that requires us to spend countless hours on the telephone with them only to be referred to the company for help.

Working with the various insurance companies does not seem to be any easier and the same characteristics plague our communications with them as well: long wait times on the phone, multiple transfers from person to person, no accountability and a "pass the buck" attitude that is forcing many seniors in my state to go without coverage because of administrative inefficiencies and errors. Often, company customer service staff are hesitant to allow our staff to talk to

[3] Exhibit 3 – Examples of abusive, aggressive, and misleading sales tactics experienced in North Dakota
[4] Exhibit 4 – Memo from CMS – 03/12/07

supervisors or those more knowledgeable about complicated or unique cases. We are transferred to a number that is not answered and the waiting time starts over.

Most surprising, some companies have even blamed CMS for some of these administrative issues and when we follow up, we find that CMS is not to blame; it is the company that is forbidding the beneficiary to disenroll from their plan, forcing seniors to remain in unsuitable plans.

The ramifications of this situation are varied. From a state senior health insurance counseling program standpoint, my staff has fielded 3,861 client contacts over the past year. (A "client contact" could represent more than one call to or from that client.) Of the total 3,861 client contacts, nearly 90 percent involved problems of some degree from either Part D or Medicare Advantage plans. That means that we have over 300 calls per month that are problems. Of the Medicare Advantage-type calls, 75 percent dealt with enrollments or disenrollments.

This data tells us that:

- 9 out of 10 of client contacts to our SHIC program were the result of some type of problem with the Medicare Modernization Act of 2003, either Part D or Medicare Advantage;
- Only 1 out of 10 client contacts are the basic Medicare/Medigap/ Prescription Assistance/LTC/Medicaid questions that our SHIC staff and SHIC counselors were answering prior to MMA 2003;
- 3 out of 4 problem-type calls involving Medicare Advantage plans are related to enrollments or disenrollments, strongly suggesting inappropriate sales and/or inefficient administrative policies and practices. (By comparison, 1 out of 3 problem-type calls involving Part D plans are related to enrollments or disenrollments.)

I must point out that the picture for us is clear—we are now committing not only the CMS SHIP grant dollars to our program, but are now also utilizing four full-time position and additional Department resources to address a problem over which I have no jurisdiction. Over 90 percent of our SHIC resources are currently being used to address this problem. And as a side note, CMS should be aware that since this has begun, our program has hemorrhaged SHIP volunteers—the very backbone of this program—who engage in peer counseling. Many of these volunteers are retired seniors themselves and are unwilling to peer-counsel under these negative circumstances. This has placed additional burdens on my staff to pick up the slack where the volunteers have left off.

From our perspective, this situation is untenable. It becomes difficult to do the good work that we desire to help our senior population. As Insurance Commissioner, my main duty is to protect insurance consumers. However, under the current circumstances, seniors in North Dakota are being shortchanged by CMS and the Medicare Modernization Act.

I have addressed these issues with CMS, as well as North Dakota's congressional delegation in letters as recently as this past May.[5] Clearly these companies need more rigorous oversight and CMS is not prepared or seemingly able to do the job. With all due respect, I find it highly unlikely, based on our experience during this situation, that CMS will be able to "do better" as Ms. Norwalk suggests in a recent press release.

And, if "doing better" is exemplified by the agreement just struck between CMS and seven insurance companies, I think "better" is not good enough.

This agreement relies on the assumption that the companies will act in good faith under the terms of the agreement. Quite frankly, I do not trust these companies to fulfill their obligations to CMS or to their policyholders – or for CMS to enforce their insufficient rules.

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[5] Exhibit 5 – Commissioner Poolman: Correspondence—CMS, Rep. Pomeroy, Sen. Conrad, Sen. Dorgan – 05/24/07

In May 2006, I started an action against Humana, one of the companies signed on to this agreement, specific to security breaches that resulted in the theft of private financial information of around 130 seniors from North Dakota who had purchased Part D plans from Humana.[6]

One would think that upon learning of this breach, Humana would have taken proactive steps to remedy the situation for their policyholders. Instead, Humana failed to properly notify any regulator about the theft and showed a complete disregard for the well-being of their customers they're supposed to be serving. It was only after repeated contact with Humana and a one-on-one meeting with Humana management that they acknowledged that the situation was serious.

While the current voluntary agreement between CMS and these insurers is a start at addressing this problem, it does not address the underlying, root causes, which are likely firmly planted in the higher rates of government reimbursement for these plans, the higher commissions that agents receive for selling them, and the complete lack of state oversight over these plans and these companies. The agreement offers no real improvement in consumer protection and companies are allowed loopholes in sales tactics. It also leaves out any close regulatory oversight that is obviously needed in this situation.

Today, I again urge you to restore and expand state insurance regulatory authority over these programs and consider the current regulation of Medicare Supplement (Medigap) insurance as a potential model.

By adopting the Medigap model:

- Consumers would still have a wide variety of standardized plans from which to choose;
- Competition would remain strong, as in the current Medigap market; and,
- State regulators would be able to adequately safeguard consumers.

[6] Exhibit 6 - Correspondence—Humana Insurance Company – 05/31/06; 06/06/06; 06/07/06

If state insurance regulatory authority is restored, all of the stories you have heard about abusive marketing tactics would be prohibited by state law, monitored and questioned by state insurance regulators, and controlled by state-based insurance regulations. By restoring state authority, you would in fact, untie my hands and allow me to take whatever steps appropriate to safeguard and protect seniors in my state.

State regulation assures that companies in North Dakota would be required to file and receive approval of advertising materials before they could be used. (North Dakota is a prior approval state.) This would be in addition to companies being required to be licensed and comply with North Dakota solvency, agent licensing, and appointment requirements. It would provide the State with enforcement authority to ensure that consumers' interests are protected. Ultimately, I believe that by taking these steps, many of the marketing abuses we are currently seeing would be eliminated. In fact, if we currently had the authority, we would have already held these companies accountable for their actions and where appropriate levied fines or issued cease and desist orders.

Mr. Chairman and members of the Subcommittee, thank you again for holding this hearing today. This is an issue that affects many seniors nationwide and this problem must be solved. I hope that the information I have shared will be of help to you and I look forward to working with you to strengthen state regulatory oversight over these companies.

EXHIBIT 1

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

FOR IMMEDIATE RELEASE
January 27, 2006

Contact: Jim Poolman
701-328-2440

Poolman: Changes Needed to Simplify Medicare Part D Program

Bismarck, ND – Insurance Commissioner Jim Poolman today urged significant changes be made to Medicare Part D that would simplify this new benefit and greatly enhance this program's benefits to enrollees.

In separate letters to Health and Human Services Secretary Michael Leavitt and the North Dakota Congressional Delegation, Poolman recommended changes that could be implemented to ease the confusion seniors are going through in signing up for the program.

"The complicated process of signing up for a drug plan is clearly overwhelming our seniors," said Poolman. "Because they are overwhelmed, many are just choosing to wait to sign up or not sign up at all." Poolman's concerns are borne out in the latest figures released by the Centers for Medicare and Medicaid Services (CMS) that show that of the 105,800 currently eligible individuals in North Dakota, only 8,720 people have opted to sign up for the new benefit. CMS figures indicate a total of 34,227 are enrolled in plans. However, 10,413 of these enrollees were automatically signed up. All of this is in the wake of a tremendous public awareness campaign waged by many government agencies and interested organizations.

In summary, Poolman is calling for:

- An extension of the enrollment deadline ~

  "We know from the enrollment statistics, the number of calls to our office and other, anecdotal information that seniors are not signing up for the program. If they miss the deadline, they will be penalized. This is unacceptable and should be avoided at all costs," Poolman said.

EXHIBIT 1

The additional time for enrollment into a Part D plan will give Medicare beneficiaries more time to understand their choices, and alleviate the feeling that they are running out of time and must act quickly. It will also give CMS additional time to correct software inaccuracies.

- A standardization of and limit on the number of plans available ~

In 1992, the Medicare Supplement plans were standardized. Under these plans, seniors retain a choice of twelve plans and the industry remains competitive. Forty-one Medicare Part D plans are currently offered in North Dakota. Poolman considers this extremely chaotic and completely unnecessary.

Poolman said, "While it is important to foster competition in the marketplace and enhance the choices available for consumers, it is also important to provide our seniors and disabled with prescription coverage benefits that are easily accessible, understandable, and above all, affordable. If CMS standardizes the plans, these goals could be achieved with the existing program."

CMS should proceed with an effort to standardize Part D plans, as was done with Medicare Supplement plans. The Medicare-eligible person could then select, from a limited number of plans, the one appropriate for them. A company could then be selected on the basis of price and reputation.

During the implementation of this new benefit, the ND Insurance Department, through its Senior Health Insurance Counseling (SHIC) program, together will all if its strategic partners, has conducted nearly 200 outreach sessions reaching around 125,000 people with the Medicare Part D message. In addition, SHIC program staff has conducted numerous sessions across the state to train SHIC volunteers on the implementation process.

"It is critically important that this program be successful for our seniors." Poolman said, "We should all be open to making improvements and changes to make sure people have access.

# # #

EXHIBIT 2

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

January 27, 2006

The Honorable Michael Leavitt
Secretary of Health and Human Services
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Leavitt and Dr. McClellan:

The North Dakota Insurance Department, through its Senior Health Insurance Counseling (SHIC) Program, is well prepared to educate and assist with timely enrollment in the Medicare Part D program. A network of strategic partners pooled volunteer resources across the state and continues to collaborate on issues and solutions. This brigade of over 150 trained volunteers stands ready to counsel seniors one-on-one on the attributes of enrollment in the program. In an effort to inform some 125,000 Medicare beneficiaries and interested parties, over 200 Part D outreach sessions have been presented throughout the state. Marketing messages were delivered reaching our target audience with more than two million media impressions in the marketplace. In spite of these efforts, the numbers show we have come up dreadfully short of our anticipated result. I am deeply concerned because relatively few of those eligible for Part D benefits are responding to our call.

The latest figures released by CMS indicate that 34,227 Medicare beneficiaries in North Dakota are enrolled in Part D plans. Of this figure 10,413 were automatically enrolled due to their dual eligible status and only 8,720 Medicare beneficiaries have voluntarily opted to enroll. Additionally, and perhaps more alarming, nearly 72,000 eligible North Dakotans are not taking advantage of the benefit and still do not have prescription coverage.

At the beginning of the enrollment period there were over 105,000 Medicare beneficiaries in North Dakota who needed to be informed about the new Medicare Part D benefit. In North Dakota there are 41 plans to choose from and they vary widely in deductibles, co-payments, premiums and formularies. To further complicate the decision process, if the convenience of a local pharmacy and the pharmacist's personal relationship is considered important to the consumer, the selected plan must be matched with one that also contracts with the consumer's preferred pharmacy.

As a result, the number of factors necessary to consider in making an individual decision is mind-boggling to the average Medicare beneficiary. The advantage of choice is usually a plus; but, unfortunately for our seniors, the obstacle of complexity is overwhelming. Since the beginning of the enrollment period, North Dakota's Insurance Department has received more than 3,500 calls from Medicare beneficiaries expressing concerns, such as: not knowing where to begin or who can help; formulary lists that don't include needed prescriptions; wide variances in drug costs between plans; pharmacies with inaccurate or no information after an individual has enrolled; dwindling time to make a decision; and, unsurprisingly, whether or not it is worth the trouble to choose a plan.

EXHIBIT 2

Medicare Part D is a benefit with tremendous potential to assist many people in need of help with their prescription drug costs. However, the implementation process has made it clear that complexities are hindering the majority of eligible persons from enrolling and stifling the program's success. A modification to the existing Part D program is needed to put it back on track for success.

Two changes will help significantly. First, the May 15, 2006 deadline for the initial enrollment into a Part D plan without penalty should be extended to December 31, 2006. Extending the deadline will give Medicare beneficiaries more time to understand their choices, obtain needed counseling, and alleviate the feeling that they must act quickly. It will also give CMS additional time to correct software inaccuracies.

Second, CMS should proceed with an effort to standardize Part D plans. This approach was taken with Medicare Supplement policies in 1992, and greatly simplified the marketing and distribution of those products. There are currently 12 standardized Medicare Supplement plans from which companies choose what plans to offer. Under this arrangement, seniors retain a good selection of choices and the industry remains competitive. Similarly, the Medicare Part D-eligible person would select an appropriate plan from a limited number of choices. After the plan is chosen, the individual would select a company to purchase the plan from, based on price and reputation.

Limiting the number of Part D plans and standardizing their design among companies will serve to: preserve the integrity of the original Part D concept; maintain the competitive marketplace which serves to lower costs; and alleviate the current high level of confusion that is a major obstacle to the program's success.

We will continue to assist the people of North Dakota with the enrollment process; nevertheless, on behalf of the more than 100,000 North Dakota Medicare beneficiaries and the millions of other beneficiaries across the country, I respectfully ask that CMS, in coordination with Congress, initiate changes critical to the success of the Part D program.

Sincerely,

Jim Poolman
Commissioner of Insurance

JP:ls

cc: Governor John Hoeven
Alex Trujillo, Administrator, CMS Region VIII

EXHIBIT 2

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

January 27, 2006

The Honorable Kent Conrad
Senator ~ North Dakota
530 Hart Office Building
Washington, DC 20510-3403

The Honorable Byron Dorgan
Senator ~ North Dakota
322 Hart Office Building
Washington, DC 20510-3405

The Honorable Earl Pomeroy
Representative ~ North Dakota
1501 Longworth HOB
Washington, DC 20515-3401

Dear Senator Conrad, Senator Dorgan and Representative Pomeroy:

As conscientious stewards of the citizens of North Dakota and our representatives in Washington, DC, you are no doubt aware of the serious and increasingly untenable situation facing our state's disabled and senior Medicare beneficiaries as they attempt to enroll in a Medicare Part D plan.

Nevertheless, it is incumbent upon me as Insurance Commissioner to inform you of my position on this issue and ask for your help in achieving this Department's goal of simplifying the Medicare Part D benefit. I have recently outlined my concerns and proposed possible solutions in letters to HHS Secretary, Mike Leavitt and CMS Administrator, Mark McClellan.

The North Dakota Insurance Department, through its Senior Health Insurance Counseling (SHIC) Program, was well prepared to educate and assist with timely enrollment in the Medicare Part D program. A network of strategic partners pooled volunteer resources across the state and continues to collaborate on issues and solutions. In an effort to inform some 125,000 Medicare beneficiaries and interested parties, over 200 Part D outreach sessions were presented throughout the state. Marketing messages were created and delivered reaching our target audience with more than two million media impressions in the marketplace.

In spite of these efforts, we have come up dreadfully short of our anticipated result. As of January 13, 2006, only 8,720 Medicare beneficiaries in North Dakota have voluntarily opted to enroll in the Part D benefit. Throughout the state a brigade of over 150 trained volunteers stands ready to counsel seniors one-on-one on the attributes of the program; nevertheless, relatively few are responding. Additionally, and perhaps more alarming, nearly 72,000 eligible North Dakotans are not taking advantage of the benefit and still do not have prescription coverage.

At the beginning of the enrollment period there were over 105,000 Medicare beneficiaries in North Dakota who needed to be informed about the new Medicare Part D benefit. In North Dakota there are 41 plans to choose from and they vary widely in deductibles, co-payments, premiums and formularies. To further complicate the decision process, if the convenience of a local pharmacy and the pharmacist's personal relationship is considered important to the consumer, the selected plan must be matched with one that also contracts with the consumer's preferred pharmacy.

EXHIBIT 2

As a result, the number of factors necessary to consider in making an individual decision is mind-boggling to the average Medicare beneficiary. The advantage of choice is usually a plus; but, unfortunately for our seniors, the obstacle of complexity is overwhelming. Since the beginning of the enrollment period, North Dakota's Insurance Department has received more than 3,500 calls from Medicare beneficiaries expressing concerns, such as: not knowing where to begin or who can help; formulary lists that don't include needed prescriptions; wide variances in drug costs between plans; pharmacies with inaccurate or no information after an individual has enrolled; dwindling time to make a decision; and, unsurprisingly, whether or not it is worth the trouble to choose a plan.

Medicare Part D is a benefit with tremendous potential to assist many people in need of help with their prescription drug costs. However, the implementation process has made it clear that complexities are hindering the majority of eligible persons from enrolling and stifling the program's success. A modification to the existing Part D program is needed to put it back on track for success.

Two changes will help significantly:

- ***Extend the deadline for initial enrollment to December 31, 2006***

  Extending the deadline for enrollment in a Part D plan will give Medicare beneficiaries more time to understand their choices, obtain needed counseling, and alleviate the feeling that they must act quickly. It will also give CMS additional time to correct software inaccuracies.

- ***CMS should simplify the plans***

  Second, CMS should proceed with an effort to standardize Part D plans. This approach was taken with Medicare Supplement policies in 1992, and greatly simplified the marketing and distribution of those products. There are currently 12 standardized Medicare Supplement plans from which companies choose what plans to offer. Under this arrangement, seniors retain a good selection of choices and the industry remains competitive. Similarly, the Medicare Part D-eligible person would select an appropriate plan from a limited number of choices. After the plan is chosen, the individual would select a company to purchase the plan from, based on price and reputation.

  Limiting the number of Part D plans and standardizing their design among companies will serve to: preserve the integrity of the original Part D concept; maintain the competitive marketplace which serves to lower costs; and alleviate the current high level of confusion that is a major obstacle to the program's success.

We will continue to assist the people of North Dakota with the enrollment process; nevertheless, on behalf of the more than 100,000 North Dakota Medicare beneficiaries and the millions of other beneficiaries across the country, I respectfully ask that you work in collaboration with CMS to initiate changes critical to the success of the Part D program.

Sincerely,

Jim Poolman
Commissioner of Insurance

JP:ls

EXHIBIT 3

North Dakota: Aggressive, abusive and misleading sales tactics:

Examples:

- Pressuring a policyholder to switch their coverage to a Medicare Advantage policy without adequately explaining the implications on the benefits provided, premiums payable, or accessibility of services.
- Telling policyholders that they *must* change, and that they must make the decision immediately.
- Seniors signing only a registration form for attending a meeting, and finding themselves enrolled in a Medicare Advantage plan.
- Agents calling seniors and saying, *"I'm from Medicare and you need to change your policy".*
- Seniors being sent a notice that says, *"Medicare Supplement insurers have increased their rates up to 30% on Medicare Supplement coverage. Based on this, there is now available a plan to supplement your Medicare coverage....Send in this card to see if you qualify for premium savings from $200 - $500 per year."* The card requires a signature, date of birth, and telephone number. If the card is completed and sent in, an agent comes to sell a Medicare Advantage plan.
- Switching Medicare Advantage policyholders from one plan to another (within the same company) without notifying the policyholder.
- Person was told not to come to a Humana meeting after she told them she works for the insurance department at a local hospital.
- An insurance agent attended a Humana meeting. A "bouncer" was present at the door assisting with controlling the attendees. When people would ask specific questions, they were told they could go into another room and talk about it.
- Agent switched an 86-year old with end stage Alzheimer's Disease to a Medicare Advantage plan by coming to her home. The lady's beneficiary has a Power of Attorney so we were able to dis-enroll her, because of the lack of a signature by the POA. The dis-enrollment took 4 months to complete.
- At meetings that serve food, people have been told to just sign the form and the agent will finish completing it for the people as "no one wants to hold up the serving of the food". Agents were told that there is a separate meeting for agents, so they should not attend the "food" meetings.
- People have life insurance or nursing home plans with an agent. So, that agent knows that the person could be eligible for PFFS plans. The agent calls the consumer to update the life insurance or nursing home policy, and sells a Medicare Advantage plan.

Centers for Medicare & Medicaid Services
Region VIII

EXHIBIT 4

Medicare Prescription Drug
CMS Customer Service TIP Sheet

The Centers for Medicare & Medicaid Services (CMS) Denver Regional Office is receiving a large number "Part D Issues" that can and should be resolved by the plans. While our goal is still to provide support to you and service to the beneficiaries, the volume of inquires (phone, fax and email) our office receives on a daily basis that do not warrant our assistance, limits our ability to assist on cases that require RO assistance.

We would like to take this opportunity to inform you of the process CMS has implemented to handle Medicare Part D Prescription Drug Plan Complaints.

1. The first point of contact is with the affected member's Medicare Drug Plan. This is the fastest course of resolution for issues and information.

2. If the issue is not resolved by contacting the plan directly, or if the issue involves the plan's customer service, contact 1-800-MEDICARE (1-800-633-4227) and request to file an official complaint. The plan will receive the complaint the following day. ***Submitting information directly to the Denver RO adds an additional 2-5 business days to this process***.
   - Please allow at least 30 days for the issue to be resolved. Follow-up with the plan, not 1-800-MEDICARE.
   - If the beneficiary has a limited supply of medications, indicate that to the individual taking the complaint.

Issues that can be sent to the RO:

- SSA deduction issues where money is being withheld and it should not be. ***Please allow 90 days from the date the disenrollment request is processed before reporting this as an issue.*** Do not contact the Social Security Administration for assistance on these cases as they cannot resolve them.

- Issues that remain unresolved after following the steps identified above.
  Note: Unless you are the authorized representative, you may not be contacted by the plan regarding the case. If you or the beneficiary have not heard from the plan and it has been more than 30 days, please contact the plan or the beneficiary to confirm status before sending the information to our office.

Centers for Medicare & Medicaid Services
Region VIII

EXHIBIT 4

When submitting an issue to the RO:

- We must have authorization from the beneficiary if requesting any change in plan enrollment or to release personal information – including plan information.
- Include a detailed explanation of the issue. Requests for us to contact the beneficiary because "they have an issue" cannot be worked.
- Please be prepared to provide specifics about your previous steps. Including names, organizations, date and time of calls or other communications.

Contacting the RO:

Please do not contact CMS staff directly to report a complaint or check the status of a case.

The following resources are for Partner use only:
To check the status of a case reported to 1-800-MEDICARE or to file a complaint (after following the steps identified above):

- Call (303) 844-4024 or 888-795-4683, or
- Email to Den_drughelp@cms.hhs.gov
  - Do not send Personal Health Information (Name, Medicare Number, etc.)
  - Email box is for Part D issues only
  - Do not send emails with jokes, wallpaper or other graphics
- Use of FAX number (303) 844-2776 should be limited only to submitting documentation when requested.

EXHIBIT 4

EXHIBIT 5

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

May 24, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Norwalk:

We are now into the second year of the implementation of the Medicare Modernization Act (MMA) of 2003, and there continue to be significant problems causing us grave concern.

As part of the MMA of 2003, the regulation of Medicare Advantage plans (MAP) and the companies marketing them, was given to CMS. This includes the review and approval of companies; the products; the marketing material; changes in availability, premiums, and formularies in the plans; and agent behavior.

The absence of state regulation is a fundamental flaw in the management of these plans. The following examples point out a few essential areas in which the lack of state regulation has resulted in poor consumer protection.

In North Dakota, I have been made aware of a number of significant abuses in the marketing and sale of Medicare Advantage plans. Specific examples include, but are not limited to:

- Pressuring a policyholder to switch their coverage to a MAP without adequately explaining the implications of the change on the benefits provided, premiums payable, or access to services.
- Telling policyholders that they *must* change, and that they must make the decision immediately.
- Seniors signing a registration form at a meeting, and finding themselves enrolled in a MAP.
- Telling Medicare beneficiaries MAPs are free, and failing to adequately explain the total out-of-pocket costs.
- Beneficiaries being called to "review their coverage", and discover later they have been enrolled in a MAP.
- Agents calling seniors and saying, *"I'm from Medicare and you need to change your policy."*
- Seniors being sent a card that states, *"Medicare Supplement insurers have increased their rates up to 30% on Medicare Supplement coverage. Based on this, there is now available a plan to supplement your Medicare coverage...Send in this card to see if you qualify for premium savings from $200 - $500 per year."*
- Telling a beneficiary "Medicare Advantage is the same as Medicare;" or "It is a supplement to Medicare."
- Telling a beneficiary that they *must* remain in a MAP for one year.
- Switching Medicare Advantage policyholders from one plan to another (within the same company) without notifying the policyholder.

The administration and response time on Medicare Advantage plans continues to be slow, inaccurate and cumbersome. Some of the more frustrating examples include:

- For one company, it has taken months to provide Part D identification cards. As a result, seniors have no verification that they are enrolled in a plan. When they go to their pharmacist, they often must pay for their prescriptions immediately because, according to the "system" and without any verification of coverage, it appears they do not have any prescription coverage (when, in fact, they do).

EXHIBIT 5

- Premiums are being deducted from seniors' Social Security checks to pay premiums on Medicare Advantage plans that they do not have. We have an example of a beneficiary who is having premiums deducted for *two* Medicare Advantage plans, without being enrolled in either one…and it is one case among many.

Marketing Medicare Advantage plans through private insurance companies has resulted in a large number of confusing choices for the senior consumer. In North Dakota, there are more than 30 Medicare Advantage plans available for sale to Medicare beneficiaries. Companies can change the number and types of plans they market; and can change the benefits, premiums and formularies for the plans they continue to offer. While policyholders are supposed to receive an annual notice of any changes, this is not always happening. In addition, medical providers choose which plans they will accept or not accept, and this can change at any time. All of these changes can be made without the regulatory supervision that is currently in place *in the states* for all other types of health insurance. The combined impact on North Dakota seniors of the complexity and the companies' ability to change is a level of consumer confusion where some now even wonder if they have any insurance at all.

One of the more disturbing developments is the deterioration of assistance provided by CMS to our Senior Health Insurance Counseling (SHIC) staff. Initially, the regional office of CMS was a resource to assist these Counselors with questions that our staff had already researched. Having access to CMS was effective in resolving these types of cases. That support has diminished significantly, with CMS now taking the position that they will help only as a last resort, after repeated attempts to work with the companies that are involved. The result of this change in position, for North Dakota seniors, is an even longer time frame to get an issue resolved. Our staff is repeatedly transferred back and forth among individuals at companies, CMS and the Social Security Administration, repeating the issues over and over…if we are even able to make contact in the first place. This lack of service to the people of North Dakota is unacceptable. North Dakotans expect better! The support from CMS has deteriorated to the point where we even had a CMS staff person hang up the phone on one of my staff while she was assisting a senior in her office.

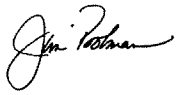
Because of funds you provide through the Senior Health Insurance Program grants, our Senior Health Insurance Counseling staff and many others across the state, including scores of dedicated volunteers, continue to work very hard to assist seniors with these difficult and complex choices. Our seniors do not need, nor do they deserve the problems they are currently experiencing regarding their Medicare coverage.

I need your help. The additional benefits introduced by the Medicare Modernization Act of 2003 can help many beneficiaries in North Dakota and across the country. However, we need changes to:

- Streamline administration
- Correct marketing abuses
- Eliminate errors, and
- Return regulation of these health insurance plans to the states.

I look forward to working with you to implement these changes to benefit that valuable segment of our population-- our seniors.

Sincerely,



Jim Poolman
Insurance Commissioner

JP:ls

cc: Byron Dorgan
Kent Conrad
Earl Pomeroy

EXHIBIT 5

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

May 24, 2007

The Honorable Kent Conrad
Senator, North Dakota
530 Hart Orffice Building
Washington, DC 20510-3403

Dear Senator Conrad:

Attached is a copy of a letter I am sending to CMS regarding the problems North Dakota seniors are having with Medicare Advantage policies.

Medicare Advantage products, as well as the companies and agents marketing them, are regulated by CMS, and not by the state insurance departments. However, it is the state insurance departments that are equipped with the skills and experience necessary to regulate insurance for the protection of consumers.

As described in the attached letter, there are a number of abuses in the marketing, sale and administration of Medicare Advantage policies that I hear about on a daily basis. These abuses are very detrimental to the financial, emotional and physical health of North Dakota seniors.

The deteriorating level of oversight and service to the people of North Dakota is unacceptable, and companies and agents must be held accountable.

I am asking for your help on behalf of North Dakota seniors to eliminate these abuses. I am asking you specifically to return regulation of Medicare Advantage plans, and the companies marketing them, to the states.

I look forward to working with you on this very important issue.

Sincerely,

Jim Poolman
Insurance Commissioner

Enc.

EXHIBIT 5

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

May 24, 2007

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Senator, North Dakota
322 Hart Office Building
Washington, DC 20510-3403

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Sincerely,

Jim Poolman
Insurance Commissioner

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EXHIBIT 5

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

May 24, 2007

The Honorable Earl Pomeroy
Representative, North Dakota
1501 Longworth HOB
Washington, DC 20515-3404

Dear Representative Pomeroy:

Attached is a copy of a letter I am sending to CMS regarding the problems North Dakota seniors are having with Medicare Advantage policies.

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Jim Poolman
Insurance Commissioner

Enc.

EXHIBIT 6

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

May 31, 2006

Mr. Michael Benedict McCallister
President and CEO
Humana Insurance Company
500 West Main Street
Louisville, KY 40202

Fax: (502)580-3690

Dear Mr. McCallister:

Our Department has learned from Humana policyholders in North Dakota that a laptop containing their personal information has been stolen while in your possession. We have also been notified that hard copy applications themselves were also recently stolen.

We are aware that Humana's only response to this critical breach of consumer trust was to write affected policyholders offering complimentary credit monitoring services for one year. In order to receive the credit monitoring service, these affected consumers would be required to provide, again, sensitive and protected information that was just stolen from them.

As the Commissioner of Insurance charged with protecting the rights of North Dakota consumers, I couldn't be more outraged that Humana did not notify our Department immediately upon discovery of the theft. Furthermore, I am appalled that Humana's only notification to the consumer was an impersonal letter.

The response to this serious breach is nothing more than inadequate. It has left North Dakota policyholders unprotected, potentially subject to their identities being stolen, and less trusting of your company. Humana's response neither served to correct the potential personal implications for your policyholders, nor did it outline procedures to ensure that this does not happen again.

Mr. McCallister, I am sure you know the problem with identity theft is an incredibly serious issue. The apparent lack of proper security for sensitive policyholder information is of great concern to me and undermines the trust that is the foundation of insurance protection. Also of concern is the apparent lack of procedure in place to protect consumers in the event of a loss of personal, private information.

EXHIBIT 6

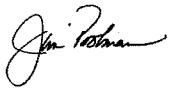
I would appreciate a response in five (5) business days to the following:

1) Specifically how many North Dakota consumers have had their personal/private information compromised? Please provide the names to this Department, so we may communicate with those policyholders independently.
2) How many consumers outside of North Dakota have had their personal/private information breached?
3) What is the security policy of Humana in storing this information?
4) What is Humana's policy in accepting applications for policies and transferring that information?
5) What are the details of the theft?
6) What assurances can you give to policyholders that there is a thorough investigation taking place to retrieve the information lost?
7) What other procedures does Humana employ to protect affected policyholders?
8) How will you respond to currently unaffected Humana policyholders who now might be concerned with the security of their information?
9) Who, specifically, can consumers contact by toll-free phone number to discuss their concerns?
10) Provide to me weekly reports of any contacts with North Dakota policyholders regarding this issue.

Please know that I am willing to use all provisions in state law to protect North Dakota consumers related to this issue. This may include preventing the marketing of Humana policies in North Dakota by cease and desist order if evidence is not shown that Humana has the policies, procedures and remedies in place to protect North Dakota seniors that are buying your insurance products. You should be aware that allowing an unauthorized individual access to a policyholder's non-public, personal financial information violates North Dakota Administrative Codes 45-14-01-11, a copy of which is attached.

A strong and healthy insurance marketplace for North Dakota consumers requires reliable and trustworthy companies. As a Commissioner elected by the people of North Dakota, I take this breach of consumer trust very seriously. I await your prompt response.

Sincerely,



Jim Poolman
Insurance Commissioner
State of North Dakota

JP:ls

Enc.

cc: Alex Trujillo, CMS, Denver
R. Glenn Jennings, Executive Director, Kentucky Office of Insurance

EXHIBIT 6

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

June 6, 2006

James S. Theiss
Chief Privacy Officer
Humana Inc.
P.O. Box 1438
Louisville, KY 40201-1438

Dear Mr. Theiss:

Thank you for your letter of June 2, 2006 responding to my request for details surrounding the serious breach of privacy resulting from the May 4, 2006 theft of a computer briefcase containing Medicare Part D insurance applications.

Although I appreciate the information your letter provided, frankly, your reply did little to assuage my outrage over the facts surrounding the theft and the manner in which Humana Inc. and GoldenCare USA, Inc. handled the situation after learning of the breach. Particularly alarming to me are: the irresponsibility and lack of protection for sensitive data while in the employee's custody; the two-week delay in notifying affected policyholders; the complete lack of notification to regulatory authorities; and the inadequate remedy to policyholders of an offer of a year's free credit monitoring service.

Offering a credit monitoring service is an essential step in rectifying the situation; however, limiting this protection to one year is not adequate. I must insist that Humana Inc. extend the monitoring service as long as necessary to protect these potential victims of identify theft.

Furthermore, I must have the assurance that these policyholders will be held harmless for any financial loss that may occur as a result of the unauthorized use of private information stolen under such lax security measures as allowing applications to be removed from GoldenCare USA's office, to be left overnight in an unlocked vehicle, parked in the driveway of the home of an employee.

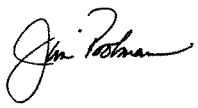
EXHIBIT 6

As of yet, I have not received sufficient information to decide whether to pursue administrative action over this breach of security. I am asking you to provide me with the following additional information, and would appreciate a response within five (5) business days:

1. An explanation of why the subsequently stolen applications were allowed to be removed from GoldenCare USA's office.
2. Specific information regarding GoldenCare USA's privacy training for employees prior to the breach, including: training materials; records of training meetings; attendance records at these meetings; and any other specifics relating to the training.
3. A copy of training materials distributed at the May 8, 2006 educational session for all GoldenCare USA employees.
4. A copy of GoldenCare USA's corrective action plan referred to in response number (3) of your letter of July 2, 2006.
5. A more specific description of the 'disciplinary counseling' provided for the GoldenCare USA employee involved in the incident.
6. A copy of the reminders sent to all contracted agencies regarding the handling of applicant information as a result of this incident.
7. An update regarding additional contractual or training requirements Humana Inc. put into place with its vendors and agents.
8. An explanation of how Humana Inc. can be confident that there were no more than 44 North Dakota policyholders affected.
9. The names and addresses of any North Dakota policyholders involved in a privacy breach in which the personal information of approximately 17,000 Humana policyholders was found on a computer available to the public in a Baltimore, Maryland hotel.

Thank you for your continued cooperation as we attempt to resolve this matter. I await your prompt response.

Sincerely,



Jim Poolman
Insurance Commissioner

JP:ls

cc: Alex Trujillo, CMS, Denver
R. Glenn Jennings, Executive Director, Kentucky Office of Insurance

EXHIBIT 6

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA
600 East Boulevard Avenue Bismarck, ND 58505
Phone: (701) 328-2440 Fax: (701) 328-4880

Jim Poolman
Commissioner of Insurance

June 7, 2006

Mr. Michael Benedict McCallister
President and CEO

James S. Theiss
Chief Privacy Officer

Humana Inc.
500 West Main Street
Louisville, KY 40202

Fax: (502)580-3690

Dear Mr. McCallister and Mr. Theiss:

Incredibly, after expressing my outrage in letters dated May 31, 2006 and June 6, 2006 over a security breach of Humana Inc.'s policyholders' private information and the company's disregard for communicating this breach to me immediately—*it has happened again!*

The North Dakota Insurance Department is receiving telephone calls from anxious Humana Inc. policyholders, distressed this time over the letter from your company advising them that their personal identification, including their social security numbers, has been inadvertently exposed to the public in the Baltimore hotel incident.

As was the case in the previous breach of security involving the theft of applications from an unlocked vehicle, we have not been notified by representatives of your company of this second exposure of personal identification data affecting North Dakota consumers. This lack of safeguards to protect the private information of your policyholders is apparently widespread and is of tremendous concern to me.

Please respond as soon as possible, but within five business days, with the following information on this latest breach of personal identification data of your policyholders:

1) Why has Humana Inc., *yet again*, failed to notify the North Dakota Insurance Department of this second serious violation?
2) How many total consumers from North Dakota and outside North Dakota have had their personal/private information exposed in this latest incident?

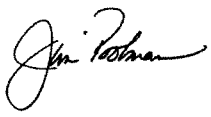
EXHIBIT 6

3) Provide to me names and addresses of *all* North Dakota consumers whose personal/private information has been compromised, so we may communicate with these policyholders independently.
4) Provide to me weekly reports of any contacts with these North Dakota policyholders regarding this incident, as well as with the 44 North Dakota consumers affected by the prior breach.

As you have been made aware in my letter of May 31, 2006, allowing an unauthorized individual access to a policyholder's non-public, personal financial information violates North Dakota Administrative Codes 45-14-01-11. Please know that I will use all provisions in state law to protect North Dakota consumers, including the prevention of marketing Humana Inc. policies through a cease and desist order, if evidence is not shown that policies, procedures and remedies are in place to protect North Dakota consumers who are buying your insurance products.

As a Commissioner elected by the people of North Dakota to protect their interests, I continue to take these breaches of consumer trust very seriously. Again, I am awaiting your prompt response.

Sincerely,



Jim Poolman
Insurance Commissioner
State of North Dakota

JP:ls

Enc.

cc: Alex Trujillo, CMS, Denver
R. Glenn Jennings, Executive Director, Kentucky Office of Insurance

Mr. STUPAK. Thank you and thank you for your testimony.

Now, we will go to questions now. Ms. Block, if I may start with you. I would assume that CMS does not approve what happened at Judiciary House as best practices, correct?

Ms. BLOCK. We totally, totally disapprove.

Mr. STUPAK. OK. Then I know you have worked with industry but has CMS taken any steps to alert Medicare beneficiaries of potential deceptive sales practices. Alabama is talking about putting together a fraud alert. Ms. Healey testified about that. But has CMS thought about doing that?

Ms. BLOCK. Actually, we have put together fraud alerts and we——

Mr. STUPAK. But sent them to the beneficiaries?

Ms. BLOCK. Those alerts, yes, those alerts are sent out. They are sent out through the SHIPs and through other outreach programs. So, yes, we have alerted beneficiaries.

But in addition to that I would say that it is really incumbent upon us working in collaboration with the States and I would really like to stress that CMS appreciates the opportunity to work collaboratively with the States. We value what the States have to——

Mr. STUPAK. Well, these two commissioners would like Congress give them the authority through CMS to regulate the policies within their own States. Do you have any objection to that?

Ms. BLOCK. Yes, I do.

Mr. STUPAK. You object to that?

Ms. BLOCK. Yes, I absolutely do.

Mr. STUPAK. Why would you object to that?

Ms. BLOCK. I object to that because this is a Federal program funded by Federal money.

Mr. STUPAK. Right, Medicare, Medigap——

Ms. BLOCK. Unlike Medigap which is privately paid for, each beneficiary pays their premium, Medicare Advantage is highly subsidized, it is a Federal program and it needs uniform consistent standard Federal oversight.

Mr. STUPAK. Then why don't we have standards in the policies that can be offered and for practice for the agents who sell these? Why don't we have that Federalized and standard so the policy whether it is in Oklahoma or North Dakota are the same and beneficiaries would know exactly what they are receiving then?

Ms. BLOCK. That is a question that has been debated from a policy perspective for many years. I used to run the Federal Employees Health Benefit.

Mr. STUPAK. Right. I am well aware of that.

Ms. BLOCK. I did that for many years. We in that organization looked carefully and at one time considered proposing standardized benefits. We decided after careful analysis that that was not the best way to run a consumer choice program. And I don't believe that it is the best way to do it in the Medicare Program either.

Mr. STUPAK. How many insurance companies are selling these Medicare Advantage policies? Do you know?

Ms. BLOCK. In terms of the total number of insurance companies, I always have trouble with this number because there are plans and then there are sponsoring organizations.

Mr. STUPAK. OK. Is there about 150, is that about right?

Ms. BLOCK. Yes, I would say that, that is probably about it.

Mr. STUPAK. OK. One 150 and you said you have 98 corrective actions going right now with these 150 companies? That is like two-thirds.

Ms. BLOCK. There are significant numbers of corrective actions but not all of them, by the way, are marketing-related by any means. Corrective actions can be put in place for many different reasons.

Mr. STUPAK. But there is a concern that CMS is looking at two-thirds of these 150 companies that are selling policies about the delivery of the product, right?

Ms. BLOCK. Well, again, many of those corrective action plans come about through routine audits, through focused audits, and they cover the whole range of compliance with all of CMS' requirements. And, in fact, the fact that we have that many corrective action plans in place, means that we are carefully monitoring these plans——

Mr. STUPAK. Or it means it is not——

Ms. BLOCK. That there is oversight——

Mr. STUPAK. Or it means they aren't working real well.

Mr. STUPAK. Right or it also could mean that it doesn't, it is not working as well as intended to be.

Let me ask you this, has CMS ever imposed a monetary penalty on a plan for any marketing abuses?

Ms. BLOCK. Not for marketing abuses specifically——

Mr. STUPAK. So the civil penalties that suggest——

Ms. BLOCK. Sanctions against plans for marketing abuses.

Mr. STUPAK. Well what are the sanctions? What would be a sanction?

Ms. BLOCK. A sanction would be freezing marketing, freezing enrollment. We did impose those penalties against a plan in Florida.

Mr. STUPAK. OK. So if you freeze it they still are allowed to get the benefits of that monthly payment and things like this, correct?

Ms. BLOCK. For existing members, yes.

Mr. STUPAK. Well, where is the penalty then?

Ms. BLOCK. Well, the penalty is that they can't increase their membership.

Mr. STUPAK. You imposed a penalty because they did something wrong and if I have a captive audience here and I am frozen, I am still being rewarded for my deceptive practices because I have this group here that has the problems, right? So where is the penalty here?

Ms. BLOCK. Let me say this. The ability to impose penalties and the penalties that can be imposed range depending upon the offense, and so——

Mr. STUPAK. Sure. My problem is I never see CMS issue a penalty.

Ms. BLOCK. When you impose civil monetary penalties you need to demonstrate very specifically, and by the way those penalties have to be approved by the Justice Department.

Mr. STUPAK. Sure.

Ms. BLOCK. You have to be able to demonstrate real harm to beneficiaries so you don't impose those kinds of penalties, you can't impose them for what would be considered to be administrative-

type violations. And that is where corrective action plans are used. In order to impose a civil monetary penalty and we did that by the way for the late delivery of ANOX. We imposed civil monetary penalties on a number of plans and we did that because we believed that there was, in fact, and could justify to the Justice Department that there was direct harm to beneficiaries because by not receiving the information they needed timely they could not make an appropriate decision in terms of their choice of plan for the next year.

Mr. STUPAK. Civil monetary penalties are not approved by the Department of Justice. Department of Justice just really checks to see if they might interfere with their open investigation, right? You don't have to get Justice Department approval?

Ms. BLOCK. My understanding is I have to go through the Department of Justice every time I want to impose that kind of penalty.

Mr. STUPAK. To make sure you are not interfering with a——

Ms. BLOCK. That is a time-consuming process.

Mr. STUPAK. Oh, I agree.

Ms. BLOCK. What I want to do, believe me, is fix these problems just as quickly as I possibly can. I want to address every problem and I want to fix it and I want to fix it right now.

Mr. STUPAK. Well, but let us be clear here. Justice Department doesn't approve or have to approve the civil penalties. All Justice Department wants to know is whether or not you are interfering with an ongoing investigation.

Ms. BLOCK. I am sorry but if I want to be exact they have to review them.

Mr. STUPAK. OK. Are there any enforcement in the so-called guidelines you are putting forth, CMS putting forth, these guidelines? What is going to be the sanction if you violate these guidelines?

Ms. BLOCK. The sanctions will be appropriate to violations and I guarantee you that they will be appropriate to the violations if there are violations.

Mr. STUPAK. Any sanctions on the company that Judiciary House here that we had today? Are you considering any sanctions against that company?

Ms. BLOCK. That company is under a corrective action plan. All of those corrective action plans remain in place and further, by the way, all investigations also remain in place.

Mr. STUPAK. My questions was sanctions.

Ms. BLOCK. Criminal action against any of those agents, those things are in no way impeded and there are criminal penalties that can be taken against agents who are——

Mr. STUPAK. Judiciary House, the one we heard from today, any sanctions, any criminal penalties, any recommendations made by CMS on that example we had today?

Ms. BLOCK. We have learned very recently of that particular incident and the plan as far as I know did everything it needed to do. It terminated its relationship with those unscrupulous agents. That is what you would expect would happen. The relationship was terminated. Those people are no longer working for that organization.

Mr. STUPAK. OK. My time is way over but, what would you do, Mr. Poolman and Ms. Holland, if Judiciary House occurred in your

State and if you had the authority? What would you do? What sanctions do you have?

Mr. POOLMAN. Well, clearly, what would happen is we would go after the agent which I think happened in the District of Columbia, but the interesting thing about this is that there is a contractual relationship between an agent and a company and if the regulatory process was set-up just like any other company. Let us say it is a life insurance company selling an annuity and somebody was duped into buying an annuity we could, therefore, go back and make the company make the transaction right to begin with. And that is the authority we don't have right now. We don't have any market conduct authority to hold those companies accountable. If we did, then the company would be held accountable in making the transaction right, getting that particular person or persons in this case, dis-enrolled from the program and enrolled in the right kind of program and holding that company accountable in doing so.

Mr. STUPAK. Thank you. Ms. Holland. Sure.

Ms. HOLLAND. If I may add something to that, I referred to in my testimony an exam that we conducted on Humana because of people's complaints.

Mr. STUPAK. Right.

Ms. HOLLAND. We actually found that in the course of that examination that there were 68 agents selling products in our State who were not licensed. They had no appointments but again as Commissioner Poolman indicated that we were unable to address that with them other than to tell them we expected their agents to be appointed. The examination actually identified numerous other failures on the part of the company, things that we would have addressed immediately had we had the authority.

And so I brought that examination to Ms. Block personally in March. I was interested to hear today that she indicated that they require agents to be licensed by their companies, so we certainly will be pursuing those agents, and I hope now that I know that CMS will be pursuing actions against those companies, Humana, specifically, for permitting 68 agents to be selling products in my State without a license.

Mr. STUPAK. Thank you. I am way over on my time.

Mr. Whitfield, for questions.

Mr. WHITFIELD. Ms. Holland and Mr. Poolman, both of you in your testimony made it quite clear that you did not feel that CMS was adequate in protecting the citizens of Oklahoma and North Dakota, respectively as it relates to Medicare products. But Ms. Block, in her testimony talked about these Memorandums of Understanding with, I think she said 26 States and Puerto Rico. Has North Dakota entered into a Memorandum of Understanding with CMS and Oklahoma also? And in her testimony she, maybe I didn't hear her correctly but I understood her to say that this Memorandum of Understanding gives the States the complete authority to go in and deal with problems with insurance agents. Is that not correct?

Mr. POOLMAN. Congressman, no, that is not correct. Being very frank it is basically as I understand it an information sharing agreement. There is no absolute downside to signing a Memorandum of Understanding with CMS when we have a responsibility in my State, a constitutional responsibility to protect the people of

North Dakota. So to share information and in getting that information is incredibly important to us.

Mr. WHITFIELD. All right.

Mr. POOLMAN. To be able to effectively regulate the agents out of it, it gives us no authority on the company side to be able to hold those folks accountable.

Mr. WHITFIELD. Ms. Holland.

Ms. HOLLAND. Yes, just as an example the MOU came about it because of our concerns about being able to address agents within our jurisdiction. It was the NAIC that really initiated the conversation with the MOU. That sat on the desk of, completed on the desks of CMS until I called and said I had an examination report and I would not deliver it until I had that MOU. And that spawned the delivery of the MOUs for the States that received them. But up until that time we had been waiting for some months for that MOU which the States had signed, those that participated, and still had not received that information. But again all it does is, as Commissioner Poolman said is agrees to an exchange of information.

Mr. WHITFIELD. Well, you heard the commissioner from or deputy commissioner from Mississippi saying that in his State it was unclear whether or not they had the legal authority to terminate a license. What about in North Dakota and Oklahoma, what is your decision on that?

Mr. POOLMAN. Because we do not have authority over the product, if you were to pull a license for the sale of a product that you don't have regulatory authority over there is some confusion. And if we pull a license, Congressman, there is an appeals process that those folks can go through, in fact, they can go to the district court and then the Supreme Court to appeal that. So we have to have very solid legal ground.

In some of the cases that you have heard today I think we could eventually go after those folks and we are in North Dakota, by they way. We have open investigations in going after those agents that are unscrupulous in this regard. And we think we have the authority when it comes to agents but it has not been tested yet, and we want to make sure it is very clear authority.

Mr. WHITFIELD. And you, same thing, Ms. Holland.

Ms. HOLLAND. We are pursuing it aggressively. Quite frankly I have an anti-fraud unit on, actually a law enforcement team on staff and I send my law enforcement team out to pursue any misbehavior, certainly.

Mr. WHITFIELD. Well, Ms. Block, you have heard these concerns expressed by the insurance commissioners in these States, do you feel like they do not have a right to terminate the licensing of these insurance agents?

Ms. BLOCK. I believe they have an absolute right. We strongly encourage them to do that and we would like to work collaboratively with them to identify and track-down and pursue everyone who is acting inappropriately or illegally in any State.

Mr. WHITFIELD. OK. So then what is the problem, why have we not been able to work together? Or have we been able to work together? Mr. Poolman.

Mr. POOLMAN. Well, Congressman, it is not a matter of not working together, it is a matter of where does the authority lie to protect the people in my State and other States? And as I have said to you before we believe we have authority when it comes to agents, but the problem is, is making the consumer right and whole in the end of a transaction that has gone wrong. And if we have the ability to regulate from a market conduct standpoint, from a advertising standpoint, those types of things, we then have some leverage with the company to make them market right in our State.

Mr. WHITFIELD. You and Ms. Holland then would be objecting to the preemption of the State's authority in this area? Do you interpret that the Federal act that established these Medicare Advantages preempts State law in this regard?

Mr. POOLMAN. Congressman, before Medicare Modernization Act we had regulatory authority over benefits, appeals processes, rates, all of those types of things. Now we have basically regulatory authority over some licensing and solvency, and that is it. Nothing related to market issues.

Mr. WHITFIELD. So your authority has been diminished significantly in your view.

Mr. POOLMAN. Yes, sir.

Mr. WHITFIELD. OK.

Ms. HOLLAND. And I think an example of that was one of the gentlemen today when you—from the carrier that was defending his—the agent population say, reminding everybody that those were independent agents not his agents, which I thought was such a disingenuous comment because quite frankly an agent is always an agent of the company by licensure, by contract. But under the MMA, appointments, that critical link that actually creates that contract, have been discontinued.

So indeed we have free agents out there where we can address the agent but if it is an unlicensed agent I can't find that person unless I do an examination on the company.

And if I try an examination on the company, like I did with Humana, they are digging their heels in and screaming preemption every opportunity they get.

They have. It was through our persistence and insistence.

Mr. WHITFIELD. Yes. Well, normally I think the American people when they think about authority, they fear Federal authority more than State authority. You take the IRS, the FBI, the Justice Department, but in this instance it appears that CMS is either not being aggressive in dealing with this, the fear is not there, in this particular instance. But with that my time has expired, Mr. Chairman.

Ms. HOLLAND. Well, may I just respond to that in one respect because I have all due respect for Ms. Block and her comment about really wanting to do something. I think that is sincere. I think it is a reality of resources. I don't have a CMS representative in my State. If one of my beneficiaries calls from Tahlequah, OK and needs help I can send one of my law enforcement officers out there in an hour to see what is going on. I have to call CMS and they are not going to come to Tahlequah, OK and deal with my senior population.

I think that is what we are trying to suggest to you is that we have got the resources on the ground that have been there. We have been dealing with these issues on these products, health care, whatever the products are, for again, 136 years. What has changed? The idea of it being Federal dollars is another area that appears disingenuous to me it is taxpayer dollars. And those seniors are paying those taxes and those seniors are paying premiums. And I am paying those taxes. So we should all be working together.

Mr. STUPAK. Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Ms. Block, let me just ask you the statement was made by, I don't remember which commissioner, it may have been, in fact, made by both commissioners that it seemed that CMS was unable or unwilling to do the job as far as enforcement. How would you respond to that statement?

Ms. BLOCK. CMS is perfectly willing to do the job and has every intention of doing the job. And again I will suggest that the best way to do the job is through a partnership of the Federal Government and the States that have a critical role to play and we would like to strengthen that partnership and do the job effectively together.

Mr. BURGESS. I think we just heard in some of the very last statements made by the commissioner from Oklahoma about, they are there. They are on the ground. They have the enforcement officials who are on duty and at their beck and call, so I guess I would ask the question why not use their offices as a force multiplier for CMS in order to reign in unscrupulous behavior.

Ms. BLOCK. But we do. I don't know how I can stress to this committee that the States have jurisdiction over the licensed agents in their States. And to address the issue that Ms. Holland raised we absolutely require that all agents be licensed and where there is a violation of that we have mechanisms to deal with that with the sponsoring organization.

Mr. BURGESS. Now, can anyone on the panel provide this committee with documentary evidence where that licensing authority did not exist, an enforcement action followed as a result of that? Or that those licensing obligations were abrogated and an enforcement action was taken on behalf of either CMS or the State Department of Insurance?

Ms. HOLLAND. No, I think we acted within our authority to address the licensure issues but licensure, the specific licensure of any one agent is intrinsically tied to their relationship with the company. And the current MMA has severed that tie at least in terms of our ability to tie that agent back to the company and compel the company, through sanctions and otherwise, for getting the behavior that we want.

Mr. BURGESS. Ms. Block, you are nodding your head, you agree with that statement?

Ms. BLOCK. Yes, I am. Ms. Holland is addressing an issue that is generally referred to as appointments.

Mr. BURGESS. I am sorry.

Ms. BLOCK. And I thoroughly understand the issue.

Ms. HOLLAND. Appointments.

Ms. BLOCK. Appointments and what we are proposing, and we would hope to move very quickly, in order to be able to deal with

this, is that we will require every plan selling Medicare Advantage products, particularly Private Fee-for-Service products, to provide to CMS the names of all of their licensed agents and all of their agents need to be licensed. We will then in turn make those names available to every State on request so that we will develop a centralized, presumably, Web site access. That would be the easiest way of doing it, to put it on a Web site so that every State insurance commissioner will be able to look at that Web site and will be able to see the name of every agent who is working for every company selling in their State. That is something, it is not in place, yet.

Mr. BURGESS. It is not, OK.

Ms. BLOCK. But it is going to be in place very soon, I guarantee.

Mr. BURGESS. All right. Well, it has been 2½ years since, I guess a year and a half, since the implementation of the part D program and it is probably time that that occurred.

How is the Medicare Advantage Program different from say the multi-state insurance company that would be governed under the ERISA statutes. Is it a similar situation with the preemption? Is it a parallel universe that the Medicare Advantage plans occupy? How does that work?

Ms. BLOCK. They are not governed under ERISA, they are governed under Medicare statute and regulation, and that is why, in my oral statement and I believe I go into even more detail in my written statement, I describe the very rigorous review process that every plan and every plan's benefit package goes through at CMS because CMS has the authority to oversee these plans and before a plans benefit package is accepted, it is reviewed by CMS and would go through that process every single year.

Mr. BURGESS. Let me just interrupt you because the chairman is not going to be nearly as indulgent with me going over as he is with other members of the committee.

Do you have similar problems, let me just ask the commissioners do you have similar problems with ERISA plans that you have with the Medicare Advantage plans?

Mr. POOLMAN. Congressman, I think that is a great question and it is a great point. Let me give you an example, if a consumer calls my office and they are under a self-funded plan that has been created by a business and they can't get their claim paid? I have to essentially refer them to the Department of Labor who administers ERISA. I have no authority to go enforce that company or force the insurance company that is administering that plan to pay that claim even if it was right to be paid. It is very similar to what is happening here. And it is a black hole of regulation because those folks get no response from the DOL either.

Mr. BURGESS. Yes, I think I fell into that black hole as a practitioner once.

Mr. POOLMAN. Yes, you did.

Mr. BURGESS. But do we see the abuses in the ERISA system that we have been talking about here this afternoon?

Mr. POOLMAN. As, Congressman, as more companies are getting away from fully insured plans because of the standardization of those plans and creating their own benefit plans we are seeing

more abuses in that regard and we are having to shuffle them off to the Federal Government and they are essentially calling you.

Mr. BURGESS. Is there, and that is fine, I will take those calls. Is there a risk of a learning curve with people observing what is happening with the Medicare Advantage plans that are having a spill-over effect to the ERISA plans, the race to the bottom, if you will?

Mr. POOLMAN. The difference, Congressman, is that ERISA plans are created by business owners and I would sense a much less vulnerable population then the folks buying typical Medicare Advantage plans because they are seniors that are in many cases duped. On the ERISA side it is a business owner setting-up a plan and they are far more sophisticated purchasers when buying a self-funded plan for their business.

Mr. BURGESS. OK. Let me just ask one last question now I know in the State of Texas, I believe the insurance commissioner is an appointed position by the governor, and you are both elected, is that correct? If I were to want to vote for either one of you in the primary election would I vote in the Democratic or Republican primary?

Ms. HOLLAND. One of each, Congressman.

Mr. BURGESS. One of each.

Mr. POOLMAN. You have a bipartisan representation here. I am a Republican and my colleague is a Democrat.

Mr. BURGESS. I was just trying to figure out a way to ask that question delecately.

Mr. POOLMAN. I am very open with that and that, well, I will let it go at that.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. STUPAK. Ms. Holland, Mr. Poolman, when Ms. Block was talking about this Web site with the insurance agents on it, is that going to solve the problems here?

Ms. HOLLAND. I think there is a couple of things here. First of all, the National Association of Insurance Commissioners maintains a National Insurance Producer Registry, the NIPR.

Mr. STUPAK. It is already there.

Ms. HOLLAND. It has every licensed agent on it, it is notified of terminations and so forth. It is accessible to companies and regulators. It is not accessible to the general public, however, anyone can call us and we can access that information. We all share information through State-based regulatory systems, as well, which requires companies to send us an appointment, when they appoint an agent.

Mr. STUPAK. Right.

Ms. HOLLAND. An appointment is necessary to get a license. If that appointment is cancelled for any reason the company has to report that and why. In the absence of that appointment process again, we won't have that information.

Mr. STUPAK. And the Medicare Modernization Act took away the appointments, right?

Ms. HOLLAND. Right, it does not require an appointment, no. The problem and the only thing that I would suggest in the example that Ms. Block gave is the 68 agents who were doing business in my State wouldn't be on her report, and I still wouldn't know about

them. It was only through the process of my investigation and examination of that company that that came to light.

Mr. STUPAK. But if we put the appointment rule back in.

Ms. HOLLAND. That would work. It would help tremendously.

Mr. STUPAK. And would that also give you some jurisdiction or control over these policies that are being sold? It doesn't, it is only the agents, right?

Ms. HOLLAND. Well, no, it does allow us to hold the company accountable for that.

Mr. STUPAK. For their agent which you cannot do right now.

So really to solve this issue, you really need, No. 1, the appointment rule back so you have some control over the agent with company. Second, you have to have some control over product being sold.

Ms. HOLLAND. Indeed.

Mr. STUPAK. If CMS put forth a Web site that listed oh, corrective actions, and Ms. Block mentioned corrective action plans that they are looking at right now for 98 companies, complaints, dis-enrollment data, would that be helpful?

Ms. HOLLAND. I think any information about company activities and actions is helpful to regulators. We are always interested.

Mr. POOLMAN. Mr. Chairman, I think any of that information as Commissioner Holland said is important. We have some questions about the corrective action plans and the oversight function of CMS and who is going to make sure that are they going to report back to anybody that who has taken what steps to make sure and what happens if they are not? What is the process that they are going to go through? That will come through some communication, I am sure, with CMS, but we are hoping that there is vigorous enforcement of self-corrective action plans that is out there. And if not, what is the, then the flip side of that in terms of punitive intentions against the company that is not following their own corrective action plan?

Mr. STUPAK. So, Ms. Block, why wouldn't CMS put this information, CMS currently pulls information on nursing homes, home health agencies, so beneficiaries and their families have the information about staffing levels, health outcome measures, and sanctions have been post. So why doesn't CMS then put the corrective action plans on the Web site, complaints, dis-enrollment and this information available and not just for these insurance commissioners but for all seniors? Why wouldn't we do the same thing?

Ms. BLOCK. We are in the process of doing that, sir, as we speak.

Mr. STUPAK. All right. That would be a good first step. How about this idea about the appointment rule, would you be opposed to giving them back they appointment rule on their MMA, that the commissioners asked for?

Ms. BLOCK. There has been a great deal of discussion about that and it is still under discussion, but let me say I need to clarify because I think what I am proposing was not completely understood. What I am proposing is that we would post the name of every agent who is selling attached to the name of the company for whom they are selling. So, Ms. Holland would be able to make the connection between John Jones and WellCare or Humana or whatever other companies John Jones is selling for. So she would have that

information and she would know that John Jones, if she is having a problem with him, is an agent for a particular company. That is the information that we are talking about making available.

Mr. STUPAK. Would that solve the problem, Ms. Holland?

Ms. HOLLAND. Well, an independent agent can sell product from any number of companies.

Mr. STUPAK. Sure.

Ms. HOLLAND. If you are not required to obtain an appointment and then subsequently not licensed, they could be carrying out a portfolio of any number of companies and have no attachment to any one company until such time as they presented an application for processing. At that time, that is backwards.

Mr. STUPAK. OK.

Ms. Block, will you make available those 98 action plans that you are currently under right now that you have proposed?

Ms. BLOCK. Yes.

Mr. STUPAK. OK. And you will make them available to the committee then forthwith?

Ms. BLOCK. Yes, sir.

Mr. STUPAK. OK. Mr. Whitfield, did you have some questions?

Mr. WHITFIELD. Mr. Chairman, I don't have any questions, but Mr. Poolman, in his testimony, enclosed some letters that were sent to Humana regarding a specific issue and in order to just complete the record we have copies of the response from Humana to Mr. Poolman and just ask Humana's consent that they be placed in the record to complete the record.

Mr. STUPAK. OK. My only concern, Humana, in the letter is that dated June 2, 2006, said they only had 44 residents of North Dakota and Commissioner Poolman's testimony on page 6, I believe, you mention there are 130 seniors from North Dakota. So I am just trying to figure out the discrepancy.

Mr. WHITFIELD. Well, I am not speaking for the truthfulness of the document.

Mr. STUPAK. Oh.

Mr. WHITFIELD. I am simply saying that he asked the question and we are putting the document in so that people could.

Mr. STUPAK. You don't mind that it goes on record.

Mr. POOLMAN. Mr. Chairman, that is fine with me.

In all due fairness to the company they deserve the opportunity to respond. In this case there were two separate privacy incidents, in breach of privacy, and I think my testimony refers to the aggregate not both instances separately.

Mr. STUPAK. Very good. OK. Without objection then that will be entered in the record.

Any other questions for this panel? If not, let me thank the panel, the commissioners and Ms. Block, for their time and their testimony and their answers to our questions are very enlightening. I ask for unanimous consent that the hearing record will remain open for 30 days for additional questions for the record. Without objection the record will remain open. I ask unanimous consent that exhibits 1 through 19 from our document binder be entered into the record. Without objection, documents will be entered in the record. That concludes our hearing. Without objections the meeting of the subcommittee is adjourned.

[Whereupon, at 1:52 p.m., the subcommittee was adjourned.]
[Material submitted for inclusion in the record follows:]

BNA, INC.

HEALTH PLAN & PROVIDER

REPORT

Medicare Private Fee-for-Service Plans: A Market-Driven Blueprint For Enhancing Value

By John Gorman and Jean LeMasurier

Summary

Almost 1.5 million Medicare beneficiaries are enrolled in Private Fee-for-Service (PFFS) plans, which are among the fastest growing types of Medicare Advantage (MA) plans operating today. Although the rapid proliferation of PFFS plans has provided greater beneficiary choices and enhanced access to MA plans, especially in rural areas, it has also created problems. These include provider refusal to serve beneficiaries who enroll in PFFS plans, higher out of pocket costs for beneficiaries who get sick, and, in some cases, marketing and sales abuses among brokers and agents who recruit beneficiaries into these types of plans.

As enrollment in PFFS plans has soared, and as more of these problems have come to light, providers, beneficiaries, traditional MA plan sponsors, and policymakers including members of Congress, have started to ask hard questions. Do PFFS products provide real value to beneficiaries and the Medicare program as a whole, or should new laws and regulations be enacted to curtail their growth or eliminate them altogether?

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This article looks at the history and evolution of PFFS plans and examines the regulatory and market forces that have been driving their rapid growth. We also discuss the strengths and limitations of PFFS plans as they operate in the market today. Finally, we suggest specific steps commercial insurers can take to enhance the value of their PFFS products for both Medicare beneficiaries and the Medicare program as a whole—steps we believe are necessary to ensure the viability of these products in the long term.

Introduction

Less than four years after enactment of the Medicare Modernization Act (MMA) of 2003, 99 percent of beneficiaries now have access to a Medicare Advantage (MA) plan. A major contributor has been the growth of MA Private Fee-for-Service (PFFS) plans. Between 2005 and April 2007, the number of insurers offering a PFFS product doubled, and PFFS enrollment grew from 200,000 to almost 1.5 million. Today, commercial insurers such as Humana, WellPoint, Coventry, and Aetna offer PFFS products nationwide.

Almost overnight, many of the long-established Medicare HMOs and Medigap supplemental insurers woke up to as find many as 22 new, competing, low-cost PFFS benefit plans in their service areas. Meanwhile, Medicare beneficiaries suddenly had access to MA products that appeared to offer them the freedom to see any doctor and not have to switch providers.

History and Background of PFFS

It wasn't always this way. In fact, PFFS plans had very slow beginnings and limited market uptake. They were first created under the Balanced Budget Act of 1997 to allay concerns among indemnity proponents that managed care plans likely to thrive under that bill's

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boost to the Medicare+Choice program would eventually take away provider choice and limit access to services. Few managed care observers believed PFFS plans would ever get off the ground, largely because these plans would not have the tools to effectively manage the risks of their capitated payments. (The legislation specifically required PFFS plans to accept any willing provider, allowed members to self-refer, prohibited use of prior authorization and required fee-for-service payments to providers at Medicare rates.)

CMS developed a regulatory structure for PFFS plans that included the concept of a "deemed" network, under which any provider who knew the terms and conditions of the plan's payment and who agreed to serve a Medicare beneficiary enrolled in the plan would be considered a "deemed" provider for that service. The regulations also allowed plans to create provider networks and pay fees higher or lower than original Medicare. A few insurers did, in fact, subsequently offer PFFS products, but with limited success.

Why PFFS Plans Have Mushroomed Under MMA

Under the MMA, Medicare payment rates were increased for all types of MA plans, including HMOs and PPOs, to encourage more plans to participate and to give beneficiaries greater choices than previously existed. CMS also imposed a two-year ban on local PPOs in order to promote the development of larger regional PPOs that could, in theory, serve larger numbers of beneficiaries, and thereby increase beneficiary access to MA options.

But regional PPOs are much less attractive to insurers than local PPOs because MA payment rates vary widely by county. For a company to offer a regional PPO, it would have to blend high and low payment rates across their service areas to offer the required uniform benefits package. By contrast, local MA plans can designate their service area on a county-by-county basis. Also, to offer a regional PPO, insurers have to build large provider networks that meet minimum access standards in both urban and rural areas. It is much easier to build smaller networks at the local level (and in urban-only markets).

As a result, many insurers steered clear of offering regional PPO products during the same period that they were barred from entering the local PPO market. Suddenly, PFFS looked like an attractive option for plans wanting to expand their MA product offerings and service areas. Insurers offering a PFFS product could enter the market very quickly because they did not have to build provider networks. Under the MMA, Medicare would pay the PFFS plan the higher of the MA rate or 100 percent of the amount original Medicare paid in that county. Companies offering PFFS products, therefore, could target more profitable counties, including rural floor counties and high payment urban counties.

Upsides, Downsides of PFFS Today for Beneficiaries and Employers

Thanks to the growth of PFFS, congressional intent that more private plans serve rural America has been largely accomplished. But the plans serving rural America are not the large regional PPOs originally anticipated by the legislation's proponents, but the PFFS plans that, until recently, had not been on many lawmakers' radar screens.

There are many aspects of PFFS plans that make them attractive for beneficiaries and employers that provide health coverage for their Medicare-eligible retirees. But there are also downsides. Let's look at these in detail.

Beneficiary Upsides:

PFFS plans often have low premiums and provide additional supplemental coverage that many beneficiaries otherwise could not afford. Many PFFS plans appear to be a bargain on the surface because they provide the same services covered under original Medicare, plus a supplemental policy, for substantially less than beneficiaries would pay otherwise. For example, a fully insured beneficiary in original Medicare would need to pay the Part B premium ($93.50 for 2007), and a Medigap premium, (e.g., $150 a month for "Plan F" which does not have copays or deductibles). By contrast, a PFFS plan offers the same coverage as original Medicare plus a Medigap policy for as little as a $0 premium, plus copays. In addition, some PFFS plans offer rebates up to the full $93.50 monthly Part B premium. In fact, more than a quarter-million beneficiaries are now enrolled in PFFS plans that offer partial or full Part B premium rebates.

PFFS plans often include additional benefits for little or no additional costs. These may include eyeglasses, hearing aids, or Silver Sneaker fitness programs.

PFFS plans are perceived as offering greater access to physicians compared with other MA products. Most PFFS plans market themselves as giving enrollees the "freedom" to choose any provider that accepts Medicare. Beneficiaries often sign up because they expect to be able to retain the same providers and physicians they have always had.

Beneficiary Downsides:

Beneficiaries who get sick often incur higher, unexpected, out-of-pocket costs if they are hospitalized or placed into a nursing home. Unfortunately, this unpleasant surprise often occurs only after the beneficiary is already locked into their plan for a year.

Why these higher costs? In exchange for $0 or low premiums, most PFFS plans today charge higher coinsurance. For example, one large PFFS plan charges $180 a day for a five-day hospital stay, while another charges $300 a day for the first seven days. A beneficiary in the latter plan who is hospitalized for a week would be liable for $2,100 in out-of-pocket costs. By contrast, a beneficiary in original Medicare with a "F" Medigap supplemental policy would incur no out of pocket costs other than premiums. Even a beneficiary in original Medicare who lacks supplemental insurance would incur only a $992 deductible for the first 60 days of hospitalization.

Also, many services covered under PFFS require the same coinsurance as original Medicare. For example, a beneficiary will pay 20 percent coinsurance for DME and could face out of pocket maximums as high as $5,000. Many beneficiaries who enroll in PFFS, however, mistakenly think they are buying insurance protection that would shield them from such costs.

Although beneficiaries can choose any provider, that provider does not have to accept the patient if the provider doesn't like the plan's payment terms. In fact, for a number of reasons we will explore below, many providers have few if any financial incentives to participate

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in PFFS. As a result, physicians and other providers in some parts of the country are refusing to serve PFFS enrollees, reducing beneficiary access to medical services. A beneficiary who enrolls in a PFFS plan and subsequently finds that his or her physician will no longer accept him or her will be locked into that plan, and, therefore, forced to find an alternate provider for the remainder of the lock-in period.

Employer Upsides:

PFFS products offer employers more convenient and affordable options for covering Medicare-eligible retirees. First, the non-network model is a highly feasible option for employers with retirees scattered throughout the country. In fact, many of the large commercial insurance companies, recognizing this opportunity, entered the PFFS market by offering a nationwide product that would appeal to the large employer segment. Because many PFFS plans have $0 or low premiums, employers can save significant costs, effectively allowing them to offer their retirees a defined contribution plan. Most importantly, both private and public sector employers can shift their retiree health care liability to PFFS plans and gain substantial FASB/GASB advantages in the process (these employers would not have to pre-fund their retiree health care liabilities on their financial statements).

Employer Downsides:

Provider push back is reducing beneficiary access to the point that PFFS is becoming an unreliable option. In fact, one private employer with one of the largest Medicare retiree health liabilities discarded a full PFFS replacement strategy for 2006 because of provider refusal to serve PFFS enrollees. Until the provider access issue can be addressed, employers will be slow to adopt PFFS on a wide scale.

Why Many Providers Refuse to Accept Beneficiaries Enrolled in PFFS

Because PFFS plans are required to pay providers the same as they would under original Medicare, many observers initially assumed, erroneously, that this would create a level reimbursement playing field. But it's not level, thanks largely to the complexity of the original Medicare and Medicare Advantage payment systems. Only now that more beneficiaries have enrolled in PFFS are these inequities and their consequences (i.e., lack of provider participation and the resulting reductions in beneficiary access) coming to light.

PFFS plans often pay providers less than what original Medicare and some MA plans pay. Non-participating physicians and those who don't accept assignment under original Medicare may be worse off under PFFS. Under original Medicare, non-participating physicians are paid 95 percent of the original Medicare fee schedule, but are allowed to balance bill the beneficiary an additional 15 percent, allowing them to earn 108 percent of the Medicare fee schedule. PFFS plans, by contrast, are allowed to limit payments to non-participating physicians to 100 percent of the original Medicare fee schedule, but prohibit physicians from balance billing. These physicians, therefore, could be paid 8 percent less under many PFFS plans than they would be paid under original Medicare.

Likewise, providers who have already negotiated higher payment rates with a MA plan than what original Medicare pays (in some cases, 135 percent of Medicare's original fee schedule) would be worse off accepting PFFS patients. Similarly, because some MA plans pay hospitals more than current Diagnostic Related Group (DRG) rates under original Medicare, these providers also have no incentives to accept PFFS enrollees.

Providers often fail to fully understand the PFFS plans' terms and conditions beforehand, putting them at financial risk. Many providers, for example, may not be aware upon initially accepting PFFS patients that they could be paid less than original Medicare or less than they would under another MA contract with the same insurer that's offering the PFFS option . Anecdotal evidence suggests that some PFFS plans may not have made their Terms and Conditions easily accessible on their websites, or have been unresponsive to provider inquiries regarding payment terms, adding to this lack of physician understanding.

Many PFFS plans do not reimburse providers in a timely or accurate fashion. As with original Medicare, PFFS plans must pay clean claims within 30 days of receipt. However, many providers who accept original Medicare are often paid within 14 days. Also, anecdotal reports suggest there is widespread difficulty among PFFS plans in paying claims accurately under the dozens of complex Medicare fee schedules, causing some to delay payment beyond 30 days to review claims' appropriateness. Thus, provider cash flow is an issue.

PFFS plans may deny more claims than original Medicare carriers. Even though non-network PFFS plans cannot impose prior utilization review, they can review claims retrospectively for medical necessity. In areas where the PFFS plans' standards are more stringent than those of the original Medicare carriers or fiscal intermediaries, providers may see more of their PFFS claims denied than they would under original Medicare.

Do PFFS Plans Offer Medicare a Reasonable Return on Investment?

As we have discussed, PFFS plans offer additional benefits that many beneficiaries find attractive and often provide a lower cost option that allows beneficiaries to purchase supplemental insurance that they might not otherwise be able to afford. And the growth of PFFS has made these additional benefits and lower-cost options available to more seniors living in more areas, especially rural communities, than at any time previously.

But are these benefits worth the added costs to the Medicare program, especially when we consider the provider access and beneficiary out-of-pocket cost issues that have recently emerged with PFFS plans?

According to recent studies by the Medicare Payment Advisory Commission (MedPAC) and the Commonwealth Fund, PFFS plans are paid 119 percent of original Medicare (based on the counties in which they are currently offered and driven by higher rates in rural areas and small urban "floor" rates). By contrast, other MA plans are paid 112 percent of original Medicare.

Managed care proponents contend that MA plans provide added value to the Medicare program that justifies the higher reimbursement rates, including lower out-of-pocket costs and greater levels of benefits for enrollees, greater levels of patient care coordination, quality improvement initiatives, and, most importantly, capitation—*which shifts financial risk away from the Medicare program.*

However, as Congress and policymakers scrutinize MA payment rates, many are skeptical of what value, if any, PFFS plans provide, for that extra 19 percent in federal spending. According to CBO and MedPAC, only 10 percent of the additional 19 percent is returned to the beneficiary, with the balance retained by the plan for administrative costs and profits. In fact, under MMA, Congress specifically excluded PFFS plans, which are essentially indemnity products, from the quality and chronic care improvement requirements that apply to other MA plans. Because virtually all PFFS plans operating today are non-network PFFS plans, they have little ability to conduct care coordination or other quality initiatives, except for the occasional voluntary nurse call line.

It is no wonder that providers, beneficiaries, traditional MA plan sponsors, and members of Congress have raised concerns about the way PFFS plans have been implemented, how they are paid, and what's happening in the marketplace. In fact, we would argue that if PFFS plans are to survive and thrive in the long-term, they must make some fundamental structural and operational changes.

A Recommended Blueprint for Improving the Medicare PFFS Program

We believe there are several areas where PFFS plans can make immediate improvements that would help them retain beneficiaries, achieve greater levels of provider participation, and quell some of the concerns raised by lawmakers.

Adopt a hybrid-network approach. Medicare regulations give PFFS plans the flexibility to include a network of key, select, contracted providers for providing some or all services to Medicare beneficiaries. We believe market forces will push PFFS plans to morph into hybrid, "PPO-lite" products in which the plan would contract with certain key providers in order to ensure provider access for beneficiaries. Employer groups that have purchased PFFS replacement products for their Medicare-eligible retirees simply will not stand by idly and allow these beneficiaries to be stranded within the system. (In fact, in the short term, plans will increasingly come under pressure from these purchasers to help retirees book medical appointments.)

Reduce the payment hassle factor. If PFFS plans could assure providers of reimbursement within 14 days, more providers would accept PFFS patients. Plans could reduce reimbursement lag times by adopting employer HSA-style debit cards or electronic funds transfer systems with banking institutions.

Get proactive with care coordination and quality improvement. Even within the limitations of the PFFS product structure, plans already have some tools for doing this. These can include setting specific terms and conditions with providers, conducting retrospective claims review, and implementing voluntary care coordination or disease management programs, making advance coverage determinations, and conducting risk assessment. By moving toward a hybrid network as we described earlier, PFFS plans will have a new vehicle to provide support to beneficiaries regarding their provider choices and implement care coordination and quality improvement initiatives.

Improve benefit design. PFFS plans should be real insurance policies that don't financially penalize beneficiaries who get sick. To that end, PFFS should offer higher-premium "Cadillac" model plans that would still be able to compete with Medigap alternatives. Meanwhile, lower premium plans should be redesigned to include out-of-pocket caps and a steady deductible amount (perhaps $500), rather than unpredictably high coinsurance.

Train, manage, and monitor sales agents and brokers to make sure they accurately and honestly represent PFFS and other MA products to beneficiaries. Increasingly, MA plans have relied largely on outside, contracted sales agents, rather than in-house sales personnel to sell their products. (The limited beneficiary open enrollment period makes it more cost effective for MA plans to contract with outside agents. This is especially true for PFFS plans, given their rapid expansion). Meanwhile, CMS has reported numerous instances of sales agents engaging in egregious marketing practices with beneficiaries. The agency vows to crack down, and stated in its recent 2008 call letter to plans that it will closely scrutinize PFFS sales agent activities in this regard.

Given the complexity of the PFFS product, including the notion of a "deemed network," it can easily fall prey to confusing marketing and sales practices by brokers — intentional or not. Many agents simply don't understand the product well enough to explain it accurately to beneficiaries. In other cases, agents may have deliberately told beneficiaries they were "guaranteed" access to any provider - even though that is not true - in order to entice more people to enroll.

These practices need to end. All MA plans should recognize the threat that independent agents who misrepresent PFFS plans pose to beneficiaries and to the industry as a whole. PFFS plans need to undertake more aggressive, proactive efforts to better educate, monitor and manage their sales forces.

Conclusion

We believe that PFFS plans offer value in the marketplace. With almost 1.5 million beneficiaries now enrolled in PFFS plans, they clearly represent a popular option. But a skeptical Congress—including key lawmakers from rural states that have benefited from the growth of PFFS—is asking hard questions about the value provided by PFFS plans and MA plans generally. In fact, proposed legislation detrimental to the Medicare Advantage program overall is being driven largely by the reimbursement considerations, structural defects, and market conduct of PFFS plans.

With the stakes this high, PFFS plans must change how they operate and do business to drive genuine program improvements. Failure to do so will only result in internecine warfare among plan types as well as targeted regulation of and enforcement against PFFS plans, and possibly, against MA plans generally.

  HPPR ISSN 1528-2953

Humana Inc.
Privacy Office
500 West Main Street
P.O. Box 1438
Louisville, KY 40201-1438
www.humana.com

June 2, 2006

The Hon. Jim Poolman
Commissioner of Insurance
600 East Blvd.
Bismarck, ND 58505

HUMANA.
When you need it most

Dear Commissioner Poolman:

Michael B. McCallister asked that I respond promptly to your May 31, 2006 letter regarding personal information that may have been compromised as the result of a theft from an automobile.

First, let me state that we understand the gravity of this situation and sincerely apologize for the error on our part of not notifying your Department. We are working to prevent errors such as this in the future, and we will keep you promptly apprised of such events and related follow up activities.

Forty-four North Dakota residents were identified by GoldenCare USA, Inc., the general agency contracted with Humana to sell insurance policies. On May 5, 2006, GoldenCare USA, Inc. notified Humana that an employee's car had been broken into and copies of Humana Medicare applications were included in the computer briefcase that was stolen. This briefcase also included a laptop which did not have access to Humana systems nor did it contain any Humana applicant or policyholder information. The employee filed a police report on said theft (Attachment #1) with the Brooklyn Park Police Department on May 5, 2006.

Humana's Privacy Office was notified on the next business day, Monday May 8, 2006 of the above incident, and we immediately began our investigation. Humana requested a complete list of the affected Humana beneficiaries. It took the agency some time to recreate an accurate list of the applications involved in the incident. We began to contact them by telephone beginning on May 17, 2006 to advise them of the incident and inform them that we would be sending them a letter and offering free credit monitoring to any affected beneficiary who so desired. A mailed notice was completed by May 19, 2006 and included a toll-free number to call to have any questions answered (Attachment #2).

At the same time we were notifying the beneficiaries, we addressed corrective actions with GoldenCare USA, Inc. Humana confirmed that GoldenCare USA, Inc., which has a business associate agreement with Humana, has a privacy policy in place to address such issues and that all GoldenCare USA, Inc. employees based in Plymouth, Minnesota received privacy training. The employee involved in the incident received disciplinary counseling on the appropriate safeguarding and storage of personal information of all clients. Further, reminder educational sessions were held on May 8, 2006 with all GoldenCare USA, Inc. agency employees. We will be sending a reminder to all of our contracted agency and staff on the handling of applicant information as a result of this incident.

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Humana has also reviewed all our current internal policies regarding the safeguarding of personal information of all Humana members and applicants. Our privacy policy is attached (Attachment #3). We are also investigating any additional contractual or training requirements we may want to put into place with our vendors and agents. We will provide you with an update as soon as that work is completed.

Humana's privacy policies and procedures comport with both Gramm-Leach-Bliley privacy and security requirements and HIPAA privacy and security requirements. Our investigation and remediation were conducted pursuant to such implementation. GoldenCare USA, Inc. is an authorized non-affiliated party to whom we can make disclosures.

Included below are our responses to your questions:

1. Specifically, how many North Dakota consumers have had their personal/private information compromised? Please provide the names to this Department, so we may communicate with them independently.

   Forty-four (44) North Dakota residents were affected. Please see Attachment #4 for a password-protected file. We will communicate the password in another communication.

2. How many consumers outside of North Dakota have had their personal/private information breached?

   Two hundred twenty-four (224) residents of three other states (Minnesota, Iowa and Nebraska) were affected, and we are communicating to officials in those states.

3. What is the security policy of Humana in storing this information?

   Our privacy policy is included in Attachment #3. We do have a Business Associate Agreement with GoldenCare USA, Inc. which states our requirements to safeguard the Protected Health Information they create, store and transfer as they perform functions on our behalf. We have conducted an investigation of the situation and requested and received a corrective action plan from GoldenCare USA, Inc. that included consultation with the individual who removed the documents from the office as well as supplementary training for all employees in the office.

4. What is Humana's policy in accepting applications for policies and transferring that information?

   Please refer to Humana's Privacy Policy, Attachment #3. In addition, Golden Care USA, Inc. has its own policies concerning the handling of Protected Health

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Information. Humana is also in the process of developing more specific guidance for our employees and business associates regarding the transportation and storage of member personal information.

5. What are the details of the theft?

   Please see details on pages 1-2 of this letter and the attached police report. We will contact this law enforcement agency if we obtain any reports of this information being used inappropriately to aid in their investigation and protect the affected individuals.

6. What assurances can you give to policyholders that there is a thorough investigation taking place to retrieve the information lost?

   The investigation into the stolen information is currently being conducted by the Brooklyn Park Minnesota Police Department. We are requesting that we be informed as soon as any of the stolen documents are recovered. At that time we will notify our members and your office of any recovery.

7. What other procedures does Humana employ to protect affected policyholders?

   In an incident such as this where a policyholder's personal information has been stolen, the immediate concern is to assist the individual in protecting him or herself from identity theft. That is the reason we offer a comprehensive credit monitoring service. The service we offer to affected policyholders (free of charge) includes:

   - Comprehensive credit file monitoring including daily notification of key changes to Equifax, Experian and TransUnion credit files
   - Online enrollees have access to a 3 in 1 credit report and unlimited copies of their Equifax credit report
   - $20,000 Identity Fraud Expense Coverage with a $0 deductible
   - Access to Equifax Premium Customer Care 24 hours a day, 7 days a week.

   Finally, my office is available to answer questions and provide guidance in this area as needed.

8. How will you respond to currently unaffected Humana policyholders who now might be concerned with the security of their information?

   We are preparing scripts as well as frequently answered question documents for our customer service representatives to respond to basic questions that policyholders may have. If questions from the policyholder are more detailed the

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customer service personnel will consult Humana's Privacy Office regarding the response.

9. Who, specifically, can consumers contact by toll-free number to discuss their concerns?

   Consumers affected by the incident can utilize the toll free number we provided in our letter. Questions requiring follow up and or any privacy related complaints are referred to our Privacy Office.

10. Provide to me weekly reports of any contacts with North Dakota policyholders regarding this issue.

    We will do this.

Again, we understand the gravity of this situation. We have already taken significant steps to alert consumers, are dealing with the agency and are evaluating processes and training improvements. Humana is ready to respond to any additional questions. We will be in contact with your office shortly to follow-up on this letter.

Thank you.

Sincerely,

Chief Privacy Officer
Humana Inc.
502-580-4322
jtheiss@humana.com

Attachments

HUMANA Fax:5025802249 Jun 2 2006 15:09 P.01

HUMANA Fax:5025802249 Jun 1 2006 8:27 P.04

----MAY 30 '06 01:55PM INSURANCE OFFICE---------- P.2/4

Date: 5/23/06 BROOKLYN PARK POLICE DEPARTMENT Page:
Time: 17:40:12 Offense Report Program: CMS301a

Case Number . : 1-06-022180 Class Code . . : THEFT FROM AUTO
Beat Assignment: 51P230 ATHLETIC COMPLEX
District . . . : 51NW
Street Number : [redacted]
City . . . . . : [redacted], MN 55445
How Received . : Radio Primary Officer: CUDD, C.
Date Reported : 5/05/06 17:15 Incd Occur From: 5/04/06 22:45
Incd Occur To : 5/05/06 7:15 Incident . . . : THEFT FROM AUTO
Location Type : SINGLE FAMILY RESIDENCE
Bias Motivation: No Attachments . : NO
Case Status . : Inactive Case Status Dt : 5/15/06
Transcribed By : LEITSCHUH, D. 5/12/06 Rpt. Coded By : RIVARD, J. 5/12/06

********** A D D I T I O N A L T I M E S **********
Time Dispatched: 17:15 Time Arrived . : 17:15
Time Cleared . : 17:35

********** C A S E M A N A G E M E N T I N F O R M A T I O N **********
Dept Class . . : THEFT FROM AUTO Case Status . : Inactive
Case Status Dt : 5/15/06 Investigator . : INCIDENT REVIEW,.

ASSIGNMENT HISTORY
Dept Unit . . : Investigations Investigator . : INCIDENT REVIEW,
Assignment Date: 5/15/06 Reviewed by . : NELSON, E.

********** O F F E N S E R E P O R T # 1 **********
Federal Class : Larceny - From Motor Vehicle(not 21
GOC . . . . . : Not Applicable
Statute/Ordin : 609-52-2 TC15S
UCR Disposition: Open/Pending
Statute Desc . : THEFT-501-2500-FE-MOTOR VEH-OTH PRO

********** C O M P L A I N A N T I N F O R M A T I O N - #.1 **********
Prompt valid in: [redacted] Birth Date . . : 1/13/1941 65
Adult / Juvenil: ADULT
Street Number : [redacted]
City . . . . . : BROOKLYN PARK, MN 55445
Home Phone No. : [redacted] Business Phone : [redacted]
Other Phone Nbr: 763/000-0000 Sex . . . . . : Female
Race . . . . . : Unknown Dangerous Para?: No

********** N A R R A T I V E # 2 **********
Summary Reported By: CUDD, C. 5/05/06

Theft from auto. Laptop computer and other items stolen from unlocked vehicle. No suspect info.

********** N A R R A T I V E # 3 **********
Original Report Reported By: CUDD, C. 5/05/06

REPORT NARRATIVE:

On 5/5/06 at 1715 hours, I, Officer Cudd was dispatched to a phone call report regarding a theft from auto.

Attachment 1

1-06-022180 (Continued)

I contacted the complainant, verbally identified as [redacted]. Date of Birth: 01/13/41. She stated that:

- She had parked her vehicle outside her house on 5/4/06 at 1045 p.m.

- She had left the vehicle unlocked.

- When she came back out to the vehicle at 715 a.m. this morning, she realised that her black nylon briefcase was missing.

- The briefcase contained a laptop computer, as well as several papers from National Independent Brokers, the company she works for, that are rather important to the company.

- She did not see who had done it, nor did she have any idea who might have done it.

- The computer was a Dell 2600 computer, with a service number of (see stolen property narrative).

- The computer had an express service code of (see stolen property narrative).

- She did not have the serial number for the computer.

- The silver Dell emblem is missing from the top of the computer.

- On the rear of the computer, there is a door, which has tape over it.

- The computer is about 4 years old, and it was bought for $1400.00.

- The case was a black nylon laptop carrying case with a handle, valued at about $50.00.

- As the vehicle was unlocked, there was no forced entry into the vehicle.

I provided [redacted] with the case number for the report. I also advised her to try and obtain the serial number for the computer and provided her with my voicemail number so that she could contact me if she found it. I advised her to call if she had any further information. No further action taken by this officer.

DISPOSITION:

Theft from auto. Laptop computer and other items taken from unlocked vehicle. No suspect information. No further action taken by this officer.

Dictated by: Officer C. Cudd, Badge #182, Squad #1518

Date: 5/23/06 BROOKLYN PARK POLICE DEPARTMENT Page: 3
Time: 17:40:12 Offense Report Program: CMS301L

1-06-022180 (Continued)

**************************** N A R R A T I V E # 4 ****************************
STOLEN PROPERTY Reported By: CUDD, C. 5/05/06

STOLEN PROPERTY

CASE NUMBER: 06-22180

- Dell 2600 laptop computer. Black in color. Dell emblem missing off of top of the computer. Door to the rear of computer has tape over it. Service code CPSRP11. Express service code 270-376-043-41. Purchased four years ago for approximately $1400.00.

- A black nylon laptop carrying case with handle. Valued at around $80.00.

- Paperwork from the complainant's place of employment, National Independent Brokers, which bare importance for the company.

Dictated by: Officer C. Cudd, Badge #182

* * * * * * * * * * * * * * * * * END OF REPORT * * * * * * * * * * * * * * * * * *

[Date] [Humana logo]

[Name]
[Address]
[Address]
[City, State ZIP]

Dear [Member Name]:

Since you are a valued Humana member, we need to tell you about a recent situation. We were recently notified that a copy of your Humana Medicare enrollment application was stolen. Unfortunately, this application contains your personal information including such items as your name, address, Social Security #, and bank routing information, if indicated on the application.

We regret this unfortunate situation and want to assure you that Humana takes all privacy incidents seriously. While Humana has policies and procedures in place to maintain the security of each member's personal information, at this time we are taking additional steps to assist in protection of your information.

We do not expect this issue to create future problems for you. However, we have set up a free credit monitoring service with Equifax for your use for one year. If you would like to put this protection in place, please follow the instructions enclosed. You can sign up for this service online, or you can simply complete and mail or fax the enclosed enrollment form.

Again, we regret this possible exposure of personal information. Your continued satisfaction and confidence in the protection of your information is of great importance to us. If you have any questions or need further assistance, please send an e-mail to PrivacyOffice@Humana.com or contact Customer Service at 1-800-281-6918. If you have a speech or hearing impairment and use a TDD, call 1-800-833-3301.

Sincerely,

James S. Theiss
Chief Privacy Official

Attachment

For your added protection ...

Humana has arranged free credit monitoring services with Equifax Personal Solutions to help you protect your identity and your credit information at no cost to you. The steps to follow:

1. Enroll in Equifax Credit Watch™ Gold with 3-in-1 Monitoring identity theft protection service.
2. Additionally, you may choose to adopt an increased level of protection by placing a fraud alert on your credit file at Equifax and the other two credit reporting agencies

Equifax Credit Watch™ Gold with 3-in-1 Monitoring
Equifax Credit Watch will provide you with an "early warning system" to changes to your credit file and help you to understand the content of your credit file at the three credit reporting agencies. The key features and benefits are listed below.

Equifax Credit Watch Gold with 3-in-1 Monitoring provides you with a one-year membership service:

- Comprehensive credit files monitoring, with daily notification of key changes to your Equifax, Experian and Trans Union credit files.
- Automatic notification of key changes to your credit files from any of the three agencies.
- If you enroll online, you have access to one 3-in-1 Credit Report and unlimited copies of your Equifax Credit Report™. If you enroll by U.S. mail, you receive quarterly updates to your Equifax Credit Report.
- Up to $20,000 Identity Fraud Expense Coverage with $0 deductible at no additional cost to you. Certain limitations and exclusions apply.†
- Premium Customer Care 24 hours a day, 7 days a week, to assist you in understanding the content of your credit information.

How to Enroll
Use the enclosed enrollment form, or go to www.myservices.equifax.com/monitor_order to enroll online.

In the Promotion Code box, insert this code: [ ]

If you choose to enroll online, just follow these steps:

- Step 1 – Registration: Complete the form with your contact information (name, address, telephone #, Social Security Number, date of birth, e-mail address). The information is provided in a secured environment.

- Step 2 – Verify Your Identity: Equifax will verify your identity by asking you up to two security questions
- Step 3 – Order Summary: During the "check out" process, insert your Promotion Code, exactly as noted above, in the box labeled "Enter Promotion Code." This code eliminates the need to provide a credit card number for payment.
- Step 4 - Go to the Member Center: Under "Product List," select Credit Watch Gold with 3-in-1 Monitoring to access the product features.

Fraud Alert
A fraud alert is a consumer statement added to your credit file that lasts 90 days. Once the fraud alert statement is added to your credit file, it alerts creditors of possible fraudulent activity and requests that they contact you before establishing a credit account in your name. To place a fraud alert on your Equifax credit file, you may contact Equifax's auto fraud line at 1-877-478-7625, and follow the simple prompts. Once the fraud alert has been placed with Equifax, a notification will be sent to the other two credit reporting agencies, Experian and Trans Union, on your behalf.

ENROLLMENT DEADLINE IS [_____]
(specify date)

† Insurance underwritten by Travelers Casualty and Surety Company of America and its property casualty affiliates, Hartford, CT 06183. Nothing stated herein affects the terms, conditions and coverages of any insurance policy issued by St. Paul Travelers, nor does it imply that coverage does or does not exist for any particular claim or type of claim under any such policy.

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ATTACHMENT

EQUIFAX CREDIT WATCH™ with 3-in-1 MONITORING ENROLLMENT INSTRUCTIONS

Use this form only if you are enrolling by mail or fax

Complete the information shown below and mail or fax this form to receive your Equifax Credit Watch™ with 3-in-1 Monitoring via U.S. mail.

☐ YES, I would like my complimentary Equifax Credit Watch™ with 3-in-1 Monitoring subscription delivered via U.S. mail.

Name (First, Middle Initial, Last)

Address (House #, Street Name)

City **State** **ZIP Code**

Date of Birth (MM/DD/YYYY) **Gender (M/F)** **Daytime Phone Number**

☐☐☐ – ☐☐ – ☐☐☐☐ HMA-_____
Social Security Number (required to obtain a credit file) **Promotional Code** (MUST FILL IN NUMBERS)

Fair Credit Reporting Act

I authorize Equifax Consumer Services, Inc. ("Equifax") to obtain my credit report and monitor my credit file at one or more consumer reporting agencies, as necessary for me to receive Equifax Credit Watch™ (the "Service"). I understand that Equifax cannot accept authorization from any person other than the individual joining the service and confirm that I am at least 18 years of age and I am requesting my own personal information. I understand that there will be additional terms and conditions included in the Service materials that I will receive, including without limitation additional provisions regarding cancellation rights, and limitations on Equifax's liability, and I will be bound by those terms and conditions unless I immediately cancel the Service upon receipt of the complete terms and conditions.

Signature (Required) **Date** **E-Mail Address (Optional)**

HUMANA	Fax:5025802249	Jun 2 2006 15:13	P.05
HUMANA	Fax:5025802249	Jun 1 2006 8:28	P.13

EQUIFAX
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Please return this form by either:

FAX: 1-800-437-4675 (toll-free)
OR
MAIL: Equifax Consumer Services
P.O. Box 105496
Atlanta, GA 30348

Humana Inc.
500 West Main Street
Louisville, KY 40202
www.humana.com

June 12, 2006

The Honorable Jim Poolman
Commissioner
North Dakota Department of Insurance
600 East Boulevard
Bismarck, ND 58505

HUMANA
when you need it most

Dear Commissioner Poolman:

Thank you for your letter dated June 6, 2006 responding to the communication we sent to your office regarding the theft of paper copies of Medicare applications. We understand your frustration and are working hard to remedy this situation as completely and as quickly as we can.

As a result of this incident, Humana has re-examined our internal employee policies and procedures relating to protecting the personal information of our members and the same policies and procedures as they relate to contracted insurance agencies with which we hold Business Associate Agreements. While this review is not accomplished quickly, we want you to know we have taken immediate steps to put all our contracted insurance agencies on notice that safeguarding member information is a priority and they should treat this information with care and protect it accordingly (please see response to Question #6 below).

Below please find our responses to your information requests.

1. **An explanation of why the subsequently stolen applications were allowed to be removed from GoldenCare USA's office.**

A. The stolen applications were taken home by an administrative assistant of GoldenCare USA to remain current in her workload. The employee received disciplinary counseling on the appropriate safeguarding and storage of personal information of all clients. In addition, GoldenCare USA updated their privacy rule memorandum to specifically address this issue by prohibiting the removal of this information from their offices (please see response to Question #3 for further detail).

2. **Specific information regarding GoldenCare USA's privacy training for employees prior to the breach, including: Training materials; records of training meetings; attendance records at these meetings; and any other specifics relating to the training.**

A. GoldenCare USA's HIPAA Privacy Training took place on February 28, 2003. Subsequent training sessions are handled by the management team of each

department and when new employees are hired. We have included in Attachment #1, training materials from GoldenCare USA as you requested.

3. **A copy of training materials distributed at the May 8, 2006 educational session for all GoldenCare USA employees.**

A. Attachment #2 is a copy of the document that was updated on May 8, 2006 by GoldenCare USA to further clarify that all customer and agent information must remain on their premises. **This memorandum was distributed to and signed by all employees of GoldenCare USA. (waiting for confirmation)**

4. **A copy of GoldenCare USA's corrective action plan referred to in response to number (3) of your letter of July 2, 2006.**

A. Attachment #3 contains a copy of the GoldenCare USA's corrective action plan. GoldenCare USA provided a draft copy of their corrective action plan which was viewed as insufficient by Humana. We forwarded to GoldenCare USA a proposed corrective action plan which is page three of Attachment #3. Humana is awaiting response from GoldenCare USA at this time. Humana will review the revised corrective action plan as well as our ongoing relationship with GoldenCare USA. All options remain open. We will forward a final copy of the disposition of the corrective action plan and our relationship as soon as it has been finalized.

5. **A more specific description of the 'disciplinary counseling' provided for the GoldenCare USA employee involved in the incident.**

A. The disciplinary actions taken by GoldenCare USA with the associate are described in Attachment #4.

6. **A copy of the reminders sent to all contracted agencies regarding the handling of applicant information as a result of this incident.**

A. The reminder that was issued on June 2, 2006 to all contracted agencies regarding the handling of personal information. The communication was sent from Humana's National Director of Delegated Sales. The text of the communication is below:

- "Dear Valued Partner:
  Humana has recently been made aware of several breaches of protected health information (PHI) of Medicare beneficiaries. Given the current climate, it would be wise to review your own internal safeguards as it relates to the PHI of not only Humana members, but any individual you may possess information on. You may wish to review Exhibit A in the GPA contract, "HIPAA Business Associate Requirements" that outlines

what your obligations are to protect Humana member information as a Business associate of ours.
Humana is reviewing its current policies and privacy practices for both internal and external partners. Assuring proper handling of enrollment applications and the physical safeguards for any data storage and protection of the same information is of critical importance and will be closely monitored. As a valued partner of Humana, we intend to work closely with you to ensure those protections are in place for the sake of everyone involved.
In the near future, we will provide additional guidance and procedures that will continue to assure we maintain and protect this data.
Thank you in advance for your cooperation."

7. **An update regarding additional contractual or training requirements Humana Inc. put into place with its vendors and agents.**

A. A detailed audit plan to audit all delegated agents regarding compliance with our Group Producing Agent Contract is being developed with a projected implementation date of June 26, 2006. Materials are under development and are not available at this time. We will be in contact with your office when the final documents are completed.

8. **An explanation of how Humana Inc. can be confident that there were no more than 44 North Dakota policyholders affected.**

A. GoldenCare USA was able to identify the copies of the paper applications by having a GoldenCare USA associate with direct knowledge of the workflow process between GoldenCare USA and Humana. This associate was able to determine which applications had been received by their office with the assistance of daily application receipt information provided by the local Humana office. The GoldenCare USA associate was then able to eliminate applications sold by other agents. GoldenCare USA is confident that they accurately identified the copies of applications.

9. **The names and addresses of any North Dakota policyholders involved in a privacy breach in which the personal information of approximately 17,000 Humana policyholders was found on a computer available to the public in a Baltimore, Maryland hotel.**

A. Attachment #5 is a password-protected spreadsheet of the names and addresses of 82 North Dakota members who were impacted by the recent situation of member information being left in a temporary file of the hotel business service computer in Baltimore. We are attaching the two letters used to notify these individuals. Attachment #6 is the letter that was sent to actively enrolled Humana members

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and Attachment #7 is the letter that was sent to formerly enrolled Humana members. This notification was sent to 17,657 individuals.

The protection of our members' personal information is a priority for Humana. Therefore, we are reviewing the length of time these affected members will have access, free of charge, to a credit monitoring service. We will also be re-contacting affected members who have not elected coverage to encourage them to take advantage of this service. In addition, we are revising our initial letter to more clearly encourage affected members to take advantage of this service.

We truly understand the gravity of this situation and are working hard to remedy this very unfortunate incident. We appreciate and welcome your continued involvement and look forward to working with you to resolve this situation.

Sincerely,

James S. Theiss

Humana Inc.
500 West Main Street
Louisville, KY 40202
www.humana.com

June 13, 2006

The Honorable Jim Poolman
Commissioner
North Dakota Department of Insurance
600 East Boulevard
Bismarck, ND 58505

HUMANA
Where we're going

RE: Response to June 7, 2006 Letter

Dear Commissioner Poolman:

This letter is in response to your communication on June 7, 2006 regarding the discovery of a file containing personal member information located on a public access hotel computer. As we noted in our June 9, 2006 notice letter to your office, the document in question was a temporary file that was not deleted due to a technical software error in Humana's Web mail system. We regret that this information did not reach your office before our letter to affected members began to arrive.

Since we have exchanged a number of communications in the last week regarding the Minnesota and Maryland incidents, I have included references to information contained in prior responses in parentheses following the answer to the question. I hope this format makes it easy for you and your staff to locate the information.

Below please find our responses to your information requests.

1. **Why has Humana, Inc., yet again, failed to notify the North Dakota Insurance Department of this second serious violation?**

A. We again apologize for the delay in our communication regarding the Maryland incident. On June 9, 2006, we sent your office a letter by e-mail (Attachment #1) that provided background on this incident, steps we had taken to notify member, and our efforts to address the security issue. That correspondence included a copy of our communication to affected members. (Humana's June 12, 2006 response to your office includes both versions of the affected member letter in our response to question 9 as Attachments 6 & 7.)

2. **How many total consumers from North Dakota and outside North Dakota have had their personal/private information exposed in this latest incident?**

A. Eighty-two North Dakota members were impacted by the Maryland incident. We notified a total of 17,657 individuals, including the 82 North Dakota members, affected by the Maryland incident. (Humana's June 12, 2006 letter includes the same information in a response to question 9.)

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3. **Provide me names and addresses of all North Dakota consumers whose personal/private information has been compromised, so we may communicate with these policyholders independently.**

A. This list was provided with our June 12, 2006 letter to your office as password protected electronic file labeled Attachment #5.

4. **Provide me weekly reports on any contacts with these North Dakota policyholders regarding this incident, as well as with the 44 North Dakota consumers affected by the prior breach.**

A. Humana will keep your office updated on our policyholder contacts for both the Minnesota and Maryland incidents (Humana's May 31, 2006 letter includes the same response in the answer to question #10.) For the week ending June 9th, we have received 4 inbound calls from North Dakota members affected by both incidents. All of these calls sought more information about the incident or about the free credit monitoring service being offered.

We truly understand the gravity of this situation and continue to work hard to remedy these very unfortunate incidents. We would welcome the opportunity to meet with you to discuss our responses to the specific questions or review the steps we have taken to address these security issues.

Sincerely,

James S. Theiss
Chief Privacy Officer
Humana, Inc.

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News Release

Humana to Implement Increased Controls Over Medicare Member Personal Information

Heightened awareness of privacy issues leads to more security measures

LOUISVILLE, KY - Jun 5, 2006 - Humana Inc. (NYSE: HUM), one of the nation's largest Medicare health benefit plans, today announced increased security measures to ensure that the personal health and financial information of the company's approximately 3.4 million Medicare health plan members meets the highest possible security standards.

Those increased measures include strengthening Humana's policies related to computer software maintenance and technical controls protecting the privacy of members' information. Increased education and awareness surrounding privacy issues is also being implemented for Humana's associates and sales agents.

"Humana takes the privacy of our members very seriously," said Steve Brueckner, Humana's vice president for senior products. "It is important that our members have confidence that we are handling their personal and private information with the highest integrity and respect. These enhanced measures, we believe, reinforce our commitment to safeguarding the privacy of our members and should give them a renewed sense of confidence in our abilities to do just that."

The heightened measures come as Humana takes action to contact approximately 17,000 current and former Medicare enrollees whose personal information was left unsecured in a hotel computer and, in an unrelated case, copies of paper applications were stolen from an independent sales agent's vehicle. Humana believes the potential exposure of personal information from these unfortunate incidents is very limited. Humana is acting quickly to contact the affected members to let them know of the possible disclosure of their private information. All affected members are being given a free one-year subscription to a credit monitoring service to help them make sure their information is not used illegally.

About Humana

Humana Inc., headquartered in Louisville, Kentucky, is one of the nation's largest publicly traded health benefits companies, with approximately 9.3 million medical members. Humana offers a diversified portfolio of health insurance products and related services - through traditional and consumer-choice plans - to employer groups, government-sponsored plans, and individuals.

Over its 45-year history, Humana has consistently seized opportunities to meet changing customer needs. Today, the company is a leader in consumer engagement, providing guidance that leads to lower costs and a better health plan experience throughout its diversified customer portfolio.

More information regarding Humana is available to investors via the Investor

Relations page of the company's web site at http://www.humana.com, including copies of:

- Annual report to stockholders;
- Securities and Exchange Commission filings;
- Most recent investor conference presentation;
- Quarterly earnings news releases;
- Replays of most recent earnings release conference call;
- Calendar of events (includes upcoming earnings conference call dates, times, and access number, as well as planned interaction with research analysts and institutional investors);
- Corporate Governance Information.

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CALIFORNIA HEALTH ADVOCATES Medicare Rights Center

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

January 2007
Issue Brief #4

By California Health Advocates and the Medicare Rights Center.

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NOTE: This Issue Brief is the fourth in a series on Medicare drug benefit issues for consumers drafted by California Health Advocates (CHA) and the Medicare Rights Center (MRC), with support from the California HealthCare Foundation.

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.

continues...

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 CMS[2] 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 obtains 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 coverage[5]) 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.[8][9]

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 country[12] 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 CMS[19] 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, than 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, individuasl 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.

8

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_10182006MAPlans.

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/

The New York Times
nytimes.com

May 7, 2007

Methods Used by Insurers Are Questioned

By ROBERT PEAR

WASHINGTON, May 6 — Insurance companies have used improper hard-sell tactics to persuade Medicare recipients to sign up for private health plans that cost the government far more than the traditional Medicare program, federal and state officials and consumer advocates say.

Insurance agents, spurred in some cases by incentives like trips to Las Vegas, have aggressively marketed the private plans, known as Medicare Advantage plans. Enrollment in them has skyrocketed in the last year, and Medicare officials foresee continued rapid growth in the next decade.

In Mississippi, George R. Dale, the state insurance commissioner, said, "Abusive Medicare insurance sales practices are spreading rapidly throughout the state." State Senator Terry C. Burton, a Republican, said, "My office is receiving calls daily from seniors who have been victims of unscrupulous salespeople."

Proponents of private plans say they are indisputably good for many older Americans because they coordinate care and may offer extra benefits, like discounts on eyeglasses, hearing aids and dental care.

But federal officials said that the fastest-growing type of Medicare Advantage plan generally does not coordinate care, does not save money for Medicare and has been at the center of marketing abuses.

These "private fee-for-service plans" allow patients to go to any doctor or hospital that will provide care on terms set by the insurer. In most cases, no one manages the care. And some patients have found that they have less access to care, because their doctors refuse to take patients in private fee-for-service plans.

Moreover, those plans may be more expensive than traditional Medicare for some patients, because the co-payments for some services may be higher. The Medicare Payment Advisory Commission says that the cost to the government is also higher because it pays the private fee-for-service plans, on average, 19 percent more than the cost of traditional Medicare.

Richard S. Foster, chief actuary for the Medicare program, said "the additional payments to Medicare Advantage plans, above and beyond the costs" of traditional Medicare, were causing higher premiums for all beneficiaries and speeding the depletion of the Hospital Insurance Trust Fund for Medicare.

Almost one-fifth of the 43 million Medicare beneficiaries are now in some type of private plan.

Much of the growth in private fee-for-service plans has come in rural areas, where doctors and hospitals are often in short supply.

In Georgia, two insurance agents were arrested last month and accused of conspiring to defraud Medicare

beneficiaries.

"The agents signed up unwilling consumers and even deceased individuals for private Medicare plans," said John W. Oxendine, the Georgia insurance commissioner. "This appears to be a national problem, based on my conversations with insurance officials around the country."

In an interview, Bobbie S. Whatley of Columbus, Ga., a 69-year-old nurse practitioner, said that a young man wearing a blue denim shirt with a WellCare logo showed up on her doorstep in November and talked to her about her insurance.

Mrs. Whatley did not sign up, she said, but he "forged my signature," and a month later she received mail thanking her for joining one of WellCare's private fee-for-service plans.

"It turned into a nightmare," she said. "I spent two months trying to cancel my enrollment. I have all my mental faculties. If I let somebody like this come into my home and take advantage of me, then I am really concerned about older people who are more debilitated and not able to take care of themselves."

John N. Aberg, a spokesman for WellCare, said the company had terminated contracts with 10 independent sales agents who had engaged in door-to-door solicitation and other prohibited marketing practices in Georgia and several other states.

"We have zero tolerance for any behavior that violates marketing guidelines," Mr. Aberg said.

The Louisiana insurance commissioner, James J. Donelon, said some agents were using "overly aggressive sales tactics," including false promises, "to market Medicare-related products with little or no concern for the needs of the consumer."

James E. Long, the insurance commissioner in North Carolina, is investigating complaints that insurance agents switched residents of an assisted living community from traditional Medicare into private plans without their permission. Officials in Kansas, Oklahoma and Wisconsin said they were investigating similar complaints.

Insurers sell private fee-for-service plans as a replacement for traditional Medicare and for Medicare supplement policies, known as Medigap insurance.

But Dr. Barbara L. McAneny, a cancer specialist in Albuquerque, said that many of her patients who signed up for such plans "suddenly found that they had huge new co-payments -- $1,250 every three weeks for a combination of five intravenous chemotherapy drugs."

In Florida and seven other states, the Universal Health Care Insurance Company offers a private fee-for-service plan that promises "the ultimate freedom to see any doctor, any time, anywhere." This product -- the Any, Any, Any plan -- got off to a fast start, enrolling 85,000 people. But it "temporarily postponed new enrollments as of Feb. 14" because of a dispute with the Florida insurance commissioner, Kevin M. McCarty, who said the company did not have adequate cash reserves to comply with state law.

Robert M. O'Malley, a spokesman for Universal, said, "Our plan was much more popular than we expected."

Coventry Health Care offered a three-night trip to Las Vegas as a reward for agents who generated the most applications for its private fee-for-service plans. By the end of January, enrollment "had already exceeded our initial expectations for the entire year," Coventry said. The company, which trains agents in the "dos and don'ts of marketing," said it had "an excellent track record" of compliance.

Insurers frequently offer cash bonuses, trips and other financial incentives for agents to increase sales in the Medicare market.

From December 2005 to April of this year, total enrollment in private plans increased 39 percent, to more than 8.5 million. Private fee-for-service plans accounted for more than half of the growth. Their membership rose to 1.5 million, from 209,000 at the end of 2005.

In a letter inviting insurance companies to participate in Medicare next year, the Bush administration expressed alarm about the marketing of some private plans. It said that beneficiaries and even doctors were often confused about them.

"Providers and people with Medicare do not clearly understand this product," said Abby L. Block, the Medicare official who supervises private plans.

Leslie V. Norwalk, acting administrator of the Centers for Medicare and Medicaid Services, said her agency had visited WellCare's corporate headquarters in Florida and conveyed "strong concerns" about the company's behavior.

"WellCare was informed that its efforts thus far to address marketing issues were inadequate and unacceptable," Ms. Norwalk said. She vowed to step up supervision of private plans.

David A. Lipschutz, a lawyer at California Health Advocates, a nonprofit group, said that insurance agents working for WellCare had made unscheduled visits to a subsidized housing complex in the San Francisco area and signed up elderly Chinese-Americans with limited ability to speak English. After being enrolled in one of WellCare's private fee-for-service plans, he said, some of the low-income patients discovered that their doctors did not accept the plan.

The private fee-for-service plan is like a privately administered version of traditional Medicare. Congress authorized such plans in 1997 at the urging of the insurance industry, rural lawmakers and the National Right to Life Committee, which opposes not only abortion, but also euthanasia and the rationing of care for older people.

Brock A. Slabach, administrator of the Field Memorial Community Hospital in rural Centreville, Miss., said that private fee-for-service plans were causing havoc at his 25-bed hospital.

"People are signing up for programs they don't understand," Mr. Slabach said. "Agents for a private fee-for-service plan set up tables in front of a grocery store or a drugstore here. Seniors think they are signing up to get drug coverage or just to get more information. The next thing they know, when they show up at our hospital,

they are in that company's plan."

Private plans generally provide all the services of traditional Medicare, and many offer extra benefits, but the co-payments may be different. Thus, Mr. Slabach said, under traditional Medicare, a beneficiary does not have any co-payment for the first 20 days in a skilled nursing home, but some private fee-for-service plans charge $100 a day, and that charge comes as a shock to some patients.

Kelly E. Van Sickle, director of managed care at Catawba Valley Medical Center in Hickory, N.C., said, "Private fee-for-service plans have flooded our market and created significant confusion for our senior population."

Michael Hagen, chief executive of Riverwood Healthcare Center, which runs a small hospital and three clinics in rural Aitkin, Minn., reported a similar experience.

"Patients buying these private fee-for-service plans are not sure exactly what they have bought," Mr. Hagen said. "They go to a meeting sponsored by an insurance company. They hear a salesman. Sometimes the salesmen do not understand the nuances of the products they are selling. They do not realize that the beneficiary's co-payments may be higher than in traditional Medicare."

ONE HUNDRED TENTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

JOHN D. DINGELL, MICHIGAN
CHAIRMAN

July 25, 2007

Ms. Abby Block
Director
Center for Beneficiary Choices
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C51916
Baltimore, MD 21244

Dear Ms. Block:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Tuesday, June 26, 2007, at the hearing entitled "Predatory Sales Practices in Medicare Advantage." We appreciate the time and effort you gave as a witness before the Subcommittee.

Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached are questions directed to you from certain Members of the Committee. In preparing your answers to these questions, please address your response to the Member who has submitted the questions and include the text of the Member's question along with your response

To facilitate the printing of the hearing record, your responses to these questions should be received no later than the close of business **Friday, August 10, 2007**. Your written responses should be delivered to **316 Ford House Office Building** and faxed to **202-225-5288** to the attention of Kyle Chapman, Legislative Clerk. An electronic version of your response should also be sent by e-mail to Mr. Kyle Chapman at **kyle.chapman@mail.house.gov** in a single Word formatted document.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Kyle Chapman at (202) 226-2424.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Bart Stupak, Chairman
Subcommittee on Oversight and Investigations

The Honorable Ed Whitfield, Ranking Member
Subcommittee on Oversight and Investigations

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

SEP 12 2007

The Honorable John Dingell, Chairman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Dingell:

Thank you for giving the Centers for Medicare & Medicaid Services (CMS) the opportunity to testify before the House Energy & Commerce Subcommittee on Oversight and Investigations regarding "Predatory Sales Practices in Medicare Advantage" on June 26, 2007.

Enclosed is the edited transcript and answers for the record to the additional written questions submitted after the hearing. A similar letter also has been sent to Chairman Bart Stupak, Rep. Joe Barton, and Rep. Ed Whitfield.

Your continued interest and support are essential for the Medicare and Medicaid programs' success. If you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Donald N. Johnson
Acting Director
Office of Legislation

Enclosures

The Honorable Bart Stupak

1. The Center for Medicare and Medicaid Services (CMS) posts information on its website regarding nursing homes so that Medicare beneficiaries and their families have information about staffing levels, health outcome measures, and any sanctions that CMS has imposed. CMS also posts information on home health agencies and hospitals. Will CMS post on its website copies of Corrective Action Plans imposed on Medicare Advantage (MA) Plans, and information regarding complaints and plan disenrollment data? When will such information be posted?

Answer: CMS will post information regarding Corrective Action Plans imposed on Medicare Advantage plans early in the fall to the CMS website.

Plan disenrollment rates are available on the CMS website through the Medicare Personal Plan Finder. Reasons for disenrollment are captured informally from various sources, some of which are posted on the CMS website. Going forward, CMS is looking into whether this information can be aggregated in a meaningful way.

At this time, CMS does not post complaint information on its website. However, CMS is exploring options to provide this data in the future.

2. What utilization data do MA Plans provide to CMS so that it can monitor the benefits Medicare beneficiaries receive from MA Plans?

Answer: Each year MA plans submit to CMS their bids for the upcoming year. These bids reflect the benefits that will be provided to beneficiaries. Changes to these benefit packages must be submitted to CMS for approval. Additionally, a component of the bid submission is aggregate actual medical expenditures, which typically represents experience for two years prior to the contract year. A component of the bid audits is the reconciliation of this data with audited plan financial statements.

In addition, through primarily the Health Plan Employer Data and Information Set (HEDIS), MA plans provide specific utilization data for several general categories. The categories include:

- Effectiveness of care
- Access/availability of care
- Health plan stability
- Use of services
- Health plan descriptive information
- Cost of care

Some of the specific measures for utilization of services (partial list) include:

- Frequency of selected procedures
- Inpatient utilization—general hospital/acute care
- Ambulatory care
- Inpatient utilization—non-acute care

- Mental health utilization

For more information on utilization measures reported by MA plans see: http://www.cms.hhs.gov/manuals/downloads/mc86c05.pdf.

3. We understand that CMS has contracted with IntegriGuard, LLC (IntegriGuard) to process certain disenrollments from MA Plans. What types of disenrollments is IntegriGuard processing (e.g., all retroactive disenrollments or certain retroactive disenrollments)? How long is it currently taking IntegriGuard to process disenrollment requests?

Answer: IntegriGuard reviews plan submitted requests for retroactive disenrollment. Plans send requests for retroactive actions to IntegriGuard, which reviews these requests to ensure that they are in accordance with CMS' policies and procedures. IntegriGuard reviews retroactive requests that cannot be processed by batch submission and where the retroactivity extends back three months or less. IntegriGuard performs a review of the request and the documentation submitted by the plan. If the documentation supports the request, IntegriGuard inputs the disenrollment into the MARx system.

IntegriGuard usually processes these requests in 14 business days when the system is active. This timeframe could be expanded to 20 business days depending on the MARx system availability.

4. Please provide a copy of the Scope of Work relating to CMS's contract with IntegriGuard to process disenrollments.

Answer: See attached.

5. What discretion do CMS Regional Offices and/or IntegriGuard have with respect to the granting or denial of disenrollment from an MA Plan? Is there an appeal procedure for Medicare beneficiaries who are denied disenrollment? If so, what is the procedure? If there is no appeal procedure, why not?

Answer: Beneficiaries who want a retroactive disenrollment from an MA plan may call 1-800-MEDICARE for assistance 24 hours a day, 7 days a week. The Customer Service Representative (CSR) will assist the individual by helping them review other plan coverage options, should they desire them, and can submit a request to enroll in a different plan if one is chosen. The CSR will then forward the beneficiary's request for a retroactive disenrollment (and, if applicable, retroactive enrollment into another MA plan or a stand-alone Prescription Drug Plan (PDP)) to the appropriate CMS Regional Office for processing by a CMS caseworker.

Special protections are in place for beneficiaries requesting retroactive enrollment or disenrollment because they were misled into enrolling in an MA plan. In the event that the caseworker determines that the retroactive enrollment and/or disenrollment for such a beneficiary is not warranted, s/he will forward the request to another caseworker for a second

review. If the second caseworker upholds the earlier decision, s/he will notify the beneficiary in writing of the decision. CMS Regional Offices rarely deny disenrollment requests from beneficiaries so there has not been an identified need to create a formal appeal process.

Beneficiaries who request retroactive disenrollment under these circumstances also receive important information about the impact that retroactive coverage changes can have on them and the payment for services they have already received. Once the disenrollment is entered into the MARx system, the plan is notified via Transaction Reply Reports, records the action in its records, and provides a refund of any plan premiums paid directly to the plan.

In response to IntegriGuard's role, which is limited to plan requested disenrollments, documentation submitted by the plans is reviewed by IntegriGuard to ensure compliance with established CMS guidelines. If the documentation does not meet the applicable guidelines, the disenrollment request is either: 1) denied and the reason for the denial is communicated to the plan, 2) returned to the organization for additional documentation, or 3) sent to the applicable RO to determine how the request should be handled. If the documentation meets the established guidelines, IntegriGuard processes the retroactive disenrollment into the MARx system.

IntegriGuard may deny a plan's request for a retroactive disenrollment request based upon the documentation submitted by the plan and the information reflected in the CMS systems. IntegriGuard ensures plans are following the guidelines established by CMS for retroactive disenrollment requests.

When there is a dispute with the disenrollment, the plan is referred to CMS staff for assistance. If a request from the plan is denied, the plan has the opportunity to submit additional documentation to substantiate the retroactive disenrollment request, submit the requested change to the RO, or contact the CMS CO regarding the requested change.

6. How many requests for disenrollment have been denied by CMS and/or IntegriGuard, and on what basis?

Answer: For the period of August 1, 2006 through July 31, 2007, IntegriGuard has received 89,601 retroactive disenrollment requests from plans. Of this amount 158 were sent to the RO to determine how the adjustment request should be handled, 3,090 were returned to the plans for addition supporting documentation, and 19,562 requests could not be processed by IntegriGuard. These latter requests were not processed mainly because they were already implemented in the system (by the RO or 1-800-MEDICARE) or it was a duplicate request to one that Integriguard already had in its queue to be worked.

CMS Regional Offices generally do not collect this data because, as stated earlier, Regional Offices rarely deny disenrollment requests from beneficiaries. However, beginning in June 2007, CMS Regional Offices began keeping track of some types of requests under Section 30.4.2 of the Managed Care Manual, those relating to beneficiary allegations of material misrepresentation and inaccurate marketing on the part of the plan. Since CMS began tracking these types of requests, there have been no denials.

7. CMS recently expanded the complaint procedures used by 1-800-Medicare that allow Customer Service Representatives (CSRs) to assist Medicare beneficiaries with disenrollment from an MA Plan. The scripts used by CSRs refer to "urgent complaints." How does CMS define "urgent" in this context?

Answer: The 1-800-MEDICARE CSRs have always been able to assist beneficiaries with an MA disenrollment so that process is not new. If the caller wants a prospective disenrollment (e.g., calls on August 10 to request a disenrollment effective August 31), the 1-800-MEDICARE CSR would handle that action. If the caller needs a retroactive disenrollment, the 1-800-MEDICARE CSR would file a complaint and the plan or CMS regional office would process the retroactive action.

In terms of the complaint script, 1-800-MEDICARE CSRs use predefined categories and subcategories outlined in the CTM database. One of the fields in the CTM database requires CSRs to enter the number of medications beneficiaries have left. The CSR will ask the beneficiary how much medication he or she has left. Based on the conversation, if the CSR selects the drop down option of 0-2 days, the complaint is categorized as an urgent complaint.

8. Vantage, Inc., which holds the CMS contract for 1-800-Medicare, currently is marketing a product called "Informis" to MA Plans. "Informis" would allow MA Plans to use their customer service call centers to identify "hot leads" and close a sale on the same call. What firewalls are in place to prevent Vantage from using its access to CMS databases and beneficiary information in connection with "Informis?"

Answer: Vangent is installing Informis at customer sites. The product is not installed at any existing Vangent properties and therefore there is no opportunity for anyone using Informis to access any systems associated with the BCC contract. Vangent takes great precautions in ensuring that data remains contractually within the program so there is no improper sharing of data with an Informis customer that may provide some type of unfair advantage. Vangent is compliant with HIPAA privacy regulations and all that entails.

9. Why has CMS failed to impose mandatory minimum training requirements and/or a required core curriculum for the marketing and sales of MA Plans?

Answer: The Medicare Marketing Guidelines require organizations that directly employ or contract with a person to market an organization's products must ensure that the agent complies with all applicable MA and /or Part D laws, all Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure beneficiaries receive truthful and accurate information. In addition, the plan is required to conduct monitoring activities to ensure compliance with all applicable MA and/or Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines. Plans accomplish this primarily through agent training. During routine or focused audits, CMS staff review agent training and other methods the plan employs to ensure agents are familiar with CMS requirements as well as the products sold. CMS has not developed agent/broker training programs for Medicare products including Medigap. Brokers generally sell a variety of products including PFFS and Medigap.

However, based on the issues that developed in marketing PFFS plans over the past year, CMS specifically requires PFFS plans to train brokers/agents on applicable federal and state regulations, marketing guidelines, compliance requirements, and PFFS product specific policies. We will continue to monitor the marketing of all Medicare products to determine if additional agent/broker training is required. In addition, CMS reviews and investigates beneficiary/advocate complaints. In the May 25, 2007, memo "Ensuring Beneficiary Understanding of Private Fee-for-Service Plans, CMS released guidance to all PFFS plans specifying additional outreach and oversight measures directed at ensuring that beneficiaries and providers receive accurate and meaningful information about the unique features of PFFS plans. While some of these provisions are unique to PFFS, in the future others could apply to all MA plan types, i.e., secret shopper and outbound education/verification calls.

1) The **STATEMENT OF WORK** - For clarity, the Statement of Work is deleted in its entirety and the following is substituted in lieu thereof: (changes are annotated in ***bold italics***)

STATEMENT OF WORK (Revised 05/13/2007)

Medicare Managed Care Payment Validation

I. SCOPE

The contractor shall support the Centers for Medicare and Medicaid Services' (CMS) program integrity efforts by completing the retroactive payment adjustments, reconciling the final payment for non-renewal contracts, and performing monthly analyses of any discrepancies submitted by the Medicare Advantage Organizations (MAO's), Medicare Advantage Prescription Drug Plans (MA-PDs), and Prescription Drug Plans (PDPs) and reporting on these activities.

A. Background

Medicare managed care programs operate under Section 1876, Section 1833, and Sections 1851 through 1859 of the Social Security Act. These statutory provisions authorize the Centers for Medicare and Medicaid Services (CMS) to make payments to eligible managed care organizations on both a cost and a risk basis. Currently there are over 25 million Medicare beneficiaries enrolled in 622 organizations that are paid over 9.5 billion dollars, on a monthly basis.

Cost-based organizations are paid based upon an annual budget submission by the contracting organization. Risk-based payments to Medicare Advantage Organizations (MAOs) and some demonstration projects consist of a monthly capitation payment based upon demographic characteristics of each Medicare enrollee. Demographic characteristics include age, sex, county of residence, Medicaid status, inpatient status, employment status, end stage renal disease status, and hospice election. Information regarding the demographic characteristics of each beneficiary comes from several sources, including Medicare beneficiaries, CMS databases, Social Security Administration (SSA) data, and contracting managed care organizations.

Monthly capitation payments are calculated differently for cost versus risk-based organizations. However, all requests for enrollment are received from the MAOs and submitted to the CMS Medicare Advantage and Pharmacy System (MARx). The CMS master beneficiary database (MBD) record is checked for Medicare entitlement, and the individual's residence and health status information (demographics) is collected from the source databases. This information, along with the type of managed care organization, determines the capitation amount the MAO will be paid for the beneficiary for that month. There are several special factors, which impact the individual beneficiary payment, and therefore, the aggregate payment to the organization. Those special factors include Medicaid status; institutional status; and ESRD status. Many of these parameters are self-reported by the MAO (e.g., institutional status) or require complex system interaction. In some instances (e.g., ESRD status) the payment level is significantly

impacted. In addition to the special factors, the geographic component of the payment, the "state and county code," is especially susceptible to fraud and error.

The Part C regulation requires that managed care organizations provide CMS with a certification of all data that affects the calculation of CMS' payments to the organizations. Pursuant to that authority, CMS has implemented a requirement that managed care organizations submit monthly statements certifying the accuracy of the enrollment data submitted to CMS for use in the calculation of payments. To make this statement, MAOs must certify the accuracy of not only their data, but also the data provided by CMS. The implementation of this requirement has led to increased scrutiny by MAOs of CMS' payment systems and reluctance to **attest** to the accuracy of data that is not controlled by the managed care organization, but rather is provided to CMS by several State and Federal agencies according to widely varying schedules. Because the certification is required monthly, MAOs now rightly expects that all adjustments, with the exception of ESRD, brought to CMS' attention will be corrected in the next month's report. While CMS is requiring MAOs to dedicate resources to meeting the certification requirement, it must also be prepared to address more timely the adjustments brought to its attention. For example, since the implementation of the certification requirement, the San Francisco Regional Office has received a significant increase in the number of requests for "state and county code" adjustments.

There have been numerous reports developed by oversight agencies that focus on the Medicare Advantage inaccurate payment issues. The recent testimony of the Government Accounting Office to the Senate Committee on Appropriations, *Medicare CMS Faces Challenges to Control Improper Payments*, cites a number of issues specific to the Medicare + Choice program. The draft testimony, dated March 9, 2000, states: "As for Medicare Advantage, CMS similarly lacks the data needed to monitor the appropriateness of payments made to health plans and the services Medicare enrollees receive." The testimony further cites that since payment rates are based in part on plan-provided information, erroneous or misreported data could lead to inappropriate payments. It suggests that CMS needs to improve its capacity to monitor MAO performance and ensure that payments are appropriate and that MAOs fulfill their obligations.

Additionally, the 1998 Chief Financial Officer's (CFO) Audit of CMS identified a number of vulnerabilities in the managed care payment system and provided recommendations for corrective action. This audit has increased the need to revise the payment validation and certification process. The current process relies heavily upon manual review of sample data and is, therefore, vulnerable to inaccuracies and potential fraud. Although CMS reconciles the retroactive payment adjustments on a monthly basis, e.g., changes to enrollment status, ESRD-status, address changes, etc.; recent CFO investigation has shed doubt on the accuracy and efficiency of the process with an assertion that there is significant opportunity for MAO fraud. CMS requires assistance in assessing and implementing the CFO audit recommendations to better ensure the integrity of the Medicare Advantage program, with consideration of industry 'best practices'.

The implementation of the Medicare Modernization Act of 2003 has created many unexpected challenges for MA, MA-PD and PDP Organizations. Enrollment, disenrollment and Plan Benefit

Package adjustment transactions processed per month have nearly tripled and become more complex. The advent of the Plan to Plan reconciliation process has created a need for monthly certifications (attestations) from Prescription Drug Plans.

B. Purpose

The purpose of this task order is to:

- Complete all retroactive payment adjustments and enrollment adjustments submitted by MAO's, Medicare Advantage Organizations, Medicare Advantage Prescription Drug Plans, and Prescription Drug Plans, including in Drug Card Sponsors.
- Complete final reconciliation of payment for non-renewals of MAO, Medicare Advantage Organizations, Medicare Advantage Prescription Drug Plans, and Prescription Drug Plans.
- Make reconsideration determinations with plans that are appealing decisions regarding payments.
- Complete monthly analysis of plan discrepancies and report out.

II. REQUIREMENTS

Independently and not as an agent of the Government, the contractor shall furnish all the necessary services, qualified personnel, materials, equipment, and facilities, not otherwise provided by the Government, as needed to perform the requirements of the Statement of Work (SOW).

The following SOW sections are incorporated by reference with the same force and effect as if they were provided in full text:

A. Tasks to be Performed/Requirements

CMS is interested in finding and implementing new and innovative approaches for performing Medicare Advantage program integrity activities. The contractor shall implement innovative techniques as appropriate for payment review and other processes to be accomplished under this SOW. The contractor shall provide a wide variety of statistical analysis, data analysis, and trending to support payment review activities. The contractor shall use all appropriate CMS Medicare data, as well as data from other sources in accomplishing requirements.

The contractor shall possess appropriate hardware, software and telecommunications equipment. All hardware and software purchases, changes, or leasing arrangements shall be approved in advance by the Contracting Officer (CO). The contractor shall maintain back up copies of all critical data. In addition, the MMC-PIC shall meet all of the minimum technical requirements defined in the umbrella SOW.

Task 1: Project Plan

The contractor shall submit an updated project plan within 30 calendars days, in accordance with SOW Section. The project plan shall be updated within 10 business days after any subsequent

change has been determined. The Government reserves the right to approve the modified project plan if necessary.

The plan shall be submitted to CMS for approval. Any additional deliverables identified by the Contractor as part of the project plan shall be added or modified as necessary.

Task 2: Data Systems Plan

The Contractor shall submit an up-date to the GTL final data/systems plan semi-annually. The Contractor shall identify, from a data/systems perspective, how it shall perform the Standard Data Analysis. It shall include a separate section reflecting the accomplishments achieved during the previous contract period.

Contractor shall track and report systems issues related to CMS System Updates to the MARx and MBD Systems. Contractor shall report any systems issue that prohibits processing of transactions or result in incorrect payments generated to organization. Contractor should periodically retry those transactions to verify systems correction and report ongoing problems to the GTL or any other established CMS Contacts designated.

Task 3: Conduct Pre-Payment Review on Proposed Retroactive Adjustments

Within 45 days of receipt, the Contractor shall conduct pre-payment review on proposed retroactive adjustments for changes in state and county code, institutional and special status categories (ESRD, Medicaid, State and County code, institutional status) and enrollment changes. After conducting pre-payment review the contractor shall process the adjustment. As part of the system implemented to process the adjustments, the Contractor shall continue the process by which MCOs, Medicare Advantage Organizations (MAO's), Medicare Advantage Prescription Drug Plans, and Prescription Drug Plans may appeal determinations made by the Contractor in processing the pre-payment reviews (See Standard Operating Procedure for the MAO Appeals Process). The contractor will follow the policies and procedures that are in place at CMS for the completion of all retroactive adjustments. See the standard operating procedures that are in the Medicare Managed Care Manual, Chapter 2, Chapter 7 and Chapter 19, Section 60.

In addition the contractor is required to maintain the ability to create special review teams as required. This will be based on the fluctuating work load. This may be the result of the number of new organizations participating in the MA, MA-PD and PDP programs, the annual enrollment period, implementation of changes in the law and/or the implementation of new systems, both at the organizations and at CMS.

Task 4: Complete all Final Reconciliations for Non-Renewing Plans

Medicare Advantage Organizations (MAO's), Medicare Advantage Prescription Drug Plans and Prescription Drug Plans that decide not to renew their contract with CMS shall submit all of their reports and documentation for any final reconciliations of payment within 45 days after the termination of their contract. The contractor will process all of these requests within 45 days of

receipt. An acknowledgement letter will be sent to the MCOs within 10 days of the contractor receiving the request. Approximately nine months after the contract termination, the contractor will process a final amount, based on final report data, if requested by the Government.

Task 5: Review Monthly Discrepancies Submitted by the Plans

Contractor will review all discrepancy reports submitted by the plans each month and provide a response to each plan by the end of the next month.

Contractor will produce a monthly and annual summary report by plan number, contract number and by region. It will list all reconciliations, retroactive payments and adjustments by special categories (i.e. institutional, ESRD). This report should provide analysis, trends and identification of any outliers in order for CMS to conduct any further investigation.

Contractor shall receive Monthly Certifications of Enrollment Changes (Attestations) from all MA, MA-PD, and PDP plans. Contractor shall process and review attestations for compliance with CMS program requirements and report the results monthly.

Contractor shall receive Monthly Plan 2 Plan Certifications (Attestations) from all PDP plans. Contractor shall process in accordance with CMS program requirements.

Task 6: Provide Information to CMS Staff to Assist in Monitoring Activities

The contractor will develop standard reports to provide data to CMS staff on a monthly basis. Additionally, the contractor will provide additional information to CMS Central Office and Regional Office upon request.

Contractor shall provide client services to MA, MA-PD and PDP Organizations, Regional Office and Central Office personnel. Contractor shall contact CMS Staff and MA, MA-PD and PDP Organizations to complete any or all of the task outlined in the SOW to as required.

Contractor shall provide MA, MA-PD and PDP Organizations with a Final Disposition Report upon completion of their request for action. Request should contain detail of actions taken and corrective actions if known.

B. Reporting Requirements

All written documents for this project, with the exception of the IntegriGuard ScoreCard, shall be delivered via a single hard copy plus an electronic version via e-mail, 3.5-inch diskette, or compact disk. The IntegriGuard ScoreCard shall be delivered electronically via e-mail. The GTL may request additional hard copies as necessary. All electronic files shall be submitted in a format that is compatible with Microsoft Office 2000. This is subject to change, and the Contractor shall be prepared to submit deliverables in any new CMS standard.

The GTL shall provide the Contractor with comments on draft reports within two (2) weeks of

receipt. If no response is received within two (2) weeks, the Contractor may assume that the draft report is approved for development of final reporting.

1. **Project Plan**: The Project Plan shall include planning for each of the requirements for this Task Order and shall highlight each step of implementation of this Task Order. The project plan shall include, at a minimum, the following information (not necessarily in the order presented here):

- Descriptions of Contractor methods for satisfying task requirements or task protocol including:
- Resource planning by activity (description of the activity, anticipated results, activity implementation schedule and delivery schedules/completion dates).
- Activity interdependency and critical path for completion of all tasks.
- Key staff types devoted to each task or activity, if appropriate, and time allocation for each.
- Key milestones signifying successful completion of each task and periodic internal assessment/progress reports planned.

2. **Data/Systems Plan**: The Contractor shall prepare a detailed plan that outlines how it shall receive, store, safeguard, manipulate, and analyze data necessary to perform data systems security in accordance with OMB Circular A-130 Management of Federal Information Resources, Appendix III, "Security of Federal Automated Information Systems" necessary for maintaining the strict confidentiality requirements of all CMS data obtained from CMS files, as well as all data collected under any potential contracts. These confidentiality requirements shall also include all requirements under the HIPAA regulations, as well as all requirements for successfully safeguarding any and all data that could identify individual Medicare beneficiaries. This data/systems plan shall, at a minimum, include the following:

- A description of assumptions and constraints under which each type of analysis shall be performed.
- A list and description of data files necessary to conduct the data analysis, given the constraints that only data stored at CMS would be provided by the GTL.
- A list and description of data the Contractor would want to access that is not stored at CMS, if necessary (e.g., stored at the local MAO site).
- A schedule of how often new or updated data would be needed (e.g., weekly, monthly, other).
- A certification that the hardware and software being proposed have the capacity to manipulate the anticipated volume of data.
- A description of how the Contractor plans to use the hardware and software products.
- A description of how the contractor will ensure compliance with The Privacy Act of 1974 and CMS MMC-PIC Security Requirements. (MMC-PIC SOW Section 11.B, Security & Appendix E)
- A discussion of how the proposed Contractor data systems environment is appropriate, given CMS' system architecture.
- List of the hardware, software and telecommunications equipment required to accomplish this Task Order, including the licensing restrictions.

- Other items as identified by the Contractor.

3. **Standard Quarterly Data Report**: The Standard Quarterly Data Report shall include at a minimum, the following:
- Statement of number of records examined, broken down by special status category and MA.
- Statement of records received and processed by RO broken down by special status, enrollment, disenrollment, PBP changes and the financial impact.
- Statement of number of records for which discrepancies were identified, broken down by special status category and MA
- Statement of number of pre-payment reviews on proposed retroactive adjustments *received*, processed.
- Statement of meaningful trends discovered during data analysis
- Statement of number of final reconciliations is being completed.
- Description of special reviews/actions being conducted as directed by Central Office.
- Statement of number of special reviews being conducted as directed by Central Office.
- Statement of the number of Probe Studies by MA, including the number of items identified and the quality of the supporting data by the MA.

4. **Meetings Every Two Weeks**: The contractor will meet, via teleconference, with the GTL and the appropriate staff to discuss progress, the reports and any issues that are identified while performing the tasks listed above.

5. **Monthly Report to CMS and Regional Offices:** Contractor shall prepare a monthly and annual summary report by plan number, contract number and by region to CMS and the Regional Offices that contains a summary of adjustments processed. It will list all special projects for CMS, reconciliations, retroactive payments and adjustments by special categories (i.e. institutional, ESRD). This report should provide analysis, trends and identification of any outliers in order for CMS to conduct any further investigation.

6. ***Report on Content of Final Report: The contractor shall provide the GTL with sample data to be approved by the GTL for submission to CBC Senior Leadership.***

7. ***Final Report: The contractor shall submit final report based on approved data approved by the GTL.***
8. Integriguard ScoreCard: The Contractor shall submit a snapshot of the status of the pending and processed transactions. It will include pertinent information related to the accomplishment of work such as transactions that cannot be processed due to systems issues, transactions that can be processed (now), and availability of the UI etc.

C. Period of Performance

The period of performance work under this Task Order be August 1, 2007 through ***July 31, 2008.***

II. Personnel Requirements

The personnel requirements for this Task Order are as defined in the MMC-PIC SOW, Section 5,

MMC-PIC Project Management. Additional requirements not otherwise identified in the umbrella SOW are identified below as appropriate.

All contractor and subcontractor personnel working on this Task Order must submit a signed Non-Disclosure Statement (Appendix D to this SOW) prior to the start of the project. The Contractor shall retain the Non-Disclosure Statements on file at the place of performance.

Key Personnel: Following are the Key Personnel positions for this task order. They are not required to be full time:

Utilization Management/Benefit Integrity (UMBI) Manager
Program Director

III. QUALITY ASSURANCE

Quality assurance for this Task Order is governed by Section 10, parts A, B, and C of the MMC-PIC SOW, Quality Assurance and MMC-PIC Evaluation Plan. In addition, the following quality assurance monitoring and performance indicators are applicable:

Cooperation/Coordination (Level of interaction between the Contractor and appropriate stakeholder(s)): The Contractor may be required to cooperate and coordinate with stakeholders other than CMS. They are MAO, providers, and other entities as appropriate. Some examples of how CMS will evaluate Contractor performance include the following:

- Demonstration of ongoing dialogue or meetings with the appropriate and necessary parties,
- Feedback from other entities with which the Contractor has had to work with, and
- Number and type of issues that arise and indicate communication, or a lack of communication, between appropriate entities and the Contractor.

- Quality (Appropriateness, completeness and error free nature of all activities conducted by the Contractor): The Contractor shall maintain the highest degree of quality for all activities performed throughout the period of performance of this contract. Some examples of how quality shall be evaluated include the following:
- Completeness and accuracy of rate cell reviews, and
- Completeness and accuracy of all deliverables.

Innovation (Creative approaches identified and/or used to protect the fiscal integrity of the Medicare Trust Fund): Some examples of how the Contractor shall be evaluated include the following:

- Review of Continuous Improvement Report,
- The extent to which the Contractor used and/or analyzed innovative data analysis approaches,
- Review of the processes that the Contractor implements and utilizes to carry out the effective and efficient performance of this contract, and
- Assessment of the outcomes that the Contractor achieves in relation to all government priorities.

Timeliness (Ability to meet established time lines): This Task Order is particularly time sensitive. The Contractor shall submit all deliverables to CMS so that they are received on or before the due dates specified. Some examples of how the Contractor performance shall be evaluated include the following:

- Demonstration that the Contractor performed tasks in accordance with the schedule set forth in this Task Order.
- The time frame under which enrollment reviews are completed.
- The time frame under which reports were completed.

Value Added (Ability of the Contractor to illustrate in a deliverable how its performance adds value to the Medicare program): Some examples of how contractor performance shall be evaluated include the following:

- CMS adopts the Contractor's approaches used in the performance of this Task Order,

Satisfaction (Ability of the Contractor to meet and manage customer expectations) The Contractor shall provide at a minimum professional and courteous service to the different entities involved with this Task Order. Some examples of how the Contractor performance shall be evaluated include the following:

- Feedback from MAs, MA-PDs and PDPs (if appropriate),
- Feedback from CMS Regional Offices (ROs), and
- Feedback from CMS Central Office (CO).

Integrity (Ability of the Contractor to uphold the highest standards of professional integrity and act in the best interest of the Medicare program): The Contractor or any Sub-Contractors, shall not engage in fraud and abuse or be found to have non-disclosed conflicts of interest while work is performed on this contract or other government contracts. Some examples of how the Contractor performance shall be evaluated include the following:

- Demonstration that the Contractor continuously maintained professionalism and honesty in its business activities.
- Demonstration that all activities were carried out in a legal and ethical manner.

The GTL shall use the performance indicators above in evaluating contractor performance and the acceptance of Contractor deliverables as appropriate. The following criteria shall be used to indicate the measure of acceptance:

- Excellent: Significantly exceeds requirements.
- Good: Exceeds requirements.
- Acceptable: Fully meets requirements.
- Poor: Requires modification to meet requirements.
- Unacceptable: Does not meet requirements.

ITEMS TO BE FURNISHED AND DELIVERABLE SCHEDULE

The Contractor shall submit all required reports and deliverables in accordance with the following schedule. Reports and/or deliverables submitted under this contract shall be in accordance with the Statement of Work entitled Medicare Managed Care Payment Validation.

ITEM	DESCRIPTION	RECIPIENT	DELIVERY DATE
1.	Updated Project Plan IAW SOW II.B.1	GTL	Quarterly; By the 15th/mo which follows the end of the contract quarter
2.	Updated Data/Systems Plan		Semi Annually; by the 15th
	IAW SOW II.B.2	GTL	(1st report within 45 days of renewal date. Updated Data/Systems Plan by the 15th of the month which follows the end of the sixth month of the contract quarter
3.	Standard Quarterly Data IAW SOW II.B.3	GTL	Quarterly (By the 15th of the month following the end of the contract quarter.
4	Telephone Conference Calls IAW SOW II.B.4	GTL	Every 2 weeks
5.	Monthly Report to Reg. Office and Central Office IAW SOW II.B.5	GTL, Regional Office Point of Contact	By the 20th of the each month.
6.	***Report on Content of Final Report IAW SOW II.B.6***	***GTL***	***90 Days before end of Task Order***
7.	***Final Report II.B.7***	***GTL***	***Draft: Aug 16, 2007 Final: Aug 31, 2007***
8.	IntegriGuard Scorecard II.B.8	GTL/DEPO Dir.	Weekly on Tuesdays

Recipient Addresses:

John Campbell, Project Officer
Centers for Medicare & Medicaid Services
CBC/MPPG/BPO
7500 Security Boulevard, MS C1-05-17

Baltimore, MD 21244-1850
Phone: 410-786-0542
Email: John.Campbell@cms.hhs.gov

Kevin M. Pope, Contract Specialist
Centers for Medicare & Medicaid Services
OAGM/AGG/DBSC
7500 Security Boulevard, MS C2-21-15
Baltimore, MD 21244-1850
Phone: 410-786-5794
Email: Kevin.Pope@cms.hhs.gov

Juanita P. Wilson, Contracting Officer
Centers for Medicare & Medicaid Services
OAGM/AGG/DBSC
7500 Security Boulevard, MS C2-21-15
Baltimore, MD 21244-1850
Phone: 410-786-5538
Email: Juanita.Wilson@cms.hhs.gov

Ex. #	Description	Date
1	Example of Misleading Sales Material (Mr. Key)	2/7/2007
2	Example of Misleading Sales Material (Phillip Minga, Sales Agent)	
3	Example of Misleading Sales Material ("No Monthly Premium")	
4	Coventry's Private Fee for Service flier	2007
5	Memo from Mike Burke to Advantra Freedom Agents; re:"Private Fee for Service Dual Eligible Enrollment."	2/1/2007
6	Complaints of forged Medicare Advantage signature to South Dakota Insurance Commissioner	May 2007
7	Coventry Field Communication to "All Distribution Partners" from Mike Burke, re: "Extension of PFFS Sales Incentive Contests."	12/04/2006
8	Wellcare "Half Time Giveaway/ Extra Points" Agent Flier	2006
9	State of Mississippi Press Release from George Dale, Commissioner of Insurance/ State Fire Marshal, re: "Abusive Medicare Insurance Sales Practices Spreading Throughout State."	4/11/2007
10	Letter to Leslie Norwalk, Acting Administrator of Centers for Medicare and Medicaid Servies from Commissioner Jim Poolman, North Dakota Department of Insurance, re: implementation concerns with the Medicare Modernization Act of 2003.	5/24/2007
11	Letter to Sen. Herb Kohl, Cmte on Aging, from Commissioner of Insurance Marcy Morrision, State of Colorado, re: consumer challenges to Medicare Advantage plans.	5/11/2007
12	Script Print from CMS Common Working File	1/1/2007
13	Wellcare brochure, re: "Wellcare Duet Plan: Extra Benefits."	9/20/2006
14	Wellcare brochure, re: "Wellcare Duet Plan: Extra Benefits."	April 2005
15	Centers for Medicare Marketing Guidelines for: Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans and 1876 Cost Plans.	7/25/2006
16	Veritas Capital press release, re: "Veritas Acquires Pearson Government Solutions."	2/15/2007
17	Informis pamphlet	
18	CMS Memo to Medicare Advantage Organizations, et al, from Abby Block, Director, Center for Beneficiary Choices, re: "Introduction from CMS on 2008 Call Letter."	4/19/2007
19	Center for Beneficary Choices Memo to Medicare Advantage Private Fee-for-Service (PFFS) Plans from Abby Block, re: "Ensuring Beneficiary Understanding of Private Fee-for-Service Plans, Actions and Best Practices."	05/29/07

Exhibit 1

IMPORTANT INFORMATION
Medicare Has approved the following:

Dental, Hearing, and Vision Benefits

Are entitled to you if you have

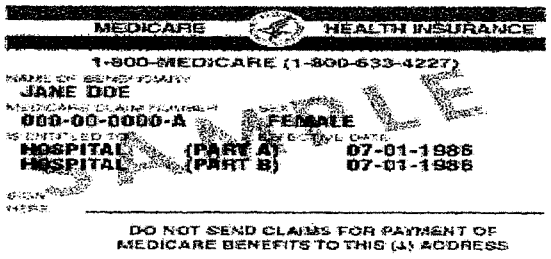
Medicare Part A and Part B

Representatives will be in the Community Room with information and refreshments.

Date: Wednesday , February 7th, 2007 at 11:30am

ATTENTION:

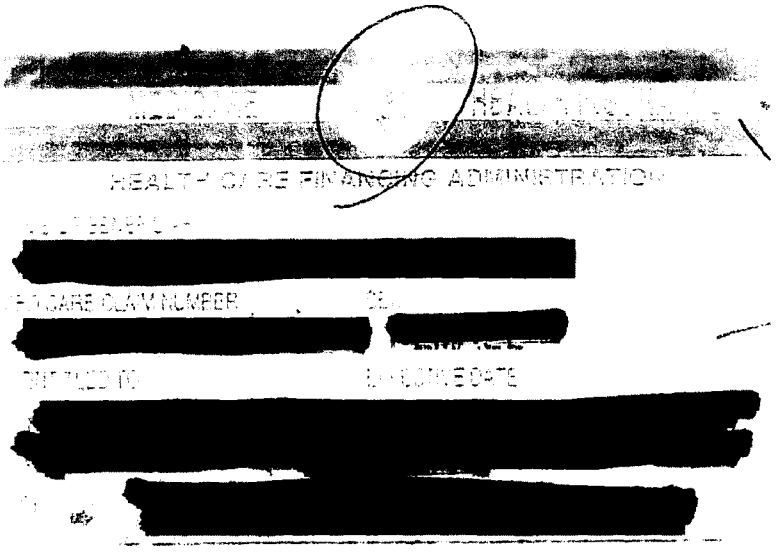
Please bring your medicare card with you for verification

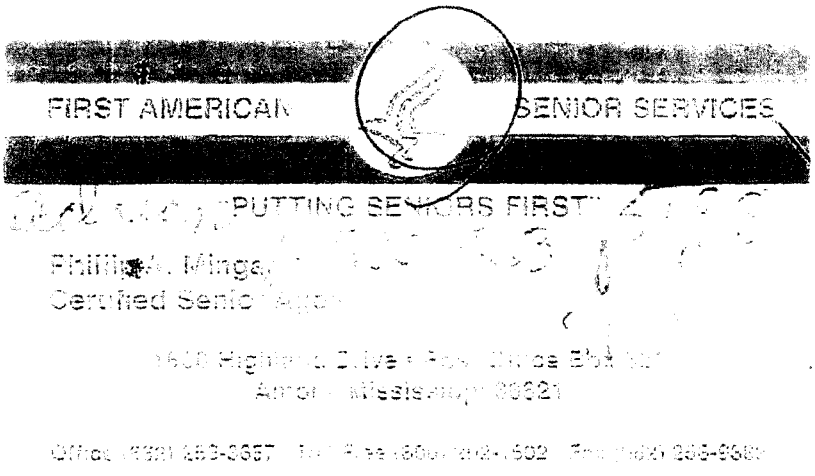


If you can't attend please call Mr. Key or TC at

301-442-8301 or 202-468-4192

Exhibit 2


HEALTH CARE FINANCING ADMINISTRATION


FIRST AMERICAN
SENIOR SERVICES
"PUTTING SENIORS FIRST"

CEDRIC B. PARMER
Certified Senior Representative

Office (205) 251-1952
Cell "Putting Seniors First" (205) 567-1852
Fax (205) 251-1952

Medcare Life / P.O. Box 5413

Exhibit 3

MEDICARE CARD HOLDERS

FREE

If you are on
Medicare and have
Parts A & B
Medicare pays 80%
You pay 20%

Now there is a Medicare Supplement
that covers your 20% and it's

FREE

"No Monthly Premium"

Call this Local Number

Don @ 765-393-0096

in Anderson

Exhibit 4

Advantra® Freedom

6705 Rockledge Drive, Suite 900
Bethesda, MD 20817-1850
1-800-711-1607 www.advantrafreedom.com

Dear Prospective Member:

If you need coverage that goes beyond Original Medicare, we've got good news for you!

Advantra Freedom – a new Medicare Advantage Private Fee-For-Service plan – can provide you with all of the following benefits and many more:

- ✔ The comfort of using the doctors and hospitals you know and trust with **no referrals**.
- ✔ No deductibles to satisfy and predictable copays for most services.
- ✔ No additional premium once you pay your Medicare Part B.
- ✔ Full coverage – not just for emergencies – while traveling anywhere in the United States.
- ✔ Many preventive care extras such as allowances for eyewear and hearing aids.
- ✔ Nurses on call 24 hours a day / 7 days a week, even on holidays.

With Advantra Freedom, you get the flexibility of private insurance but at a lower cost. And with low copays for most services, your monthly expenses are more predictable eliminating many surprise bills.

All Medicare Beneficiaries in the Advantra Freedom service area may apply. You must continue to pay your Medicare Part B premium.

All of the information you need to lower your medical and prescription drug costs is contained in this packet including:

- "New Option for Medicare Beneficiaries" (Information Booklet).
- Summary of Benefits.
- Benefit Chart with monthly premiums and copays for your service area.
- Enrollment Application with instructions.
- Provider Outreach Form.
- Pre-paid Reply Envelopes.
- Referral Card.

Advantra Freedom is a Medicare Advantage Private Fee-for-Service Plan offered through First Health Life & Health Insurance Company, a subsidiary of Coventry Health Care Inc., who contracts with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare. Coventry Health Care, Inc., one of the nation's respected insurance carriers, currently serves over 3 million members, including many Medicare beneficiaries like you. You can trust Coventry Health Care to deliver the benefits and service you need at a cost you can afford.

There are four convenient ways to enroll:

1. **BY PHONE:** Call us at **1-800-711-1607**, (TDD) 1-866-386-2335 for the hearing impaired. Hours of operation are: November 15, 2006 through March 1, 2007, 7 days a week including holidays, 8:00 a.m. – 11:00 p.m., Eastern Standard Time. From March 2, 2007 through November 14, 2007, Monday through Friday, 8:00 a.m. – 11:00 p.m., Eastern Standard Time. You can also contact your insurance agent.
2. **ON THE INTERNET:** Visit our website at **www.advantrafreedom.com**.
3. **THROUGH THE MAIL:** Fill out the enclosed enrollment form and return it in the postage-paid reply envelope.
4. **Medicare beneficiaries may enroll in Advantra Freedom through the Centers for Medicare and Medicaid Services Online Enrollment Center, located at www.medicare.gov.** For more information contact the Advantra Freedom plan at the number noted above.

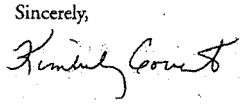
Don't Miss Out!

Join the millions of Medicare beneficiaries who are already realizing:

- **Added convenience** of using local participating doctors and hospitals with no referrals.
- **Peace of mind** that comes from knowing you can afford the health care you need whenever you need it– now and in the future.

Sign up for Advantra Freedom today! We look forward to hearing from you.

Sincerely,



Kimberly Covert
Vice President

This document is available in alternate formats.

The Advantra Freedom contract with CMS is renewed annually and the availability of coverage beyond the end of the current contract year is not guaranteed.

You are eligible to join Advantra Freedom if you are entitled to Medicare Part A and are enrolled in Medicare Part B and reside within the plan's service area. Please note the following important enrollment dates as they apply to you:

- When you first become eligible for Medicare, you can join Advantra Freedom during the three months before or after your 65th birthday or when you are first eligible for Medicare. Your enrollment will be effective either when you are first eligible for Medicare or the first day of the month after you sign up.
- If you are already Medicare-eligible, you can join Advantra Freedom during the annual Open Enrollment Period from 11/15 to 12/31 each year. Your coverage will be effective on1/1.
- You can make one selection into or out of a Medicare Advantage plan from 1/1to 3/31 each year. Your coverage would generally be the first of the month following Advantra Freedom's receipt of your application.
- If you move out of your current plan's service area or lose other group coverage - you can switch to Advantra Freedom at the time of your move.

Exhibit 5

Advantra® Freedom

Memo

To: Advantra Freedom Agents

From: Mike Burke

CC: J. Stelben

Date: February 1, 2007

Re: Private Fee For Service Dual Eligible Enrollment

Coventry Health Care believes that our Private Fee For Service Advantra Freedom products may not be the best health care coverage solution for Medicare beneficiaries who have both Medicare and Medicaid coverage (dual eligible.)

There are several reasons that have contributed to our conclusion:

- Most dual eligibles will have limited financial exposure when enrolling in plans designed specifically for their situations. Our Advantra Freedom products will in many cases increase their financial exposure for covered services in the form of increased co-pays or coinsurance.
- Coordination of benefits with most states is often arduous and in some cases, state Medicaid departments prohibit coordination of benefits with Medicare Advantage Plans, thereby further increasing a dual eligible's potential financial exposure as referenced above.
- Dual eligible residents of nursing homes are especially challenged in that they may not be able to properly evaluate the positive or negative impacts to their coverage when enrolling in Advantra Freedom.
- Our analysis of Advantra Freedom's benefit structure to that of a dual eligible's needs has concluded that in most cases we will be increasing their out of pocket cost for covered health care services (i.e. co-pays and coinsurance).

Coventry believes that we have designed and introduced PFFS products that are a good fit and value for the majority of Medicare beneficiaries. We all must work together to ensure that we do everything possible to educate Medicare beneficiaries on their choices and enroll them in products that best fit their individual needs. Agents should not sign up dual eligible individuals unless the dual eligible has verified with their local SHIP (State Health Insurance Assistance Program) or Medicaid office that the plan is beneficial to the dual eligible.

Coventry's primary interest is in providing Medicare beneficiaries with the appropriate products that meet their health care benefit needs. We expect you to represent our company consistent with these values and in accordance with all CMS requirements. We thank you in advance for your support and cooperation.

Attached you will find additional information regarding enrolling members in a nursing home or institutional setting.

Exhibit 6

Medicare Advantage Complaint

Beneficiary Name: [redacted]

RC SD 57702

[redacted]

Family Contact: [redacted]

Basis of Complaint: Enrolled in a MA without authorization
Enrollment application signature FORGED by Agent

Company Involved: [redacted]
Agent: [redacted]
Date: 5/3/07

1) Did you request written information? No

2) Did an agent then call you to set up appointment? No

3) Where did you meet the agent? [redacted] met the agent in 2005. He was told by [redacted] at that time that Medicare was changing and [redacted] had to enroll in an MA Plan. [redacted] enrolled in [redacted] (the company that [redacted] wrote for at the time)

4) Did you invite him/her to your home? [redacted] has not seen [redacted] since 2005.

5) Did you get a Summary of Benefits from the Agent when he/she came to your house?

N/A

6) Did the agent go over your cost sharing/co-pay responsibility for? N/A
- Hospitalization
- SNF
- Office Visits
- Emergency Room
- Durable Medical Equipment
- Lab, X-rays, Radiation

7) Did the agent tell you that some hospitals and doctors will not accept this plan? N/A

8) Did agent explain or provide written information on disenrollment procedure? N/A

9) Give you their business card? Have you been able to reach them? [redacted] contacted the plan and had him disenrolled.

10) What did you think you were signing up for? N/S

11) Were you pressured into taking the product or filling out the application? [redacted] never filled out the application. [redacted] completed an application without [redacted] knowledge, forged his signature and sent it to his current company, [redacted]

12) Did the agent indicate to you that they would hold the application until you called and confirmed that you wanted the product? N/A

13) Did the agent tell you that you had to sign up right away or that he would only be in your area for a limited time? N/A

14) Did you understand you were that you are discontinuing the Medicare program?
N/A

15) Are you qualified for any Medicare premium assistance such as QMB, SLIMB or QI-1?

NO

16) Are you still in the MA plan? NO

17) Have you had difficulty accessing doctors and getting the health care you need?

NO

18) Have you presented your card for medical services or prescription drugs? (If not check Retroactive disenrollment) [redacted] has for lab work. [redacted] hasn't (he has VA Benefits)

19) Do you have any outstanding bills that the MA plan has not paid? Not that they know of

Name of Plan: [redacted]
Effective date: 1/01/07-2/31/07

Name of Agent: [redacted] **Phone #** [redacted]

Notes: [redacted] called my office on Wednesday responding to the PSA that was put out by the Atty. General's office on the MA plans. [redacted] said that his grandfather, [redacted] was enrolled in [redacted] without his permission. He said he felt it was outright fraud. They first became aware of the problem when they received a premium notice from [redacted]. [redacted] began calling the company at that time and was told by the company that [redacted] had indeed signed up. [redacted] disputed this and the company then sent him a copy of the enrollment application. Both [redacted] insist that [redacted] did not fill this information out, and the signature is forged. They believe [redacted] was able to submit this application using information he obtained by Mr. [redacted] the year before, when he enrolled in a [redacted] product through [redacted] (Mr. [redacted] disenrolled from the [redacted] product also, because he was so confused. He stated that Mr. [redacted] told him he HAD to enroll in the [redacted] product in 2005/06 because "Medicare was changing and everyone had to choose a new plan". He later found out that wasn't true and switched back to his Medicare Supplement through AARP.

They would like to file charges or file a complaint to have Mr [redacted] prosecuted.

I will be faxing you a copy of the application with the forged signature. Let me know if you need anything else.

Person filling out complaint form: [redacted]

Send complaint to:

S.D. Div. of Ins.
Denver CMS Ofc.
MEDIC
Attorney Generals Office
Plan

~~March 16, 2007~~ April 10, 07

To Whom It May Concern:

I want to file a complaint against [redacted] selling [redacted] Medicare Advantage Plan.

My husband and I kept hearing the message to sign up for Part D before the deadline. Not really understanding Part D we decided since we were in [redacted] to stop and visit with the [redacted] agent. [redacted] was at the [redacted] booth and we asked him about Part D. I did mention to Mr. [redacted] that I had prescription drug coverage but wasn't sure if it would continue. I am not sure if I mentioned TriCare by name or not. Nevertheless, Mr. [redacted] did not ask any questions about our current coverage. If he had we would have learned that TriCare was "better than" Medicare's Part D benefit and we did not need to enroll to avoid a penalty. We also have NALC (National Association of Letter Carriers) as a secondary insurance to Medicare.

Mr. [redacted] did not advise us that he was enrolling us in a Medicare Advantage Plan. We were not told about our co-pay responsibilities for hospitalization, office visits, lab work, etc. We were given no written information, no Summary of Benefits and no discussion about network providers. We both thought we were getting just a Part D stand alone plan.

Evidently the plans became effective 1/1/07. We still do not have cards or enrollment information or Summary of Benefits. My husband was hospitalized in February and that is when I learned we were in a Medicare Advantage Plan.

My daughter and I set up an appointment and met with [redacted] again at [redacted] I was very upset about this whole mix-up and stressed about my husbands medical problems and became adamant with Mr. [redacted]. I told him "Do you realize what you have done to me and all you have put me through". Mr. [redacted] responded by saying "If you are good/nice to me then I will be good/nice to you and help you." He told me exactly what I needed to write to [redacted] to disenroll from the **Medicare Advantage plan.**

I wrote it down on a slip of paper and mailed the request to [redacted]. I also told him that we had TriCare benefits and he said "Well you should have told me and I would have never enrolled you in this plan."

We were then told that [redacted] didn't have the information it needed to process the request. Mr. [redacted] told us the plan needed our [redacted] ID #'s, which I still didn't have. I was able to get that information from the Heart Hospital and again wrote a letter of disenrollment.

I feel this agent should be investigated and stopped from selling this plan. My husband is currently in rehab and unable to sign this, so I am signing for him.

Sincerely,

[redacted]

[redacted]ue
Sioux Falls, SD 57103
[redacted]

[redacted]

[redacted]
Sioux Falls, SD 57103
[redacted]

cc: S.D. Division of Insurance
MEDIC
CMS Denver Regional Office

Exhibit 7

COVENTRY
Health Care

Field Communication

To: All Distribution Partners
From: Mike Burke, Vice President of Medicare
Date: 12/04/06
Category: Contests and Incentives
Field Communication FC 21

Subject: Extension of PFFS Sales Incentive Contests

Keep pushing on! We have extended the PFFS Sales Incentive Contest until January 31, 2007. Participants that submit Medicare PFFS enrollment applications to Coventry between now and January 31, 2007 , will still be eligible to win Weekly Application Production Awards (WAPA's). On each Saturday during the contest period, Coventry will run a report to determine the number of applications accepted and processed by Coventry during the previous seven days (i.e., Saturday through Friday). Applications are counted by the date of processing by Coventry and not by the date of receipt by Coventry. For each seven day period, Coventry will determine the number of applications submitted by Participants which have been accepted and processed by Coventry (a "Valid Application"). Applications that are rejected by Coventry for any reason shall not be counted as valid Applications. Each Valid Application may only count towards one weekly production amount for a Participant.

Coventry will provide the following WAPA to each Participant that submits the following:

Between 10-24 Valid Applications in a week = $25 Debit Card
Between 25-49 Valid Applications in a week = $50 Debit Card
Between 50-99 Valid Applications in a week = $500 Cash
Between 100+ Valid Applications in a week = $1,000 Cash

In addition to the WAPA's, Coventry will provide a trip to Las Vegas, Nevada to the twenty-five (25) Participants that generate the most Valid Applications for the period between November 15, 2006 and March 31, 2007. Only Valid Applications received by Coventry on or before March 31, 2007 will accumulate to a Participant's total production.

BROKER CONTEST AND AWARD PROGRAM
TERMS AND CONDITIONS

PLEASE READ CAREFULLY. These Terms and Conditions govern the Broker Contest and Awards Program described below.

A. Program Sponsors

This Broker Contest and Awards Program (the "Program") is sponsored jointly by Coventry Health and Life Insurance Company, Cambridge Life Insurance Company and First Health Life and Health Insurance Company (collectively hereinafter "Coventry").

B. Eligibility

1. The Program is only open to licensed brokers, agents and producers who have entered into agent contracts with Coventry to sell Medicare Private Fee For Services Plans and have completed the Coventry on-line agent training certification ("Participant"). Employees of Coventry are not are not eligible for the Program. This Program is void where prohibited by law.

2. Participation in the Program constitutes the Participant's full and unconditional agreement to these Terms and Conditions.

C. Program Description and Duration

1. Agent Contract Drawing. Coventry will hold a one-time drawing to determine the winner of Five Thousand Dollars ($5,000.00). To be eligible for the drawing, a Participant must submit his/her agent contract to Coventry postmarked by no later than November 1, 2006. All Participants with agent contracts postmarked by no later than November 1, 2006 will be entered into the drawing. Each Participant who eligible for the drawing will have one entry placed in the drawing. The drawing will be held and winner will be announced on November 9, 2006.

2. Weekly Application Production Awards. Participants that submit Medicare PFFS enrollment applications to Coventry between November 15, 2006 and December 31, 2006, will be eligible to win Weekly Application Production Awards ("WAPAs"). On each Saturday during the contest period, Coventry will run a report to determine the number of applications accepted and processed by Coventry during the previous seven days (i.e., Saturday through Friday). Applications are counted by the date of processing by Coventry and not by the date of receipt by Coventry. For each seven day period, Coventry will determine the number of applications submitted by a Participant which have been accepted and processed by Coventry (a "Valid Application"). Applications that are rejected by Coventry for any reason shall not be counted as Valid Applications. Each Valid Application may only count towards one weekly production amount for a Participant.

   Coventry will provide the following WAPA to each Participant that submits the following:

   Between 10-24 Valid Applications in a week = $25 Debit Card
   Between 25-49 Valid Applications in a week = $50 Debit Card
   Between 50-99 Valid Applications in a week = $500 Cash
   Between 100+ Valid Applications in a week = $1,000 Cash

Valid Applications accumulate only for the Participant that is the writing agent and only count towards the Participant's production for the week in which the Valid Application was accepted and processed by Coventry. Only one WAPA will be issued per Participant per week. WAPAs are not cumulative (i.e., if a participant submits 26 Valid Applications in a week, the Participant will only receive the $50 Debit Card; the Participant will **not** receive both a $50 and a $25 Debit Card). Coventry will review the applications accepted and processed for each week and make the WAPAs within three weeks of each Saturday report.

Coventry reserves the right to shorten, extend, modify, or cancel the Weekly Application Production Award program, at its sole discretion, at any time.

3. Trip to Las Vegas, Nevada. Coventry will provide a trip to Las Vegas, Nevada to the twenty-five (25) Participants that generate the most Valid Applications for the period between November 15, 2006 and March 31, 2007. Only Valid Applications received by Coventry on or before March 31, 2007 will accumulate to a Participant's total production.

   Each of the twenty five (25) top Participants will receive round trip economy class airfare and hotel accommodations for one person for a three (3) night stay in Las Vegas, Nevada. The dates for the trip shall be selected by Coventry, in its sole discretion. If a Participant is unable to attend the trip, the Participant will forfeit his/her right to the trip. Coventry will provide more details of the trip as such time for the trip approaches. Winners will be announced on or before April 20, 2007.

   Coventry reserves the right to shorten, extend, modify, or cancel the Trip to Las Vegas Program, at its discretion, at any time.

D. Program Prohibitions and Requirements

1. A Participant may not combine, transfer, sell or otherwise convey member applications with other Participants in any manner. Any attempt to combine, transfer, sell or otherwise convey applications will result in Participant's disqualification from the Program and forfeiture of all awards. Coventry reserves the right to take any other or additional action, including, but not limited to, termination of Participant's agent contract, it deems appropriate in its sole discretion in the event that Coventry believes (in its sole discretion) that a Participant has violated this provision.

2. Coventry reserves the right to change, add, or remove the methods by which Participants earn awards. Participants are responsible for the payment of all taxes which may result from the award(s) received as part of the Program.

3. All member application submissions will be subject to verification by Coventry. Awards will not be awarded until after the verification process is complete.

4. If a Participant believes that an award was not properly awarded to him/her, the Participant must notify Coventry by contacting 800-743-5727.

5. If Coventry terminates a Participant's agent contract, for any reason, Participant forfeits his or her eligibility to participate in this Program and any awards that the Participant may have won or be eligible.

E. Modifications and Termination of the Program

1. Coventry reserves the right to modify any and all of the Terms and Conditions set forth herein, at any time, with or without notice, even though these changes may affect an Participant's ability to claim an award.

2. Coventry reserves the right to terminate the Program at any time, for any reason, with or without notice, even though termination may affect a Participant's ability to receive an award.

3. A Participant's participation in the Program constitutes the Participant's acceptance of any changes to these Terms and Conditions. Participants are responsible for remaining knowledgeable as to any changes that Coventry may make to these Terms and Conditions. The most current version of these Terms and Conditions will be available at www.AdvantraFreedom.com and will supersede all previous versions of these Terms and Conditions.

F. General Terms and Conditions.

1. Coventry reserves the right to discontinue the participation privileges of any Participant who engages in any fraudulent activity or uses the Program in a manner inconsistent with these Terms and Conditions or any federal, state or local, laws, statutes or ordinances. Discontinued participation may result in the loss of all accumulated awards and/or termination of Participant's agent contract. In addition to discontinuance of participation, Coventry shall have the right to take appropriate administrative and/or legal action, including civil or criminal prosecution, as it deems necessary in its sole discretion.

2. The Program is provided to individuals only. Corporations, associations or other groups may not participate in the Program. It is fraudulent for any individual or company, association, or group to direct, encourage, or allow Participants to attempt to accumulate member applications for combined use.

3. All questions or disputes regarding eligibility for the Program, collecting or awarding awards, or a Participant's compliance with these Terms and Conditions will be resolved by Coventry in its sole discretion.

G. Limitation of Liability and Disputes

1. Coventry is not responsible for problems related to Participant's application submission including, but not limited to any human error, for any interruption, deletion, omission, defect, or line failure of any telephone network or electronic transmission, for problems relating to computer equipment, software, inability to access the Website or online service, or for any other technical or non-technical error or malfunction. UNDER NO CIRCUMSTANCES, INCLUDING, BUT NOT LIMITED TO, NEGLIGENCE, SHALL COVENTRY, ITS AFFILIATES OR ANY OF THEIR RESPECTIVE OFFICERS, DIRECTORS, EMPLOYEES, AGENTS AND ASSIGNS, BE LIABLE FOR ANY DIRECT, INDIRECT, INCIDENTAL, SPECIAL OR CONSEQUENTIAL DAMAGES ARISING OUT OF THE PROGRAM, EVEN IF ANY OR ALL OF THE FOREGOING OR ANY OF THEIR AUTHORIZED REPRESENTATIVES HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. IF COVENTRY IMPROPERLY DENIES A PARTICIPANT ANY AWARD, LIABILITY WILL BE LIMITED TO THE CASH EQUIVALENT OF THE AWARD. BY PARTICIPATING IN THE PROGRAM, A PARTICIPANT WAIVES ANY

AND ALL RIGHTS TO BRING ANY CLAIM OR ACTION RELATED TO SUCH MATTERS IN ANY FORUM BEYOND ONE (1) YEAR AFTER THE FIRST OCCURRENCE OF THE KIND OF ACT, EVENT, CONDITION OR OMISSION UPON WHICH THE CLAIM OR ACTION IS BASED. **TO THE FULLEST EXTENT ALLOWABLE BY LAW, COVENTRY SPECIFICALLY DISCLAIMS ANY REPRESENTATIONS OR WARRANTIES, EXPRESS OR IMPLIED, REGARDING ANY PRODUCTS AND/OR SERVICES OFFERED BY AS AN AWARD, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE AND IMPLIED WARRANTIES ARISING FROM COURSE OF DEALING OR COURSE OF PERFORMANCE.** Some jurisdictions do not allow limitations on how long an implied warranty lasts, so the above limitation may not apply to you. Participants agree to rely solely on the manufacturer's warranties, if any, for any products awarded through this Program.

2. As a condition of participating in this Program, Participant agrees that (1) any and all disputes, claims, and causes of action arising out of or connected with this Program, or any awards obtained through the Program, shall be resolved individually, without resort to any form of class action and exclusively by arbitration under the rules of the American Arbitration Association. Arbitration will take place in Bethesda, Maryland; (2) any and all claims, judgments and rewards shall be limited to actual cash equivalent of an award, but in no event attorneys' fees; and (3) under no circumstances will Participant be permitted to seek recovery for, and Participant hereby waives all rights to claim, punitive, incidental and consequential damages and any other damages, and waives any and all rights to have damages multiplied or otherwise increased.

3. All issues and questions concerning the construction, validity, interpretation and enforceability of the Terms and Conditions, or the rights and obligations of Participant and Coventry in connection with the Program, shall be governed by, and construed in accordance with, the laws of the State of Delaware, without giving effect to any choice of law or conflict of law rules or provisions (whether of the State of Delaware, or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of Delaware.

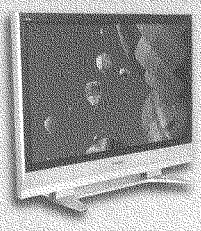
4. These Terms and Conditions constitute the entire agreement between Participants and Coventry pertaining to the subject matter hereof and supersedes all prior or other arrangements, understandings, negotiations and discussions, whether oral or written. No waiver of any of the provisions of these Terms and Conditions shall be deemed or shall constitute a waiver of any other provisions hereof (whether or not similar), nor shall waiver constitute a continuing waiver unless otherwise expressly provided.

5. If any provision of these Terms and Conditions is found to be invalid or unenforceable by a court of competent jurisdiction, such provision shall be severed from the remainder of these Terms and Conditions, which will otherwise remain in full force and effect.

* * *

Exhibit 8

HALF-TIME Giveaway



Panasonic 42" Plasma HDTV, model number TH-42PX60U

Half-Time Giveaway

This year's half-time entertainment will be brought to you on a Panasonic 42" Plasma HDTV. Every new WellCare 2007 Private Fee for Service (PFFS) applications submitted between November 15th and December 29th, 2006 counts as one entry in WellCare's *Half-Time* Plasma HDTV giveaway. The more PFFS applications you submit to WellCare each week, the greater your chances of winning – it's even possible to win more than once!

Four Winners in December

Four lucky WellCare producers will win a Panasonic 42" Plasma HDTV in December. See *Half-Time* Official Rules for details.

Earn Up To $100 Bonus on Every Application

WellCare's *First and Goal* bonus program pays an additional $75 for every PFFS application approved for January 1, 2007 effective dates.

Our *Extra Points* bonus program offers an additional reward for volume producers. Enroll 100 or more PFFS members for January 1, 2007 effective dates and earn a **$100 bonus per application** in addition to your PFFS base compensation.

Official Rules *(First and Goal / Extra Points)*

- The *First and Goal* and *Extra Points* bonus programs are for WellCare's 2007 Private Fee for Service (PFFS) applications received on or before December 31, 2006 for January 1, 2007 effective dates and approved by The Centers for Medicare and Medicaid Services (CMS).
- The *First and Goal* and *Extra Points* bonus programs apply to writing agents, only.
- Agents must be contracted with WellCare and its affiliates and be in good standing at the time of qualification and payout to receive the bonus.
- Agents may not assign, combine, transfer business, change agent-of-record or writing agent status with other agents for the purpose of earning bonuses.
- If commissions are assigned, bonuses will be paid to the assignee at the time of payout.
- The bonus is taxable as income. WellCare will report its value on IRS Form 1099 Miscellaneous Income.
- Bonuses are considered fully-earned when PFFS applications are received by WellCare prior to December 31, 2006 for January 1, 2007 effective dates and approved by CMS.
- WellCare reserves the right, at its sole discretion, to determine eligibility for this program on a case-by-case basis and may disqualify agents if they've violated any of these provisions, the Producer Agreement, CMS Marketing Guidelines, or the law.
- An individual Solicitor Agent must sell 100 or more PFFS applications to qualify for the *Extra Points* bonus. All bonuses to be paid to the Solicitor Agent's assigned up-line.

Official Rules *(Half-Time Giveaway)*

- No purchase necessary to enter the *Half-Time* prize drawing.
- A total of four (4) prizes will be awarded.
- Retail value of the Panasonic is $1,499.99, not including sales tax (source: www.bestbuy.com, 11/27/06). In lieu of the Panasonic 42" Plasma HDTV, model number TH-42PX60U prize, one $1,500 Best Buy gift card will be awarded to each prize drawing winner. Prize winners are free to use the gift card to purchase the Panasonic 42" Plasma HDTV or any other Best Buy merchandise they choose.
- To qualify, new PFFS applications must be received by WellCare before midnight each Friday in December 2006 (12/8, 12/15, 12/22, and 12/29). Business received beginning 11/15/06 will be entered in the first drawing. Prize drawing will occur one week following the close of each qualifying week.
- Weekly winner determined by random drawing from all PFFS applications received before the midnight Friday deadline.
- Winners will be notified via the telephone number indicated in the Producer Use Only section of the PFFS member application.
- Incomplete, ineligible, or illegible PFFS applications will be disqualified from the prize drawing.
- Estimated odds of winning each week 1:1,000. Odds subject to change.
- Prize value is taxable to the recipient and will be reported on IRS Form 1099.
- The *Half-Time* prize drawing applies to writing agents, only.

FOR AGENT USE ONLY. NOT INTENDED FOR CONSUMERS.

WellCare

www.wellcarepro.com

WellCare National Distribution • 8735 Henderson Rd, Ren-4, Floor 2 • Tampa, FL 33634

EXTRA POINTS

The Playing Field

Get in the Medicare game in a big way when you offer Private Fee for Service (PFFS) plans from WellCare. Our new suite of Open Access plans allow your clients to visit any doctor or any hospital that accepts Medicare and agrees to WellCare's PFFS terms and conditions, while offering them benefits that may include:

- No additional premiums over Part B
- Prescription drug coverage
- Low, predictable co-pays on hospital and doctor's services
- Comprehensive dental/vision/hearing coverage

First And Goal

Earn an additional $75 for every PFFS application you get over the goal line on or before December 31, 2006 for January 1, 2007 effective dates. Of course, all applications must be approved by The Centers for Medicare and Medicaid Services (CMS) to qualify for payment.

Extra Points

NEW!

You tasted victory with WellCare's *First and Goal* bonus program and now it's time to score again with *Extra Points*. Kick 100 or more PFFS applications through the uprights on or before December 31, 2006 for January 1, 2007 effective dates and **you'll earn an additional $25 on every application.** You already know this rule, but league Officials require us to repeat it. All applications must be approved by The Centers for Medicare and Medicaid Services (CMS) to qualify for payment.

Keeping Score

You'll run up the scoreboard and win when you add WellCare's already competitive base PFFS compensation, plus *First and Goal*, plus *Extra Points*.

50 PFFS Sales x $250 (base), plus $75 per sale = $16,250 total

100 PFFS Sales x $250 (base) plus $75 per sale = $37,500
PLUS $25 Extra Point per sale = $31,000 total

250 PFFS Sales x $250 (base), plus $75 per sale = $84,250
PLUS $25 Extra Point per sale = $90,500 total

There's no limit to how much you can earn!

Our Winning Team

Join our independent agent sales team and you'll have the power of experience and focus on your side. Our seasoned coaching staff has shaped WellCare into one of the fastest growing publicly traded Medicare Advantage companies in the nation. Contact your Field Marketing Organization (FMO) to join us for Training Camp, or visit us at www.wellcarepro.com.

FOR AGENT USE ONLY.
NOT INTENDED FOR CONSUMERS

WellCare

www.wellcarepro.com

Official Rules

- The *First and Goal* and *Extra Points* bonus programs are for WellCare's 2007 Private Fee for Service (PFFS) applications received on or before December 31, 2006 for January 1, 2007 effective dates and approved by CMS.
- The *First and Goal* and *Extra Points* bonus programs apply to writing agents, only.
- Agents must be contracted with WellCare and its affiliates and be in good standing at the time of qualification and payout to receive the bonus.
- Agents may not assign, combine, transfer business, change agent-of-record or writing agent status with other agents for the purpose of earning bonuses.
- If commissions are assigned, bonuses will be paid to the assignee at the time of payout.
- The bonus is taxable as income. WellCare will report its value on IRS Form 1099 Miscellaneous Income.
- According to the provisions of the Producer Agreement, a portion of these bonus programs may be subject to chargeback in the event a member terminates within their first year of membership.
- WellCare reserves the right, at its sole discretion, to determine eligibility for this program on a case-by-case basis and may disqualify agents if they've violated any of these provisions, the Producer Agreement, CMS Marketing Guidelines, or the law.

Exhibit 9

GEORGE DALE
Commissioner of Insurance
State Fire Marshal

LEE HARRELL
Deputy Commissioner

STATE OF MISSISSIPPI
Mississippi Insurance Department

501 N. West Street
1001 Woolfolk Building (38201)
Post Office Box 79
Jackson, Mississippi 39205-0079
(601) 359-3569
http://www.doi.state.ms.us

FOR IMMEDIATE RELEASE
George Dale, Commissioner of Insurance/State Fire Marshal
Mississippi Insurance Department
Jackson, Mississippi
Wednesday, April 11, 2007
For additional information, please contact
Donna J. Cromeans, Public Relations Director 601-359-3569

ABUSIVE MEDICARE INSURANCE SALES PRACTICES SPREADING THROUGHOUT STATE

Seniors Urged to be Vigilant in Selecting Program

(Jackson)-Commissioner George Dale today announced that the Mississippi Insurance Department (MID) is joining State Senator Terry Burton (Lauderdale, Newton, Scott Counties) and Colonel Don Taylor and the Mississippi Department of Human Services (MDHS) in alerting Mississippi's senior citizens to be aware that abusive sales practices relating to Medicare Insurance, first reported late last year, are spreading rapidly throughout the state.

According to complaints, some Medicare recipients are being enrolled in these plans without fully understanding their terms, and in some cases, without even knowing they have been enrolled. All Medicare recipients and their family members are urged to be vigilant when selecting a Medicare Part C or Part D plan, and if an agent uses abusive sales practices, to contact the MID immediately.

"My office is receiving calls daily from seniors who have been victims. It is unacceptable to have these individuals preying on some of the most vulnerable citizens in the state. I want people to know that the exploitation of our senior citizens by these unscrupulous sales people and the companies that condone such exploitation will not be tolerated. Every effort will be made to stop those practices and protect our seniors," said Senator Burton.

Although the Medicare Program is under federal regulation, Commissioner Dale is concerned with reports that some agents are continuing to use a variety of confusing and deceptive sales practices to sell Medicare- related Part C and D Plans.

"From the calls we continue to receive we're learning that the problem we first recognized in the northern part of the state is now spreading further and further south. We are finding that some individuals preying on our state's seniors and senior oriented communities are using tactics that are confusing and downright deceptive and it must be stopped. Abusive sales practices will not be tolerated by this department. Anyone engaging in such practices will be subject to severe regulatory action by the MID, such as suspension or revocation of a license and/or a fine," said Commissioner Dale.

The Commissioner is quick to point out that these plans could be beneficial to some people and not all agents are engaging in these deceptive practices. However, he did note that the MID, working with state and local law enforcement, has successfully revoked the license of one agent and have a number of others under investigation.

Companies offering Medicare plans are subject, under federal regulation, to strict marketing guidelines for such plans, which include prior approval of marketing material. MID will consider any deviation from or violation of federal Medicare Marketing Guidelines to also be a violation of the Mississippi Insurance Code.

Among the abusive Medicare Part C and D practices being reported are door-to-door solicitations. Conducting a door-to-door solicitation or outreach prior to being invited by a Medicare recipient is prohibited. If someone comes to your door without you having invited them, do not let them into your home. Also, do not give that person any information about yourself or let him or her see any of your personal documents. Especially do not sign anything for that person.

"The Mississippi Insurance Counseling and Assistance Program (MICAP) of MDHS's Division of Aging and Adult Services, is designed to answer seniors' questions about health insurance. Our volunteers are trained to answer questions, compare policies, organize paperwork, help with claims and filing appeals on Medicare, Medicaid, supplemental insurance and other coverage. I would strongly encourage any senior with questions to contact one of the 10 Area Agencies on Aging offices throughout the state," said Colonel Don Taylor, Executive Director of MDHS.

Anyone who suspects they have been the victim of abusive Medicare Insurance sales practices is urged to contact MID as soon as possible at 1-800-562-2957. For any other questions regarding Medicare Part C and D policies, they should contact MDHS at 1-800-948-3090.

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SCENARIOS USED IN ABUSIVE MEDICARE PART C AND D SALES PRACTICES

A number of scenarios are currently being reported to the Mississippi Insurance Department (MID) as being in use by these agents. Commissioner George Dale urges all Medicare recipients that if you find yourself in a similar scenario, such as the ones described below, a red flag should go up and you should contact the MID immediately. Scenarios that are proving to be of particular favorites to the agents using abusive sales practices include:

1). The agent will actually claim to be from Medicare. In many instances, the agent will present a red, white, and blue card that looks like a Medicare recipient's card.

2). The agent will have the Medicare recipient fill out a "request for more information," form, when in fact the "request" form is actually an enrollment form for whatever Part C or D plan the agent is selling.

3). The agent will ask the Medicare recipient to sign a form "just to show [my] boss" the agent contacted the recipient.

4). The agent assures the Medicare recipient that enrollment will not affect his/her Medicare coverage. While this may be true of some portion of Medicare plans, MID is finding that the recipient no longer receives benefits under traditional Medicare Part A and B policies. Often the recipient discovers this fact when a health care provider informs them that Medicare has declined to pay a charge.

5). The agent tells the Medicare recipient that enrollment in the plan he or she is selling will not cost anything. Nothing is free. The agent receives a commission from the sale and premiums will be collected from policyholders.

6). In a particularly serious case, MID found that several recipients had no knowledge of being enrolled in a Medicare Part C plan, and had never had any contact at all with the agent responsible for enrolling them. It is believed that the recipient's personal information was obtained fraudulently, and was used on the plan enrollment forms.

Exhibit 10

DEPARTMENT OF INSURANCE
STATE OF NORTH DAKOTA

Jim Poolman
Commissioner of Insurance

May 24, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Norwalk:

We are now into the second year of the implementation of the Medicare Modernization Act (MMA) of 2003, and there continue to be significant problems causing us grave concern.

As part of the MMA of 2003, the regulation of Medicare Advantage plans (MAP) and the companies marketing them, was given to CMS. This includes the review and approval of companies; the products; the marketing material; changes in availability, premiums, and formularies in the plans; and agent behavior.

The absence of state regulation is a fundamental flaw in the management of these plans. The following examples point out a few essential areas in which the lack of state regulation has resulted in poor consumer protection.

In North Dakota, I have been made aware of a number of significant abuses in the marketing and sale of Medicare Advantage plans. Specific examples include, but are not limited to:

- Pressuring a policyholder to switch their coverage to a MAP without adequately explaining the implications of the change on the benefits provided, premiums payable, or access to services.
- Telling policyholders that they *must* change, and that they must make the decision immediately.
- Seniors signing a registration form at a meeting, and finding themselves enrolled in a MAP.
- Telling Medicare beneficiaries MAPs are free, and failing to adequately explain the total out-of-pocket costs.
- Beneficiaries being called to "review their coverage", and discover later they have been enrolled in a MAP.
- Agents calling seniors and saying, *"I'm from Medicare and you need to change your policy."*
- Seniors being sent a card that states, *"Medicare Supplement insurers have increased their rates up to 30% on Medicare Supplement coverage. Based on this, there is now available a plan to supplement your Medicare coverage…Send in this card to see if you qualify for premium savings from $200 - $500 per year."*
- Telling a beneficiary *"Medicare Advantage is the same as Medicare"* or *"It is a supplement to Medicare."*
- Telling a beneficiary that they *must* remain in a MAP for one year.
- Switching Medicare Advantage policyholders from one plan to another (within the same company) without notifying the policyholder.

600 EAST BOULEVARD DEPT 401 • BISMARCK, ND 58505-0320 • (701) 328-2440 • FAX (701) 328-4880
Consumer Hotline: 1-800-247-0560 • Relay North Dakota 1-800-366-6888 (TTY)
insuranc@state.nd.us

Marketing Medicare Advantage plans through private insurance companies has resulted in a large number of confusing choices for the senior consumer. In North Dakota, there are more than 30 Medicare Advantage plans available for sale to Medicare beneficiaries. Companies can change the number and types of plans they market; and can change the benefits, premiums and formularies for the plans they continue to offer. While policyholders are supposed to receive an annual notice of any changes, this is not always happening. In addition, medical providers choose which plans they will accept or not accept, and this can change at any time. All of these changes can be made without the regulatory supervision that is currently in place *in the states* for all other types of health insurance. The combined impact on North Dakota seniors of the complexity and the companies' ability to change is a level of consumer confusion where some now even wonder if they have any insurance at all.

One of the more disturbing developments is the deterioration of assistance provided by CMS to our Senior Health Insurance Counseling (SHIC) staff. Initially, the regional office of CMS was a resource to assist these counselors with questions that our staff had already researched. Having access to CMS was effective in resolving these types of cases. That support has diminished significantly, with CMS now taking the position that they will help only as a last resort, after repeated attempts to work with the companies that are involved. The result of this change in position, for North Dakota seniors, is an even longer time frame to get an issue resolved. Our staff is repeatedly transferred back and forth among individuals at companies, CMS and the Social Security Administration, repeating the issues over and over...if we are even able to make contact in the first place. This lack of service to the people of North Dakota is unacceptable. North Dakotans deserve better! The support from CMS has deteriorated to the point where we even had a CMS staff person hang up the phone on one of my staff while she was assisting a senior in her office.

Because of funds you provide through the Senior Health Insurance Program grants, our Senior Health Insurance Counseling staff and many others across the state, including scores of dedicated volunteers, continue to work very hard to assist seniors with these difficult and complex choices. Our seniors do not need, nor do they deserve the problems they are currently experiencing regarding their Medicare coverage.

I need your help. The additional benefits introduced by the Medicare Modernization Act of 2003 can help many beneficiaries in North Dakota and across the country. However, we need changes to:

- Streamline administration
- Correct marketing abuses
- Eliminate errors, and
- Return regulation of these health insurance plans to the states.

I look forward to working with you to implement these changes to benefit that valuable segment of our population...our seniors.

Sincerely,

Jim Poolman
Insurance Commissioner

JP:ls

cc: The Honorable Byron Dorgan
The Honorable Kent Conrad
The Honorable Earl Pomeroy

Exhibit 11

STATE OF COLORADO

DEPARTMENT OF REGULATORY AGENCIES
D. Rico Munn
Executive Director

DIVISION OF INSURANCE
Marcy Morrison
Commissioner of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Bill Ritter, Jr.
Governor

May 11, 2007

The Honorable Herb Kohl
Chairman
Special Committee on Aging
United State Senate
Washington, DC 20510

Dear Chairman Kohl:

My office was contacted by your staff to identify issues in the marketplace of Medicare Advantage plans. Medicare Advantage plans are quite popular in Colorado, with approximately 30% of our Medicare beneficiaries selecting such plans. There are, however, some significant issues and challenges that Medicare Advantage plans have presented for Colorado consumers.

Among the particular issues that consumers have brought to our Senior Health Insurance Program (SHIP) are:

- Colorado has over a dozen Medicare Advantage providers with over 80 plan options. This does not include the Medicare "cost" plans. Much of our Medicare-eligible population has not experienced, and do not understand, aspects of managed care. This is particularly true where they have participated in original Medicare and have established provider relationships.

  The Medicare Advantage products, particularly the private fee-for-service (PFFS) plans, are new and not well understood by insurance producers, consumers or providers. This has caused confusion with consumers being sold plans inappropriate for them, and then they are not able to "unwind" the enrollment.

  It is further complicated by delays and technical difficulties of various computer systems (including the Centers for Medicare and Medicaid Services (CMS), the Social Security Administration (SSA), and the Medicare Advantage plans) "talking" to one another to process enrollments, disenrollments, payment issues, etc.

- Consumers have contacted us reporting that Medicare Advantage sales agents, particularly for the PFFS plans, are telling seniors that purchasing a Medicare Advantage plan will not affect how or from whom they get care. We have found that some producers do not understand the product they are selling, and the Medicare Advantage companies' producer training and monitoring is lacking.

Consumers are not being informed that their physician may not participate in a Medicare Advantage PFFS plan. In some instances, consumers have not been told that a Medicare Advantage plan replaces original Medicare and takes the place of their Medicare supplement (Medigap) insurance. Some consumers that did not drop their Medigap policy when enrolling in a Medicare Advantage plan have been forced to pay premiums for both the Medicare Advantage and the Medigap until the annual election period allowed them to drop the Medicare Advantage plan.

Moreover, consumers who find that a Medicare Advantage plan is not suitable for them are locked into that plan, sometimes for a full year, before they can change back to original Medicare or another plan. Some consumers who dropped their Medigap policy when they enrolled into a Medicare Advantage plan are not able to get back into their Medicare supplement when they leave the Medicare Advantage plan.

- One of the larger hospitals in a rural part of the state announced that it was withdrawing from the HMO network of a Medicare Advantage carrier. The hospital cited problems with pre-authorizations of care and failure of the carrier to pay claims in a timely manner. Consumers contacted our office because they were unable to find physicians, primary care or specialists, to treat them within the HMO network and the geographic area.

  We are also receiving reports that physicians participating in the original Medicare program will not take Medicare Advantage PFFS patients, and are making the decision on a patient by patient basis. Meanwhile, consumers are reporting to us that insurance producers have told them they could see any Medicare provider under a Medicare Advantage PFFS plan.

Thank you for the opportunity to describe some of the problems we are seeing in the marketplace of Medicare Advantage plans for Colorado consumers. If we can provide additional information or insight for you, please do not hesitate to contact me.

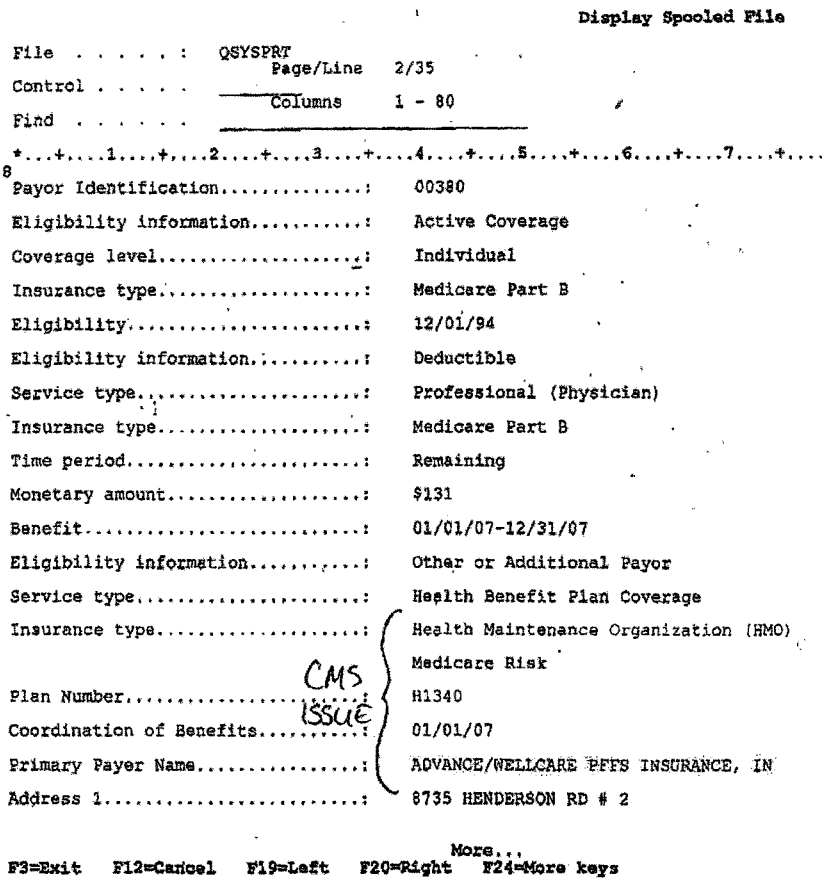
Sincerely,

Marcy Morrison

Marcy Morrison

Cc: The Honorable Wayne Allard
The Honorable Ken Salazar

Exhibit 12



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                                                          Display Spooled File

File . . . . . :   QSYSPRT
                        Page/Line   2/35
Control . . . . .
                        Columns     1 - 80
Find . . . . . .

*...+....1....+....2....+....3....+....4....+....5....+....6....+....7....+....
8
Payor Identification.............:   00380
Eligibility information..........:   Active Coverage
Coverage level...................:   Individual
Insurance type...................:   Medicare Part B
Eligibility......................:   12/01/94
Eligibility information..........:   Deductible
Service type.....................:   Professional (Physician)
Insurance type...................:   Medicare Part B
Time period......................:   Remaining
Monetary amount..................:   $131
Benefit..........................:   01/01/07-12/31/07
Eligibility information..........:   Other or Additional Payor
Service type.....................:   Health Benefit Plan Coverage
Insurance type...................:   Health Maintenance Organization (HMO)
                                      Medicare Risk
                          CMS
Plan Number......................:   H1340
Coordination of Benefits.....ISSUE:   01/01/07
Primary Payer Name...............:   ADVANCE/WELLCARE PFFS INSURANCE, IN
Address 1........................:   8735 HENDERSON RD # 2

                                                                    More...
F3=Exit    F12=Cancel    F19=Left    F20=Right    F24=More keys
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* Script Print from CMS Common Working File

Exhibit 13

There are two ways to save on dental, vision and hearing.

When you choose the WellCare Duet Plan, you save on dental, vision and hearing services. Best of all, you can save even more when you choose "great rate" preferred providers.

Our regular benefits are great.

- 20% co-insurance on Medicare-covered services
- 50% co-insurance on all other dental, vision or hearing services—that's significant savings on things like crowns, glasses, contact lenses, hearing aids and more
- The maximum benefit each year is:
  - $500 for dental services
  - $140–$260 for vision services (depending on your lens prescription)
  - $1,000 for up to two hearing aids every three years

Our "great rate" benefits are even better—check out the chart inside.

We've negotiated with doctors, dentists, optometrists and other medical providers nationwide to bring you the extra levels of coverage listed on the chart inside. For a full list of preferred providers who offer these savings, call or visit our Web site. You'll find trusted names like Pearle Vision, For Eyes, Sears Optical, Target Optical and Eye Care Centers of America, just to name a few.

WellCare is a Health plan with a Medicare contract. You must continue to pay your Part B premium if not otherwise paid for under Medicaid or by another third party. To become a member of WellCare Private Fee-for-Service (PFFS), you must have both Medicare Part A and B and live in an area where the plan is offered. As a member of WellCare PFFS, you can go to any Medicare doctor, specialist or hospital that accepts Medicare payment and accepts the terms, conditions and payment rate for WellCare PFFS. Benefits may vary by county. There are limitations on benefits. Please call WellCare for more details.

Benefits are available in counties of these states:

Alabama, Arkansas, D.C., Hawaii, Indiana, Kansas, Maryland, Mississippi, Nevada, Utah

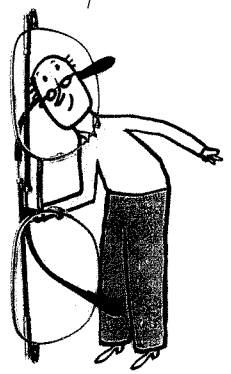
1-866-238-9898
TTY/TDD users 1-866-239-6265
Mon–Sun, 8am to 2am EST
www.wellcarepffs.com

WellCare®
Get more from your Medicare℠

WELLCARE DUET PLAN

Extra Benefits

"Get all the extras without paying any extra!"



WellCare®
Get more from your Medicare℠

M0012 NA01995_FFS BRO_ENG (09/20/2006)

Get more from your Medicare with the WellCare Duet Plan.

You'll get great dental, vision and hearing coverage—and other healthy extras—with the WellCare Duet Plan. And best of all, it will be easy to find doctors and health professionals to give you care.

Extra #1 Dental, vision and hearing from your choice of doctors.

Good vision and hearing help you enjoy life to the fullest—and stay safer, too. Healthy teeth are just as critical. In fact, according to the American Dental Association, poor dental health is linked to heart disease, stroke and diabetes. So WellCare's extra coverage can really boost your good health.

Extra #2 Get $20 monthly in Personal Care Extras.

The Personal Care Extras Program is like having a drug store come to your door! Get up to $20 monthly in over-the-counter products delivered right to your home—everything from Vitamin C to toothbrushes and aspirin!

Extra #3 Preventive Care

You may have some preventive care now, but are you getting your mammograms, flu shots and prostate screenings for no extra cost? With WellCare, you can!

WellCare Duet Plan "Great Rate" Benefits.

Remember, you get this extra coverage with our "great rate" preferred providers. Call us, or visit our Web site, to find providers in your area.

BENEFIT	BENEFIT SUMMARY	PREFERRED CO-PAY
Dental **(Up to $1,000 in covered services annually)**	Preventive/Diagnostic Services • Exams • Cleanings • X-rays	$0
	Basic Services • Fillings • Extractions • Emergency Treatment	$10
	Major Services • Crowns • Root Canals • Gingivitis Treatment	$20
Vision **(Up to $260 on 1 pair of glasses or up to $100 on 1 pair of contacts annually)**	• Vision Exam • Glasses (includes UV and basic anti-reflective coating and progressive lenses) • Contacts	$0 $10 $10
Hearing **(Up to $1,000 on 2 hearing aids every 3 years)**	• Hearing Exam • Hearing Aid (plus 3-year warranty on any private label hearing aid)	$0 $10

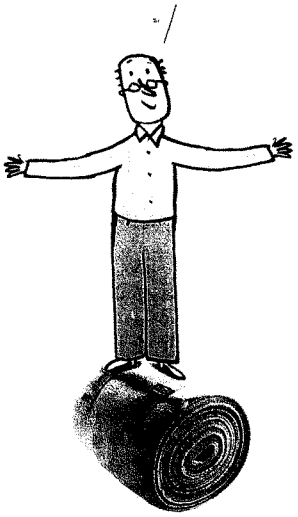
Exhibit 14

WellCare is a Health plan with a Medicare contract. Benefits and limitations may vary by plan and by county. Please call WellCare for more details.

WELLCARE DUET PLAN

Personal Care Extras

"Need a few things from the drug store? It's our treat!"



1-866-238-9898
TTY/TDD users 1-866-239-6265
Mon–Sun, 8am to 2am EST
www.wellcarepffs.com

WellCare®
Get more from your Medicare℠

WellCare®
Get more from your Medicare℠

M0012_NA01826_FFS_OTC_ENG

Get $20 Monthly In Personal Care Extras

Personal Care Items are medications and other healthcare items that do not require a prescription, which you can have delivered to your home every month.

ITEM	BRAND DESCRIPTION	GENERIC COMPARABLE	PRICE
ANALGESICS			
1	Advil Tablets	Ibuprofen 200mg FC Tablets	5.00
2	Aleve Caplets	Naproxen Sodium 220mg Caplets	7.00
3	Bayer Aspirin	Aspirin 325mg Tablets	3.00
4	Bayer EC Aspirin (Adult Regimen)	Aspirin EC 81mg Tablets	4.00
5	Ecotrin Maximum Strength Tablets	EC Aspirin Maximum Strength Tablets	6.00
6	Tylenol Extra Strength Caplets	Acetaminophen Extra Strength Caplets	5.00
7	Ben Gay	Muscle Rub	5.00
ANTACIDS			
10	Mylanta Gas 80mg	Anti-Gas 80mg	5.00
11	Tums Tablets	Antacid Chewable Tablets	4.00
12	Zantac Tablets	Ranitidine HCL 75mg Tablets	8.00
ANTI-DIARRHEALS			
13	Imodium Caplets	Anti-Diarrheal 2mg Caplets	4.00
14	Pepto-Bismol Liquid	Pink Bismuth Liquid	4.00
ANTI-FUNGALS			
15	Gyne-Lotrimin Cream	Clotrimazole Vaginal 1% Cream–1 Application	8.00
16	Tinactin Cream	Tolnaftate 1% Cream	5.00
ANTI-HEMORRHOIDALS			
17	Anusol Ointment	Anusert HC-1 Ointment	6.00
18	Preparation H Ointment	Prompt Relief Hemorrhoid Ointment	7.00
EYE CARE			
36	Visine Drops	Sterile Eye Drops Irritation Relief	3.00
FIRST AID CREAMS, OINTMENTS AND ANTISEPTICS			
39	Calamine Lotion	Calamine Lotion	3.00
40	Cortaid Cream	Hydrocortisone 1% Maximum Strength Cream	4.00
42	Neosporin Ointment	Triple Antibiotic Ointment	5.00

ITEM	BRAND DESCRIPTION	GENERIC COMPARABLE	PRICE
COUGH/COLD			
28	Benadryl Tablets	Diphenhydramine 25mg Caplets	4.00
29	Benadryl Elixir	Diphenhydramine Liquid Alcohol Free	4.00
30	Chloraseptic	Throat Lozenges--Cherry	3.00
31	Vicks VapoRub	Medicated Chest Rub	4.00
32	Robitussin Syrup	Guiatuss Syrup	4.00
35	Afrin Nasal Spray	Nasal Decongestant Spray	5.00
66	Claritin	Loratadine 10mg Tablets	7.00
FIRST AID SUPPLIES			
43	Cotton Balls	Cotton Balls	3.00
44	Ace Bandage	Athletic Bandage	5.00
45	Adhesive Tape	Adhesive Tape 1" x 5 Yards	3.00
46	Band-Aids	Band-Aids Assorted	3.00
47	Butterfly Closures	Butterfly Closures	3.00
48	Ear Wax Removal	Ear Wax Removal	4.00
49	J&J Gauze	Stretch Gauze Bandage 2" x 5 Yards	3.00
50	Cotton Swabs	Cotton Swabs	4.00
51	Oral Thermometer	Oral Thermometer	4.00
52	Alcohol Swabs	Alcohol Swabs	3.00
75	Ice Bag 9"	Ice Bag	8.00

– List continued on back

How to order personal care extras

Each month you simply review the list above and identify the items you want. To place your order, call WellCare toll free at 1-866-238-9898 (TTY/TDD 1-866-239-6265) Mon--Sun, 8am to 2am EST. Your order will be processed and shipped directly to you within 10 business days. YOU DO NOT NEED TO SEND THIS FORM.

Any unused portion of your monthly allowance does not carry over to the next month. Please call us toll free at 1-866-238-9898 (TTY/TDD 1-866-239-6265) Mon--Sun, 8am to 2am EST for more information.

ITEM	BRAND DESCRIPTION	GENERIC COMPARABLE	PRICE
LAXATIVES			
53	Colace Softgels	Dos 100mg SG Caplets	6.00
54	Dulcolax Suppositories	Reliable Gentle Laxative Suppositories	4.00
55	Dulcolax Tablets	Reliable Gentle Laxative Tablets	4.00
56	Glycerin Suppositories Children	Glycerin Child's Suppositories	3.00
PEDICULICIDES			
58	Rid Extra Strength Shampoo	Lice Treatment Maximum Strength Shampoo	7.00
VITAMINS & MINERALS			
59	B-Complex w/B-12 Tablets	B-Complex w/B-12 Tablets	6.00
60	Caltrate 600 Tablets	Calcarb 600 Tablets	5.00
61	Centrum Tablets	Certagen Tablets	7.00
62	Flintstones	Fruity Chewable Tablets (NF)	6.00
63	Stuart Prenatal Tablets	Prenatal-S Tablets	6.00
64	Vitamin C Tablets	C Chewable 500mg Tablets	4.00
65	Vitamin E Softgels	E DL Alpha 400 IU SG Caplets	5.00
67	Vitamin A 10,000 IU	Vitamin A 10,000 IU	4.00
HERBALS			
68	CoQ-10	CoQ-10	10.00
69	Ginkgo Biloba	Ginkgo Biloba	7.00
70	Glucosamine/Chondroitin	Glucosamine/Chondroitin	10.00
71	Saw Palmetto	Saw Palmetto	8.00
FAMILY PLANNING			
72	Condoms	Condoms	3.00
MISC ITEMS			
73	Pill Box	Pill Box	2.00
74	Toothbrush	Toothbrush	2.00
76	Toothpaste	Toothpaste	4.00
77	Waxed Dental Floss	Waxed Dental Floss	4.00
78	Anbesol	Anbesol	8.00

Items, rates and quantities subject to change depending upon availability.
Call WellCare to obtain the most current list.
Brand items may be supplied as generic equivalents.

Exhibit 15

MEDICARE MARKETING GUIDELINES FOR:

Medicare Advantage Plans (MAs)

Medicare Advantage Prescription Drug Plans (MA-PDs)

Prescription Drug Plans (PDPs)

1876 Cost Plans

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Published: August 15, 2005
Revised: November 1, 2005
2nd Revision: July 25, 2006

6. MARKETING MATERIAL DEVELOPMENT

Advertising (A)

Guidelines for Advertising Materials (A)

Organizations are prohibited from comparing their organization/plan to another organization/plan by name.

Advertising materials are defined as materials that are primarily intended to attract or appeal to ***current and*** potential enrollees. They are intended to be viewed quickly by a potential enrollee and are short in length/duration. Specifically, these advertisements are:

- Television ads;
- Radio ads;
- Banner/banner-like ads;
- Outdoor advertising;
- Print ads (newspaper, magazine, flyers); and
- Internet advertising
- Direct Mail that does not include enrollment forms (postcards, self mailers, home delivery coupons, and reply cards). ***Whether direct mail is available under the File & Use program is not based on how the letter is mailed (e.g., first or third class mail) or whether the envelope is addressed to a specific individual. Rather, the determination is based on the characteristics of the direct mail piece itself. Direct mail will not be available for File & Use if it possesses one or more of the following characteristics: (1) pertain to rules or benefits of existing coverage or any other type of coverage offered, (2) is greater than two pages of content, and/ or (3) has a salutation to a specific individual.***

Advertising Material Language Requirements (A)

Disclaimer (A)

1. For all advertising materials except banner ads, banner-like ads and outdoor advertising (ODA), (i.e., television and radio ads, direct mail, print ads and internet advertising), organizations must include the statement that the organization contracts with the Federal government. For banner ads, banner-like ads, and ODA, organizations are not required to include any such disclaimers or disclosures on the ads.

2. In addition to the disclaimer required in # 1 above, flyers and invitations to sales presentations that are used to invite beneficiaries to attend a group session with the intent of enrolling those individuals attending must also include the following two statements:

   - "A sales representative will be present with information and applications."
   - "For accommodation of persons with special needs at sales meetings, call <insert phone and TTY/TDD numbers>."

3. Benefit Changes in Marketing Materials (A)

Effective October 1, 2006, organizations must include a statement in their current contracting year marketing materials when advertising a current year benefit, formulary, pharmacy network, premium, or co-payment that may or will change in the upcoming contracting year or whenever it accepts an election for a revised effective date in the current contracting year.

The following model disclaimer may be used by organizations with benefit changes in the upcoming contracting year.

<[Insert any or all of the following, whichever is appropriate: Benefits, formulary, pharmacy, network premium and/or co-payments/co-insurance may change on January 1, <XXXX>. Please contact [insert organization name] for details.]

Additional regional office review and approval is not required if this disclaimer is used verbatim, but is required if it is modified.

Claim Forms and Paperwork (A)

If a ***piece of*** material addresses claim forms or paperwork, organizations are allowed to say:

- Virtually no paperwork
- Hardly any paperwork.

Organizations cannot say:

- No paperwork
- No claims or paperwork / complicated paperwork
- No claim forms

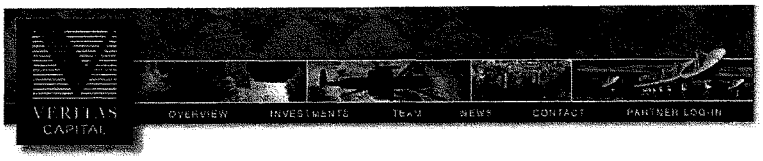
The Medicare Advantage Organizations MAY:

1. Conduct outreach for only a portion of its plan membership. Selection of the focus population may be based upon demographic data and/or may focus on a specific geographic area. However, the organizations must provide outreach to all individuals within those pre-identified population segments. Additionally, if the organization receives an inquiry from a plan member not previously identified in the targeted group, it must provide assistance to that member as if he or she had been included ***in the initial group***.
2. Provide hands-on assistance to the member in completing all necessary applications for financial assistance including submitting the paperwork to the appropriate State office. This assistance can be in the member's home only if the member requests such a visit.
3. Use the "Authorization to Represent" ***form*** limited to the specific purposes of completing and submitting paperwork on behalf of the member, discussing the member's case with case workers, and gather***ing*** information from and on behalf of the plan member. The "Authorization to Represent" form must specify that the authorization is limited to securing benefits under "the Medicare Savings Program" or "the Medicaid Program" and cannot extend to other programs unless agreed upon and noted by the member. "Authorization to Represent" shall not give the outreach specialist the authority to sign any documents on behalf of the member, make any enrollment decisions for the member, ***or file a grievance or request an initial decision or appeal on a member's behalf***.
4. Follow-up with members who do not respond to the initial member letter. This follow-up may be in the form of a second and/or third letter or telephone calls. If the member does not respond to the third effort, the MA organization refrain from contacting the member for at least six months following the last outreach attempt.
5. Provide assistance to members reapplying for financial benefits if and when required to do so by the State Agency.
6. Subcontract all outreach efforts to another entity or entities. In such cases, while the MA organization retains all responsibility for meeting CMS's requirements, it must still submit all documentation to the ***appropriate*** CMS ***Regional Office*** for approval including contracts held by the subcontractor with all entities related to the program. The MA organization must also coordinate changes and revisions between the subcontractor and CMS.

The Medicare Advantage Organization Shall NOT:

1. Conduct door-to-door solicitation or outreach prior to receiving an invitation from the member to provide assistance in his or her home.
2. Share any member information, financial or otherwise, with any entity not directly involved in the outreach process.
3. Store or use member financial information for any purpose other than the initial screening eligibility, the submission and follow-up of an application for benefits, for recertification purposes, and as required by law.

Exhibit 16



NEWS

Veritas Acquires Pearson Government Solutions

Government Outsourcing Firm Renamed Vangent

New York (February 15, 2007) – Veritas Capital Partners, a leading private equity firm focused on companies providing outsourcing services to government, today announced it has completed the acquisition of Arlington, VA-based Pearson Government Solutions (PGS) from Pearson plc, the international media and education company. Under terms of the transaction, Veritas Capital paid $600 million of consideration and Pearson plc is retaining a minority interest in PGS, which has been renamed Vangent.

Vangent's more than 5,500 employees serve national and local governments, education institutions and corporations in the U.S. and around the world. The company designs, builds and operates solutions to provide information, benefits and services to its clients' customers. Clients include the U.S. Departments of Defense, Education, Health, Justice and Labor, and the London, England, Borough of Southwark.

"Vangent comes to the Veritas Capital portfolio of companies with a strong record of client retention and a well-deserved reputation for delivering high-quality services and solutions to government and commercial customers," said Robert McKeon, Veritas Capital's founder and president. "Together with Vangent's strong management team, we are committed to expanding its geographic presence as well as its client base in vertical, high-potential markets such as healthcare and business process outsourcing."

Vangent will maintain its headquarters in Arlington, Virginia.

About Vangent
Vangent has 5,500 employees working across the U.S. and in the U.K., Canada, Mexico, Argentina and Venezuela. Vangent is ranked #36 on Washington Technology's annual "Top 100" list of federal prime contractors, #38 on Government Executive's list of Top 200 Government Contractors, and #14 on Government Executive's list of Top 100 Civilian Agency Contractors.

About Veritas Capital
Veritas Capital is a private equity investment firm headquartered in New York. Founded in 1992 by Robert B. McKeon, Veritas invests primarily in companies specializing in outsourcing services to the government, primarily in the areas of defense and aerospace, security and infrastructure. Veritas' portfolio of companies includes, or has included, DynCorp International, Integrated Defense Technologies, Athena Innovative Solutions, Vertex Aerospace, McNeil Technologies, The Wornick Company, and TRAK Communications, among others. Veritas is dedicated to providing the highest level of critical services and equipment to the defense and federal sectors around the world. For more information, please visit http://www.veritascapital.com.

Contacts:

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Veritas Capital Partners
Tel: 212-415-6701

Lawrence Budgar
Burson-Marsteller
Tel: 212-614-4140
Lawrence.budgar@bm.com

back to news

Pearson Government Solutions wins $440 Million contract
16 November 2006

With centers for Medicare and Medicaid services

CMS Expands Work with Pearson as Sole Provider of 1-800-MEDICARE Help Line;

Pearson Poised to Significantly Expand Health Business

ARLINGTON, VA. - Pearson Government Solutions was awarded a $440 million contract by the Centers for Medicare and Medicaid Services (CMS) to manage the Beneficiary Contact Center program. The contract expands and continues Pearson's work with CMS for an additional two and a half years in support of the 1-800-MEDICARE Help Line, considered one of the largest citizen contact management programs in the Federal government. Pearson Government Solutions has successfully managed the program since 2002.

"We are extremely proud that the Centers for Medicare and Medicaid Services continue to place their trust and confidence in Pearson for this important program by allowing us to be the sole provider of the Beneficiary Contact Center program," stated Mac Curtis, President and CEO, Pearson Government Solutions. "We look forward to continuing our partnership with CMS and helping the agency meet its mission of providing complete, accurate, and consistent answers to over 43 million Medicare beneficiaries who rely on 1-800-MEDICARE for critical information about their health."

Under the new contract, Pearson Government Solutions will manage all 1-800-MEDICARE calls. With over 20 millions calls annually, the Help Line is accessible 24 hours a day, 7 days a week in English or Spanish in all 50 states, Washington, D.C., Puerto Rico, Guam, American Samoa and Northern Mariana Islands. Medicare beneficiaries call the Help Line to receive general information and printed materials on Medicare and Medicare health plan options and the new Medicare Prescription Drug Program known as Part D. In addition, Pearson will manage Medicare claims calls and written correspondence.

This award represents the first task order under the Contact Center Operations Indefinite Delivery-Indefinite Quantity (IDIQ) valued at $9 Billion over 10 years. In addition, Pearson also won the Contact Center Systems and Support IDIQ valued at $1 Billion over 10 years. The two contract vehicles represent a combined total of $10 Billion in potential new health business opportunities for Pearson Government Solutions over the next decade.

"Pearson has done well working with CMS over the past four years implementing the Prescription Drug Discount Card and Prescription Drug Coverage under the Medicare Modernization Act. CMS has greatly benefited from working with a capable, flexible partner during times of significant change. We are confident they will continue to deliver world class customer assistance to Medicare beneficiaries," stated Mary Agnes Laureno, Director, Beneficiary Information Services Group, Center for Beneficiary Choices at the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

Also in this release

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Pearson Government Solutions has more than 20 years experience in managing award-winning, customer interaction centers for federal agencies in the U.S. and internationally. Pearson has four major domestic contact centers and over 3,000 information specialists who serve as the voice of the federal government including 1-800-4-FED-AID for the U.S. Department of Education Student Financial Aid program, 1-800-CDC-INFO for the Centers for Disease Control and Prevention and 1-800-MEDICARE for the Departments of Health and Human Services, Centers for Medicare and Medicaid Services.

About Pearson Government Solutions
With over 5,500 employees worldwide, Pearson Government Solutions, Arlington, Va., serves the U.S. federal, state and local and international governments; higher education institutions and student financial aid entities. The company designs, builds, and operates solutions that optimize the performance of public sector entities in delivering information, benefits, and services to their constituents. Clients include the Centers for Medicare and Medicaid Services, the U.S. Departments of Education, Health and Human Services, Homeland Security, Justice, Labor, and Veterans Affairs; the Equal Employment Opportunity Commission and the U.S. Office of Personnel Management.

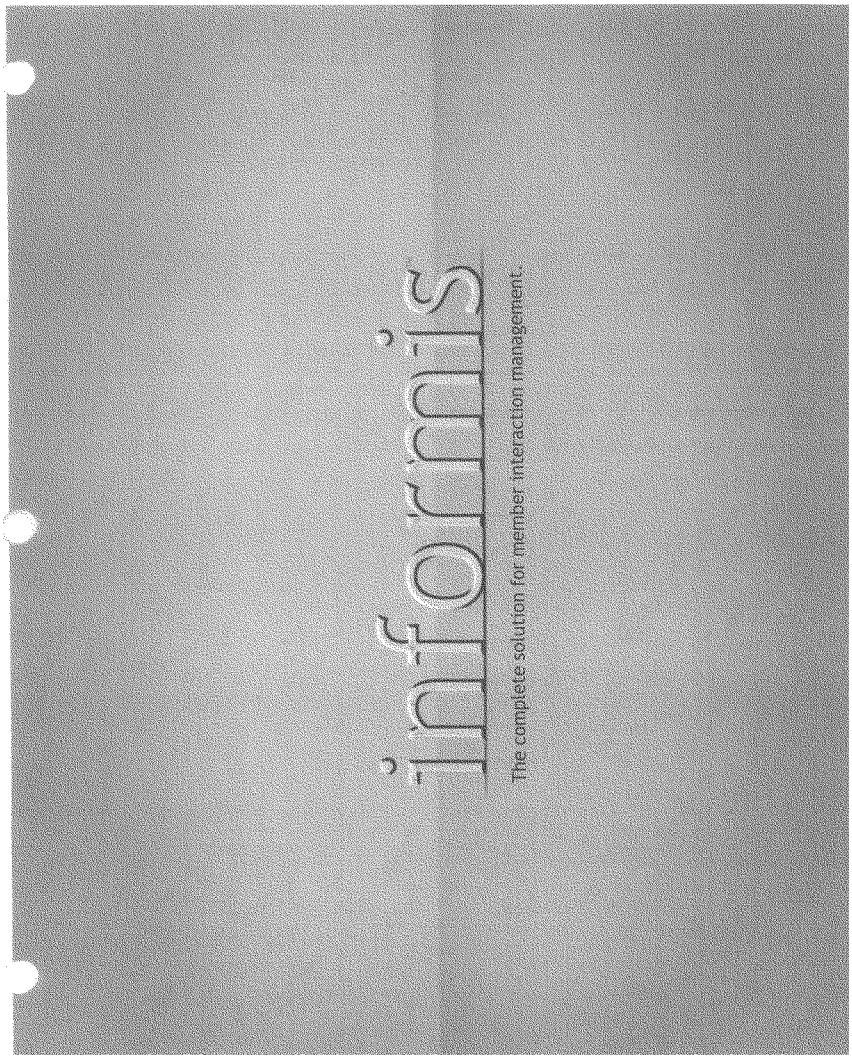
Pearson Government Solutions is a business of Pearson, the international publishing, education and professional services company, including the Financial Times Group, and the Penguin Group.

Pearson Government Solutions is ranked #36 on Washington Technology's annual "Top 100" list of federal prime contractors, #38 on Government Executive's list of Top 200 Government Contractors, and #14 on Government Executive's list of Top 100 Civilian Agency Contractors.

Contact: Eileen Rivera

(703) 284-5674

Exhibit 17


informis
The complete solution for member interaction management.

The Medicare landscape is changing—new programs, new guidelines and more members. Get consistent answers with informis.

Your member management infrastructure must be robust and adaptable in order to capitalize.

The landscape of the Medicare market is undoubtedly changing. New programs, such as Part D, have given seniors more choices than ever before. Based on the belief that the new options are too confusing for seniors, the government wants to cull the number of health insurers. Add to the landscape complexity the torrent of baby boomers poised to flood into the system—and your need for remarkable member management increases exponentially.

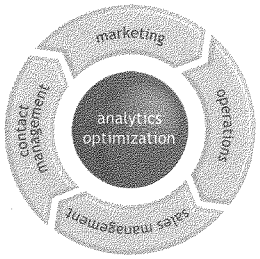
Combine these factors with your daily dilemma of escalating costs and meeting enrollment goals, and an imperative need emerges. You need a simple yet robust solution that delivers accurate enrollment projections, proper staffing, sales force support, CMS compliance and truly unsurpassed member service.

The future landscape of Medicare will be as slippery as it is jagged. Only insurers with a vision and a rock-solid, integrated business approach will thrive.

Introducing informis—the industry's only complete solution for member interaction management.

In these changing times, informis *allows you to overcome obstacles and outmaneuver competitors.*

Exceptional member experiences create loyalty—ready to be parlayed into sales potential.



The only complete member management solution available, informis combines extensive knowledge of CMS' national Medicare program, a unique member service model and performance-based pricing accountability. By selecting informis, you can be assured that your members will receive a customer service experience that is unsurpassed in the industry—from sales to enrollment to retention—resulting in a distinct competitive advantage. **Simple, but profound, informis' turnkey approach can:**

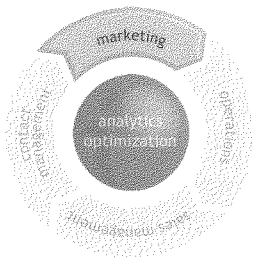
- Improve the service your members receive
- Leverage that exceptional service into loyalty
- Boost your enrollment rate and significantly reduce disenrollment
- Accelerate your sales process
- Reduce your operating costs
- Assure CMS compliance
- Integrate all of your services into a single, fully accountable source
- Eliminate multi-vendor finger-pointing and disputes

At the heart of the informis member interaction management solution is a framework of analytics and measurement, continually extracting actionable intelligence to fuel system optimization.

Consisting of four core components, informis synergistically works to support your brand and establish a sustainable competitive advantage: marketing, contact management, sales management and operations.

With masterful—rather than mass—marketing, inform*is*
creates meaningful dialogues with your members and prospects.

Complement your sales force with perfectly orchestrated, metrics-based marketing fueled by sophisticated forecasting.



Challenge:

Every health plan executive faces the formidable tasks of forecasting accurate enrollment and market share projections, aligning marketing efforts with member needs and sales force requisites, generating leads while supporting a brand, and elevating themselves from the seeming parity of a highly competitive landscape.

Solution:

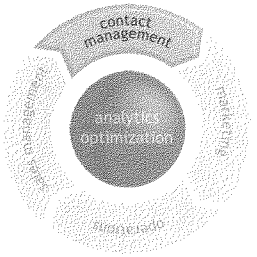
A brand's ultimate measure is the ability to connect with customers in an individual, meaningful way. The strategic approach at the center of informis is based on a brand direct strategy, which marries brand marketing with the discipline of direct response. This technique reinforces your plan's relevant differentiation with prospective and current customers as it generates qualified responses.

The strategic planning that powers informis stems from advanced forecasting and modeling tools based on proven, real-world analysis of response volume. From that, an integrated, proactive marketing plan is developed, using the most effective and cost-efficient communications mix for your plan.

Each interaction you have with a current or prospective member is a chance to build a personal relationship that facilitates up-sell and cross-sell opportunities. While many of your competitors overlook the strategic advantage of organically growing member relationships from the first day they say "yes," informis has vast experience in effectively extending your brand to member service.

A confused customer is a lost customer. Accuracy, clarity and speed are key to informis.

Create an efficient, scalable environment that's a powerful relationship extension of your company.



Challenge:
All too often, contact management systems are plagued by inaccuracies and inefficiencies, difficult to scale, cumbersome in terms of training, and are incongruent with branding efforts. The focus of most systems is strictly on service, with no or sub-par attention paid to the importance of sales.

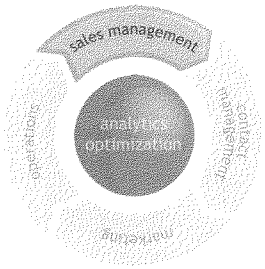
Solution:
With a unique approach to member service, the informis contact management component offers an unparalleled customer experience. Because all system information is accurate, timely and consistent, members are able to make informed choices without confusion or aggravation. Plus, informis increases member loyalty while supporting and growing your brand.

A specialized Integrated Workstation is both the brains as well as the brawn powering this informis component. With pre-approved, specialized scripts from which to refer, you won't find a solution with a more extensive Medicare knowledge base. This enables your customer service representatives (CSRs) to maximize your plan's acquisition, up-sell and cross-sell rate. In addition, automated metrics collection, derived directly from script activity, provides the unprecedented ability to quickly identify which scripts and sales strategies are most persuasive—allowing you to seamlessly redirect your CSRs to use the most effective communications possible.

Finally, informis is completely scalable for enrollment peaks and valleys, ensuring that you don't overspend or lose sales due to staffing problems or infrastructure restrictions.

Expert qualifications allow informis to efficiently optimize and
power your agent performance.

Arm your sales force with a fully integrated lead management system.



Challenge:

Many insurers lose leads or hot prospects because information from their contact center is not fully integrated with their lead management system. Thus, the time, effort and resources spent identifying a lead can be wasted if the prospect selects another plan while awaiting a callback or sales visit.

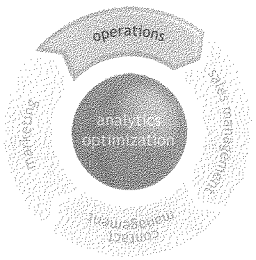
Solution:

informis provides your sales force with a closed-loop lead management system featuring direct prospecting, inbound inquiries to entice prospects, and the ability to set real-time appointments for your insurance agents in the field. It also allows you the convenience to track and monitor sales force performance from your desktop.

Since the stakes are extremely high for pre-qualified hot leads, informis has licensed "standby agents" immediately available to close hot prospects still on the phone. These informis agents possess the extensive training, experience and acumen needed to accelerate and finalize the sales cycle—often accomplishing within 30 minutes what would normally take three to five days if a lead moves out to the field.

Streamline processes, remove silos and optimize your service delivery with informis' *turnkey operation management.*

Now's the time for end-to-end solution management that reduces operational staff and simplifies accountability.



Challenge:

Most health plans struggle to integrate and manage complex, often highly "siloed" systems riddled with operational inefficiencies. In fact, 10-15 percent of upper management time is spent dealing with issues stemming from multiple vendors. This lack of overall solution accountability is not only a waste of internal resources, it's also incredibly frustrating. Failure in operations also negatively impacts your plan's service level—a significant cause of beneficiary dissatisfaction and driver of disenrollment.

Solution:

With informis, turnkey integration and management of all member interaction components ensures operational efficiency, smoother service delivery and single-owner responsibility for the management of the project.

This affords you not only the convenience of dealing with a single vendor, but also gives you the peace of mind of knowing that your internal resources are now free to focus on moving your business forward, as opposed to managing internal solution integration projects and resolving multi-vendor disputes.

What's more, because informis' operational processes are continually analyzed and streamlined, you can be confident that your members are receiving paramount service and your sales force is optimally equipped to sell.

With informis, *precision enrollment, unsurpassed member service and lifetime loyalty is transformed into a distinct advantage.*

Seize the opportunity presented by the tumultuous, rapidly changing Medicare landscape.

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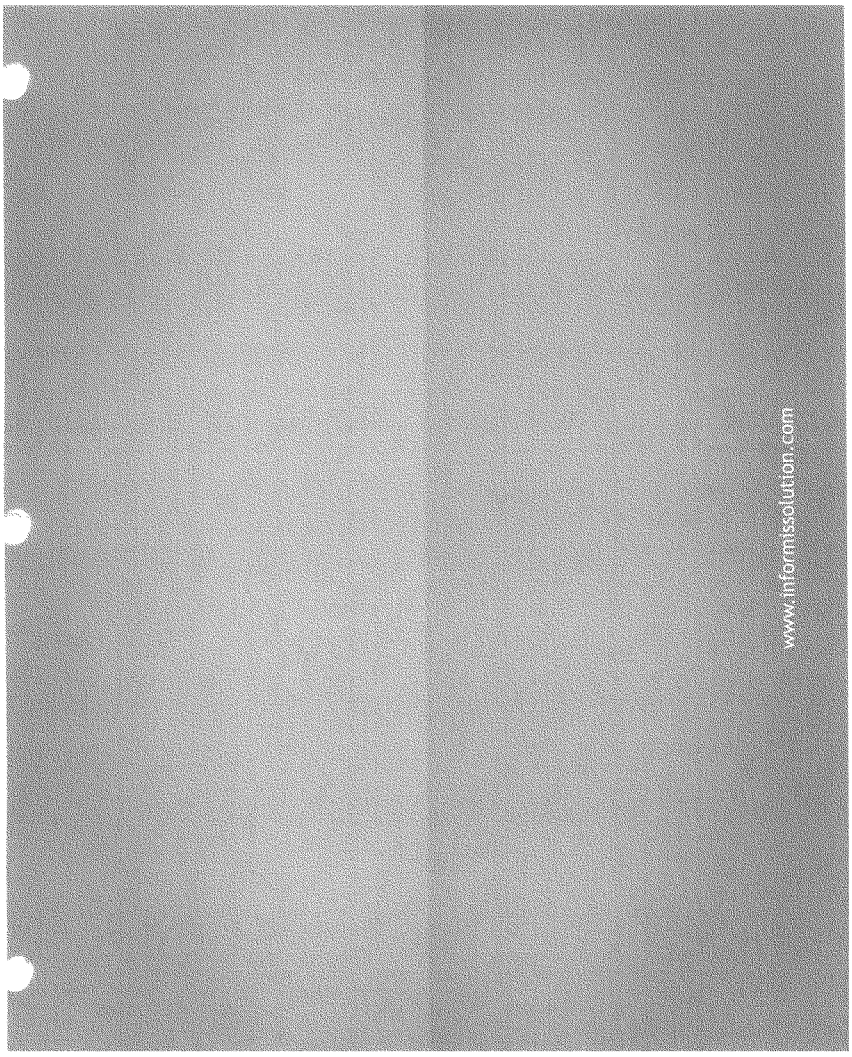
www.informissolution.com

Exhibit 18

2008 Call Letter

DATE: April 19, 2007

TO: Medicare Advantage Organizations
Medicare Advantage-Prescription Drug Organizations
Cost-Based Plans
Stand-Alone Prescription Drug Plans
Employer/Union-Sponsored Group Health Plans

FROM: Abby L. Block, Director, Center for Beneficiary Choices

RE: Introduction from CMS on 2008 Call Letter

Summary

I am pleased to provide you with the 2008 Call letter for Medicare Advantage (MA) organizations, Section 1876 cost-based contractors, prescription drug plan (PDP) sponsors, demonstrations, and employer and union-sponsored group plans, including employer/union-only group waiver plans (EGWPs). We have redesigned our call letter to direct your attention to CMS strategic goals for the Medicare Advantage (Part C) and prescription drug (Part D) programs, while also providing new information, and operational reminders to help you prepare for contract year 2008.

This Call Letter is dramatically different from previous versions in which we summarized many of the instructions issued over the past year. In contrast, the 2008 Call Letter discusses information we believe you will find especially useful as your prepare for the upcoming year. It references current CMS guidance and directs you to the documents or web sites where you can locate in-depth information on important topics. We hope this information helps you implement CMS policies and procedures and comply with critical program requirements. We also hope it will act as a catalyst in strengthening our partnership so that together we may design and provide a variety of high quality health care products to help people with Medicare meet their health care needs.

Because this Call Letter focuses on information designed to help you prepare for the 2008 contract year, it is essential that you review all program requirements, the Managed Care and Part D Manuals, Health Plan Management System (HPMS), and other CMS guidance for comprehensive information on both programs. As part of our efforts to help you meet all requirements, we are now updating the Managed Care and Part D Manuals quarterly and consolidating guidance so that these primary resources for the programs will contain detailed and current information.

I. Background

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) added outpatient prescription drugs to Medicare (offered by either stand-alone prescription drug plan sponsors or MA organizations) and significantly revised the Medicare + Choice (now Medicare Advantage) managed care program. The MMA changes make managed care more accessible,

Continuing MAOs must complete the HPMS plan crosswalk when uploading their CY 2008 bids. For more information on the crosswalk see Section IV of this Call Letter.

III. Outreach and Marketing

Because marketing is the primary means for organizations to attract people with Medicare to their products, accuracy and timeliness in data file submissions and exchanges, compliance with systems requirements, and timely and reliable outreach are essential to helping inform people with Medicare about their choices. The benefit information included in marketing and outreach materials must be based on information submitted in the bidding process and captured in HPMS through tools such as the Plan Benefit Package tool. It is essential that all information is accurate, and presented clearly and timely in the required format so that people with Medicare can make informed decisions about which plan types and plan benefit packages best meet their needs. In addition, MAOs are responsible for making sure that brokers or others authorized to represent an organization's plan or plans operate according to all guidance and requirements related to marketing, including those stated in our marketing guidelines on the CMS website; the marketing chapters of the Managed Care and Part D Manuals; the program requirements for Part C; and, if offering a Medicare prescription drug benefit, Part D (Parts 422 and 423, respectively, of Title 42 of the Code of Federal Regulations). Below, we highlight some of the aspects of outreach and marketing organizations should be aware of as they plan for the 2008 program year.

A. Marketing of CY 2008 Plans by Agents and Brokers

With the significant expansion of MA enrollment we remind organizations that they are responsible for the actions of sales agents/brokers whether they are employee or contracted. Organizations must ensure agents/brokers are properly trained in both Medicare requirements and the details of the products being offered. Medicare Advantage organizations must provide strong oversight and training for all marketing activities. This is especially critical for the marketing of private fee-for-service (PFFS) plans which are unfamiliar to many beneficiaries and providers. For example, organizations should be sure that brokers/agents explain to prospective enrollees that while they can see any provider who agrees to accept the plans terms and conditions, providers may decline to accept the PFFS terms and conditions. Employees of an organization or independent agents or brokers acting on behalf of an organization may not solicit Medicare beneficiaries door-to-door for health-related or non-health-related services or benefits. Employees, brokers and independent agents must first ask for a beneficiary's permission before providing assistance in the beneficiary's residence, prior to conducting any sales presentations or accepting an enrollment form in person. Additionally, beneficiaries must not be coerced into accepting an in-home appointment or enrolling into a plan in which they have indicated no interest.

B. Plan Submission and CMS Review of Marketing Materials

Medicare Advantage organizations may begin submitting CY 2008 marketing materials (e.g., Summary of Benefits (SB) and Annual Notice of Change (ANOC)) on June 15, 2007, in accordance with the marketing guidelines via the HPMS marketing module. The regional

offices will review the materials and approve or disapprove. Organizations that do not have a final CMS contract approval will receive a "conditional approval" on marketing materials. If the materials are conditionally approved, CMS is indicating to the organization that materials are approval based on the current plan bid submission which has not yet been approved. The organization may not use conditionally approved marketing materials in the market. If materials are disapproved, the organization must revise the materials and continue to work with the regional office until it receives a conditional approval on the materials.

After we approve the MAO's bid, any necessary changes to the conditionally approved or approved marketing materials must be resubmitted to us based on the CMS approved bid/PBP. The organization must clearly highlight only changes that result from the approved bid/PBP. This step will ensure a timely review of the final materials.

In order for an MAO to be able to market its plans, it is essential that it follow the review process found in the Marketing Guidelines on the CMS website. If an organization fails to submit materials timely or to clearly highlight changes in the submitted materials, then it is at risk of not being able to market by October 1, 2007.

Note: If there are no changes to the bid or marketing materials from when the materials received the conditional approval, the MAO need not resubmit the marketing materials. Instead, all marketing materials with a status of "conditional approval" will be changed to an "approved status" upon approval of the bid and CMS contract.

C. Expedited Review Process Reminder

Medicare Advantage organizations are encouraged to submit qualified marketing materials under the expedited review process. The expedited review process permits organizations to submit template materials without cost sharing information for review and approval by the regional office. This process requires organizations to populate the appropriate cost sharing and benefit information once the bid is approved. These populated materials do not require resubmission to the Regional Office (RO) for additional approval prior to use, however organizations must submit each variation of the template to the RO through HPMS within 30 days of populating materials. Any changes or corrections that occur after the bid has been approved must be corrected in all marketing materials. The following materials qualify for an expedited review: Summary of Benefits (SB), Annual Notice of Change (ANOC), and Evidence of Coverage (EOC), provider or pharmacy directories.

D. Annual Beneficiary Notification Materials

For CY 2008 we encourage the redesign and streamlining of the annual renewal materials to provide better, timely information for beneficiaries; reduce the demand on staff resources (CMS and health plans); and create a more efficient process. Below are the steps we are taking to redesign the renewal materials and other actions we are taking to streamline the process and ensure that people with Medicare receive timely information so that they can make confident, informed decisions about their health care options.

- Integrate the ANOC and EOC into one document which beneficiaries can receive from MAOs by October 31.
- Standardize the formatting and certain sections in the ANOC/EOC. Medicare Advantage organizations and Part D sponsors will have the flexibility to enter plan-specific text in certain sections of the document, while other text will be standardized.
- Create one model ANOC/EOC with optional modules based on type of plan (e.g., cost, PDP, PFFS, etc.).
- Utilize the streamlined marketing review process so that organizations submit the ANOC/EOC template.
- Release the annual renewal material in late spring.
- Streamline the text/content of the ANOC/EOC to reduce duplication and unnecessary information. This will be a multi-year effort to reduce redundancy, improve the clarity of material, and organize materials to help people with Medicare understand their benefits, rights, and obligations.

The redesign process for annual renewal materials is optional. Organizations will have the following two options for the distribution of the ANOC and EOC:

Combined ANOC/EOC

Organizations that choose to utilize the combined standardized process will be required to mail annual notification materials (combined ANOC/EOC) by October 31, 2007. MA-PD organizations must send an abridged or comprehensive formulary in addition to the combined ANOC/EOC. In this option, the SB is only needed for pre-enrollment marketing. Organizations utilizing the combined (standardized) ANOC/EOC should utilize the streamlined marketing review process.

Stand Alone ANOC and EOC

Organizations that choose not to use the combined standardized ANOC/EOC option must mail ANOCs along with their SBs to existing members by October 31, 2007. ANOCs may be submitted as model or non-model. Additionally, MA-PD organizations must send an abridged or comprehensive formulary with the ANOC and SB. Under this option, EOCs and low income subsidy riders (LIS) must be mailed by January 31, 2008.

Organizations mailing the EOC separately will have the option of using the model EOC or creating a non-model EOC document. Non-model EOCs will be subject to a 45-day review period.

Organizations must mail CY 2008 EOCs to new members no later than when they notify the member of acceptance (confirmation) of enrollment.

We will be releasing additional guidance regarding these changes later in 2007.

E. Plan Comparisons

We received a significant negative response to the proposal in the draft Call Letter to allow plan comparison of Medicare Advantage and prescription drug plans in a specific service area. Based on these comments, we are persuaded that it is not practical or meaningful to develop a comparison that does not include formulary drug costs and availability specific to an individual beneficiary. .

F. Medicare Options Compare Data and Medicare Prescription Drug Plan Finder

1. General

On or about October 11, 2007, the CY 2008 health plan and health plan drug data will appear on the Medicare Options Compare (MOC) and the Medicare Prescription Drug Plan Finder (MPDPF) on Medicare.gov. The online tools are important components of our initiative to provide people with Medicare information to help make them confident and informed about their health care choices. The MOC will continue to include out-of-pocket cost data, charts displaying several HEDIS and CAHPS measures, and disenrollment reasons data for the MA plans. Please note that employer/union-only group waiver plans (EGWPs) will not be included in the MOC. Plans must preview their health plan data for MOC and drug plan data in HPMS this fall. We will issue instructions and specific dates for the previews at a later date. It is critical that plans review their information so that submitted data is not suppressed.

Online enrollment will continue to be available to MA organizations through the MOC and to MA-PD and PDP plans through MPDF. This year, the enrollment function will be available for 2007 plans through December 2007, and for 2008 plans beginning November 15, 2007. Online enrollments must be downloaded daily.

2. Quality Checks for the Medicare Prescription Drug Plan Finder

Quality checks for data submitted to CMS for display on the MPDPF will continue to be required for contract year 2008. Guidance has already been released via HPMS that outlines the expected quality checks that MA-PD and PDP Sponsors should routinely perform on their data both prior to submitting it to us and after it has been posted on the MPDPF. Modifications and additions to the quality assurance (QA) check list may be added for implementation in 2008. Failure to conduct these QA checks may result in suppression of the MA-PD and PDP Sponsor's pricing data from the website.

G. 2008 Medicare & You

The 2008 *Medicare & You* handbook will contain health plan benefit and Medicare prescription drug plan comparison information. This information may be similar to the health plan information provided in the 2007 *Medicare & You* handbook released last fall. One CAHPS measure will be included in the 2008 *Medicare & You* handbook. Plans will be able to preview their handbook plan data September 10 through 12.

IV. Systems, Data, and HPMS Crosswalk

Exhibit 19

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

CENTER FOR BENEFICIARY CHOICES

DATE: May 29, 2007

TO: Medicare Advantage Private Fee-for-Service (PFFS) Plans

FROM: Abby L. Block
Director, Center for Beneficiary Choices (CBC)

SUBJECT: Ensuring Beneficiary Understanding of Private Fee-for-Service Plans, Actions and Best Practices

Private Fee-For-Service (PFFS) plans are a growing segment of the Medicare Advantage (MA) program. These plans differ from other MA products. As more PFFS plans become available, CMS began to work with beneficiaries, providers and MA organizations to provide education and information describing this plan option.

As described in the 2008 Call Letter, CMS is providing additional model documents and requiring new outreach processes to ensure beneficiaries and providers are informed about the distinctive features of Medicare PFFS plans. MA organizations offering PFFS plans are strongly encouraged to implement these new elements and practices as quickly as possible. Several of these must be implemented immediately as indicated in the discussion below. All PFFS organizations must have these processes in place prior to marketing CY 2008 PFFS plans.

PFFS Marketing Processes

1. Sales presentation schedules
   MA organizations offering PFFS plans must provide their CMS Regional Office Plan Manager with listings of planned PFFS marketing and sales events, using the attached spreadsheet (refer to **Attachment 1**). Data for events conducted by both employed and contracted sales representatives is required. Beginning June 20, 2007, by the 20th of each month you must provide information for all events scheduled for the following month. The first report is due by June 20, 2007 and must list all events planned for July 2007. The Regional Office Plan Manager must be notified of updates to the schedule as appropriate. In addition, CMS encourages PFFS plans to maintain an up-to-date schedule of sales events on the plan's website. Each submitted spreadsheet must be accompanied by a signed and dated attestation from the organization's Medicare program vice president or director, attesting to

best knowledge, information and belief, that the information provided to CMS is accurate as of the date submitted.

2. Prohibition against implying PFFS plans function as Medicare supplements
MA organizations offering PFFS plans are prohibited from using any materials or making any presentations that imply PFFS plans function as Medicare supplement plans or use terms such as "Medicare Supplement replacement". MA organizations may not describe PFFS plans as plans that cover expenses that Original Medicare does not cover nor as plans that offer Medicare supplemental benefits. It would be permissible, however, for PFFS plans to clarify that the plan does not pay after Medicare pays its share, but rather, it pays instead of Medicare and the beneficiary pays any applicable cost-share or co-pay. Immediately discontinue use of any materials not meeting this requirement. Revised materials may be submitted through the File and Use Certification process.

3. PFFS marketing material disclaimer
MA organizations offering PFFS plans are required to prominently display the following disclaimer in all advertisements and enrollment related materials:

> *A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: [insert link to PFFS terms and conditions].*

This language is also required in sales presentations in public venues and private meetings with beneficiaries. Any statement indicating that enrollees may see any provider must also include, the phrase ". . . who agrees to accept our terms and conditions of payment." CMS approval of this language prior to use is not required. Plans should begin using the disclaimer language immediately in sales presentations and as soon as possible in printed materials.

4. Beneficiary and provider leaflet
All MA organizations must provide enrollees with a complete description of plan rules, including detailed information on a provider's choice whether to accept plan terms and conditions of payment. A model document that beneficiaries may show their health care providers has been developed for this purpose (refer to **Attachment 2**). The model is a two-sided leaflet, with information for beneficiaries on one side and information for providers on the reverse.

The leaflet must be included in all enrollment kits that prospective enrollees receive. This leaflet must be available on your website for beneficiaries who enroll online. CMS will also post a model leaflet on the Medicare.gov website. It may be helpful to provide several copies to each beneficiary so that they can give copies to their health care providers. The leaflet must be implemented as quickly as possible and submitted to CMS using the File and Use Certification process prior to marketing CY 2008 PFFS plans.

5. Outbound education and verification calls
   All MA organizations offering PFFS plans are required to conduct outbound education and verification calls to ensure beneficiaries requesting enrollment understand the plan rules. It is important for your sales staff to obtain from the beneficiary the verification phone number and provide a description of the enrollment verification process to the beneficiary during the application process. Your approved enrollment application form must accommodate this requirement.

   Outbound calls mean that calls are made to the beneficiary after the sale has occurred. Calls cannot be made at the point of sale. You must ensure that the verification calls made to beneficiaries who request enrollment through sales agents are not made directly by those sales agents and also that the sales agents are not with the beneficiaries at the time of the verification call. You will be required to conduct these calls for all new enrollments except enrollments into employer or union sponsored PFFS plans or switches from one PFFS plan to another PFFS plan offered by the same MA organization. A model script has been developed for this purpose (refer to **Attachment 3**). You may continue to use existing scripts provided the information in the attached model document is conveyed during verification calls. Your script needs to be submitted to CMS through the normal process for approval.

   Three documented attempts to contact the applicant by telephone within 10 calendar days of receiving the application are required. If you are unable to successfully complete the verification after the first attempt, you must send the applicant the model education letter (refer to **Attachment 4**). You must provide this letter in addition to any required enrollment notice, such as enrollment acknowledgement and confirmation letters (refer to **Attachments 5 and 6**, respectively). After the model education letter has been sent, you must make and document at least two additional attempts to successfully complete the verification. Be certain to document verification activities as they will be subject to compliance audit by CMS or its contractors.

   Immediate implementation of this process is recommended; however, you must have this process in place before marketing CY 2008 PFFS plans.

6. PFFS Enrollment Processing
   The special processes and marketing practices described in this memo are designed to ensure new enrollees have all required information to understand the plan in which they are enrolling. Conducting this outreach and education does not change the requirements to which all MA organizations must adhere for processing MA enrollment requests. Please refer to the CMS MA Eligibility, Enrollment and Disenrollment Guidance, available at www.cms.hhs.gov, for more information.

Best Practices

1. PFFS-specific sales presentation language

Model language is provided to incorporate into sales presentations describing the special aspects of PFFS plans which differ from supplements and other MA plans (refer to **Attachment 7**). You may submit this language with revised sales presentations using the normal marketing submission process.

2. Participation in HEDIS and HOS
We encourage organizations offering PFFS plans to participate in HEDIS and the Health Outcomes Survey (HOS) in 2008. Submitting this information helps CMS calculate and display much of the comparative information featured in the Medicare Options Compare tool. This tool is used by beneficiaries and their representatives in making informed health care decisions. You will receive more information regarding how to take advantage of this opportunity in the future.

3. Provider education plan
You are required to have staff available to assist providers with questions concerning plan payment and payment accuracy. Please refer to the document entitled "MA Payment Guide for Out of Network Payments" available on our web site at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats. In addition, we encourage PFFS plans to develop provider relations strategies to encourage a wide range of providers to accept PFFS enrollees. We suggest PFFS plans develop a provider education process and educational materials that includes establishing relationships with and educating providers in the PFFS plan service area.

To further assist providers, we have posted on the CMS website all the PFFS plans' contact information concerning PFFS plan terms and conditions of payment. Also, PFFS plans are required to make their terms and conditions of payment reasonably available to U.S. providers. A provider has reasonable access to a plan's terms and conditions of payment if the plan makes this information easily accessible through electronic mail, fax, telephone, or the plan website. The contact information for all PFFS contracts is posted on http://www.cms.hhs.gov/PrivateFeeforServicePlans/. Updates to the contact information will be made on a monthly basis.

New fields will be added in HPMS to allow PFFS plans to provide their plan terms and conditions of payment contact information for providers, which will be used to update the CMS website. CMS will inform all PFFS plans when the information may be entered in HPMS.

You should consider sending a provider educational material packet to those providers listed on enrollment requests (if provided), and those who call or bill for services that have not already received a packet. The contents of the provider education material packet could include the updated CMS provider education letter (refer to **Attachment 8**), the provider educational information in the document described above (refer to **Attachment 2**), and the terms and conditions of payment. We may require that organizations offering PFFS plans having documented provider access problems provide data about provider education and outreach efforts.

As stated in the 2008 Call Letter, CMS remains vigilant in protecting Medicare beneficiaries. We will focus compliance oversight activities on ensuring the provision of information to beneficiaries accurately represents the access, network, and payment features of PFFS plans generally, and each organization's specific plan. CMS has the authority to impose intermediate sanctions and penalties including the freezing of all marketing and enrollment, civil money penalties and other enforcement actions as described in Federal regulations at 42 C.F.R. §422 Subpart K and O, against organizations violating Medicare program requirements. We are closely monitoring beneficiary complaints and other marketplace-based information to determine whether compliance and/or enforcement actions are warranted.

We appreciate your cooperation in implementing these important steps. Please notify your Regional Office Plan Manager as you implement each of the items described above. You may direct any questions concerning these requirements to your Regional Office Plan Manager.

Attachment 2 – Side 1

What *People on Medicare* need to know about **Private Fee-for-Service plans**

<Plan name> is a Medicare Advantage private fee-for-service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than Original Medicare or an HMO, PPO, or Medicare supplement plan.

<Plan name> gives you the ability to choose your health care provider. However not all providers may accept this plan, even Medicare providers may not accept this plan. If you choose this plan, it is very important that all the providers you choose know, before providing services to you, that you have <plan name> coverage in place of Medicare. This gives your provider the right to choose whether or not to accept <plan name> terms and conditions of payment for treating you. Providers have the right to decide if they will accept <plan name> each time they see you. This is why you must show your <plan name> ID card every time you visit a health care provider.

If your provider agrees to <plan name> terms and conditions of payment
If your provider decides to accept the <plan name> plan, they must follow our plan's terms and conditions for payment. They must thereafter bill <plan name> for those services. However, providers have the right to decide if they will accept <plan name> each time they see you.

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.*] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

If your provider does not agree to <plan name> terms and conditions of payment
A provider may decide not to accept <plan name>'s terms and conditions of payment. If this happens, you will need to find another provider that will. You may contact us at <phone number> for assistance locating another provider in your area willing to accept our plan's terms and conditions of payment.

What happens if a provider declines to accept <plan name>'s terms and conditions of payment?

1. They should not provide services to you except for emergencies.

2. If they choose to provide services, they may not bill you. They must bill <plan name> for your covered health care services. You must pay the appropriate copays or coinsurance at the time of service.

For more information about PFFS plans see Beneficiary Qs & As at CMS's web site http://www.cms.hhs.gov/PrivateFeeforServicePlans/. If you have questions about <plan name>, please call our <customer service> department at <phone number>.

[Optional: plan logo and tagline]

Attachment 2 – Side 2

What *Health Care Providers* need to know about Private Fee-for-Service plans

<Plan name> is a Medicare Advantage private fee-for-service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than an an HMO, PPO, or Medicare supplement plan.

A beneficiary who enrolls in a Medicare Advantage PFFS plan is free to use any provider willing to treat the enrollee and accept our plan's terms and conditions of payment. You can view our terms and conditions of payment by visiting our website at <plan website>, and if you have questions, then you can call us at <phone number>. Enrollees must inform you, before obtaining services from you, that they have purchased <plan name> for their Medicare coverage. This gives you the right to choose to accept <plan name> enrollees. You have a right to make that choice each time service is needed by a <plan name> enrollee. You do not have to sign a contract to see <plan name> enrollees.

[*Include if plan uses network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept the plan's terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract*] Enrollees of <plan name> can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept the plan's terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

If you decide to accept <plan name> terms and conditions of payment
Your agreement to our plan's terms and conditions of payment is inherent in your decision to treat a <plan name> enrollee. If you decide to treat a <plan name> enrollee, you will be subject to our plan's terms and conditions of payment and must bill <plan name> for covered services. However, you have the right to decide, on a patient-by-patient and visit-by-visit basis, whether to treat <plan name> enrollees. You may learn our terms and conditions of payment and other information about our plan <on our website at _____/by calling us at _____>. [Optional: insert brief description of payment rates, enrollee cost sharing, or other aspects of the plan's terms and conditions of payment.]

If you decide not to accept <plan name> terms and conditions of payment
If you decide not to treat a <plan name> enrollee, you should not provide services to the enrollee, except for emergencies.

If you choose to provide services, then you have by default agreed to our terms and conditions of payment and you must bill <plan name> for covered health care

services. You must collect from the enrollee only the appropriate <plan name> copays or coinsurance at the time of service. You may at any time, on a patient-by-patient and visit-by-visit basis, decide that you do not want to treat a <plan name> enrollee.

We will follow CMS requirements for timely payment of claims. [Optional: provide average claims payment timeframe, such as, "Our average payment timeframe during <year> was <____ days>."] You may learn our billing requirements <on our website at _____/by calling us at _____>.

For more information about PFFS plans see Provider Qs & As at CMS's web site http://www.cms.hhs.gov/PrivateFeeforServicePlans/. If you have questions about <plan name>, please call our <provider relations> department at <phone number>.

[Optional: plan logo and tagline]

Attachment 3: Model PFFS Education and Verification Script

[Greeting:]
Hello, my name is <caller's first name>, and I am calling from <MA Organization or plan name>. We have recently received your request to enroll in <plan name>, a Medicare Advantage Private Fee-for-Service Plan. This call is to make sure that you understand how a Private Fee-for-Service Plan works and to answer any questions that you have. You don't have to provide any information to me, and any information you do provide will in no way affect your ability to join our plan. This should take about XX minutes. May we continue? [*If applicable*: This call may be monitored or recorded]

[If yes, proceed to [Introduction to Plan Rules:] below.]

[If no:] Alright, <Mr./Ms.><beneficiary name>. Is there a better time when I should call again?

[If yes, take down date and time to call and proceed to close.]

[If no:] Thank you for choosing <MAO name/plan name>. We will be sending you letters about your enrollment request soon. **[End call.]**

[Introduction to Plan Rules:]
Thank you, <Mr./Ms.> <applicant name>. In order to make sure you understand how the plan works, I will review some important information about getting care as member of <Name of Plan>.

[PFFS plan rules:]

- <Plan name> is a Medicare Private Fee-For-Service plan and not a Medicare supplement, Medigap, or Medicare Select plan. This means that <plan name> pays ***instead*** of Medicare. You will pay the cost sharing listed in <plan's name> the summary of benefits provided with the application.
- Once enrolled, you can not use your red, white and blue Medicare card to get healthcare, because the Original Medicare Plan won't pay for your healthcare while you are enrolled in this plan. You should keep your Medicare card in a safe place in case you return to the Original Medicare Plan in the future.

- You may get health care services from any provider allowed to bill Medicare and who agrees to accept our payment terms and conditions.
- It is important that all of your health care providers be made aware, before you get any services, that you have joined <plan name>, which is a PFFS plan. This gives your provider the right to choose whether to accept our plan's payment terms and conditions. The provider can make a different choice to accept the terms and conditions of payment each time you need service. This is why you must show your <plan name> ID card every time you visit a health care provider. It is important to understand that Medicare providers and suppliers are not obligated to treat Medicare beneficiaries enrolled in PFFS plans, though they can choose to do so. There is a <phone number and/or website> on your <Plan name> ID card for the provider to find out about the terms and conditions of payment.
- If your provider decides to accept the payment terms of the <plan name> plan, he or she must bill <plan name> for those services. However, each provider has the right to decide whether or not they will accept <plan name> each time they see you.
- If your provider decides not to accept the payment terms of the <plan name> plan, you will need to find another provider that will. They should not provide services to you, except in an emergency.
- [***Include if plan uses a network of contracted providers:*** <Plan name> has direct contracts with some providers who have already agreed to accept our plan's terms and conditions of payment. [Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.] You can still get care from other providers who do not contract with us as long as they agree to accept our plan's terms and conditions of payment. [Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.]]
- [*Use if applicable:* You must use network pharmacies to obtain prescription drugs, except in emergencies or urgent situations.]
- [***Include if plan offers Part D:*** *If you have limited income and resources,* you may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048,

24 hours a day, 7 days a week. Or, call the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778. You may also call your State Medicaid Office.]

<Mr./Ms> <applicant name>, do you understand what I have just explained to you?

[If yes, continue to [Enrollment cancellation policy] below.]

[If no: you must ask the applicant about any specific questions they have, and answer those questions. You may need to explain the information above again until the applicant understands.]

[Enrollment cancellation policy]

If you have any questions or would like to cancel the processing of your enrollment, please call our Member Services Department at <phone number>. You must notify us of your intent to cancel the processing of your enrollment within 7 calendar days after receiving this phone call or by <last day of the month in which the request for enrollment was received>, whichever is later. TTY users should call <*TTY* number>. We are open <insert days/hours of operation and, if different, *TTY* hours of operation>.

[Close:]

- <Mr./Ms.> <applicant name>, it was a pleasure speaking with you today. We will soon send you a letter telling you we received your completed enrollment form. [*Use if plan uses enrollment acknowledgement letter as temporary proof of coverage:* You should use this letter as a temporary <plan name> ID card before you get health care.] We will also send you a member ID card soon. Once you get it, remember to show your ID card to your doctor or hospital before you get healthcare. Thank you for your time and for choosing <plan name> as your health plan. **[End call.]**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244

This letter is intended to inform providers of a new option, not to endorse
<name of plan>

Dear Provider:

In the Centers for Medicare & Medicaid Services' (CMS) continuing mission to improve access to health care for the [44] million Medicare beneficiaries nationwide, we have worked with various organizations that have expressed an intent to contract with CMS as Medicare Advantage (MA) Organizations, and to offer MA plans to Medicare beneficiaries. Historically, all MA plans offered to beneficiaries were "managed care" products, under which beneficiaries who enrolled were limited, at least to some extent, to a specified network of providers.

On <date>, <organization name> received authorization from CMS to offer an MA "private fee-for-service" (PFFS) plan, under which a beneficiary who enrolls is free to seek services from any provider who is willing to accept the plan's terms & conditions of payment and treat the enrollee. Because this type of MA plan is new to many providers, the following information is furnished concerning some of the special features of a MA PFFS plan.

[*Include the following if you have no signed contracts with any providers:*
In order to offer a PFFS plan without entering into signed contracts with a sufficient number of providers to meet MA access standards, the MA Organization must agree to pay all Medicare eligible providers at least the current Medicare Allowable rates (including original Medicare deductibles and coinsurance) minus any MA plan specific enrollee cost sharing. This minimum payment rate for non-network PFFS plans is mandated via regulation (42 CFR 422.114) as well as the contract that CMS holds with an MA Organization. (For details on provider eligibility see Provider Q & A #1 on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans.)]

If a PFFS plan establishes payment rates for any category of providers (e.g., physicians, hospitals, etc.) in its terms & conditions of payment that are less than original Medicare payment rates, it then must have that category or categories of providers under direct signed contract. The reason for this requirement is that if a PFFS plan establishes a payment rate that is less than that of original Medicare, the plan will need to have direct contracting providers to ensure that its enrollees can go to those providers to receive services. While enrollees in PFFS plans can always seek care from any eligible provider in the U.S. who is willing to accept the plan's terms & conditions of payment, if the plan's payment rate is less than original Medicare, many providers may decline to treat the enrollees.

[*Include the following if you have signed contracts with some, but not all, categories of providers:* <Plan name> has established a PFFS model where we pay some category of providers at least the original Medicare rate and for certain other categories of providers we pay less than the original Medicare rate. [List provider types paid less than original Medicare]

The PFFS payment rules for providers are mandated via regulation (42 CFR 422.114 and 422.216) as well as the contract that CMS holds with an MA Organization. (For details on provider eligibility see Provider Q & A #1 on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans.)]

Providers are prohibited from balance billing enrollees of the PFFS plan unless the PFFS plan allows the provider to do so in its terms & conditions of payment. PFFS plans have the option of allowing providers to balance bill members up to 15% of the plan payment rate (42 CFR 422.216 (b)). Other than any plan allowed "balance billing" amount, providers must bill only for copayments, deductibles or coinsurance described in the MA Organization's terms and conditions of payment. Providers must always abide by the PFFS plans terms & conditions of payment for any services he or she chooses to furnish to PFFS enrollees.

Other important aspects of PFFS plans include:

- If a provider decides to accept the PFFS plan, they must follow the PFFS plan terms and conditions of payment. Provider agreement to the plan terms and conditions of payment is inherent in their decision to treat a PFFS plan enrollee. If a provider decides to treat a PFFS plan enrollee, then the provider must bill the PFFS plan for covered services. The provider has the right to decide, on a patient-by-patient and visit-by-visit basis, whether to treat PFFS plan enrollees. If a provider decides not to accept the PFFS plan terms and conditions of payment, then the provider should not provide services to the PFFS plan enrollees, except in an emergency.

- CMS audits the MA Organization to ensure that it pays providers the appropriate amount for services furnished to plan enrollees and that it pays clean claims within 30 days.

- An authorized MA Organization that offers a PFFS plan is subject to the same financial solvency requirement as any other MA Organization approved by CMS.

- Payments made by an MA Organization that offers a PFFS plan cannot place providers at risk by using such reimbursement methods as capitation or withholds; and correspondingly, cannot base payment on the organization's performance using bonuses or incentives.

- Any advertising, marketing collateral or marketing practice must be filed with CMS prior to their use.

- An organization that wants to offer a PFFS plan is required to seek and receive acknowledgement and approval from every State Department of Insurance prior to offering a PFFS plan. [note this does not apply to certain employer only PFFS plans which have used the EPOG state licensing waiver.]

We recognize that as with any new plan, there can be confusion both from the provider and beneficiary communities. We continue to work with <organization name> to make sure all parties involved have sufficient information when deciding whether to accept the <plan name> plan or any Medicare Advantage program available to them in the area. Additional information, including questions and answers addressing frequently asked beneficiary and provider questions can be found on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans/, as well as the <plan name> web site at <plan web site>.

Sincerely,

David A. Lewis
Director
Medicare Advantage Group

Exhibit 20

Drug Coverage Fraud Marketing Sales

If the beneficiary received misleading or false information from an agent, broker and/or marketing representative NOT related to prescription drugs, refer them to the Office of Inspector General Fraud Hotline at 1-800-HHS-TIPS (1-800-447-8477).

If the beneficiary received misleading or false information from a prescription drug plan broker or marketing representative, READ: You will need to report this complaint to the Medicare Drug Integrity Contractor who handles issues related to potential fraud, waste, and abuse in the Medicare Prescription Drug program. You can call them at 877-7SAFERX or (877) 772-3379.

I also need to get some information from you.

****Enter the caller's information into the CSR feedback tool under the functional area of "AEP Issues."**

Please enter the following information:

- Agent/Broker's name and company
- Beneficiary's name
- Location of incident
- Date of call to 1-800-Medicare
- Plan name, if applicable. For example, if the broker is selling a particular plan.
- The incorrect or misleading information. For example, if the broker was marketing a Medicare Advantage Prescription Drug Plan and misleading the beneficiary to think it was a Medigap policy.

TIP BOX:

TIP = A broker is an independent agent who markets health plans or health systems.

REFERRAL = If caller suspects or wants to report potential fraud, waste, and abuse in the Medicare prescription drug program, they can call 1-877-7SAFERX (1-877-772-3379). This number is for Medicare drug coverage fraud, waste, and abuse only.

SCRIPT = Medicare Card Rights Preventing Identity Theft, if caller thinks that someone is misusing their personal information

REFERENCE MATERIAL = Medicare Approved Seal

WEB PUBLICATION= Quick Facts About Medicare prescription Drug Coverage and Protecting Your Personal Information (11147). See page 1 for sample of the "Medicare Approved" seal.

Plan Complaints

SPANISH

Use this script if a beneficiary, pharmacist or anyone on behalf of a beneficiary has a complaint related to Medicare drug plans or Medicare Advantage Prescription Drug Plans. This script can also be used by Help Queue for EEs (both drug plans and MA Plans).

**If caller wants to join, switch or disenroll from a plan, READ Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage.

**If caller was denied enrollment into a drug plan, READ: RP Drug Coverage Denial Claim Enrollment Appeal.

What is the problem?

- You have a problem with your plan and you want to stay enrolled in that plan.
- You are in the plan that you want, but you are still having problems with a previous plan.
- You were enrolled into a plan that you don't want and you want to switch plans.
- You are having problems disenrolling and you don't want to be in any plan.
- **Help Queue agent filing an Enrollment Exception (EE).**

Keep in mind that you have to be in a valid election period to join another plan or to disenroll.

Is the complaint related to Fraud, Waste, or Abuse?

YES / NO

(CSR NOTE: Ask any of the following probing questions if needed and click on the appropriate link above.)

Did someone call you and try to enroll you into a drug plan over the telephone?

Are you listed on the National "Do Not Call" Registry and a plan called you even though you are on this registry?

Did you get an email that you did not request from someone claiming to be from Medicare or SSA about the Medicare drug coverage that asked for personal information?

Did someone come to your home uninvited, claiming to be from Medicare or SSA?

Did a plan ask about your personal health history when you tried to enroll in a plan?

Did a plan ask for payments when you enrolled over the Internet?

Did a plan send you materials without the "Medicare-Approved" seal?

Did someone ask you to sell your prescription drugs to another person?

Did someone ask you to sell your ID card to another individual?

Did someone ask you to have a prescription filled for them using your ID card?

Do you feel that your plan has discriminated against you in some way?

Are there prescriptions on your Explanation of Benefits (EOB) that you didn't receive?

Did you receive misleading or false information from a broker or marketing representative? CLICK HERE

Is your plan incorrectly calculating the amount that you spent out-of-pocket on drug costs? For example, you spent $1500 out-of-pocket and the plan tells you that you only spent $1200.

Is your plan encouraging you to disenroll when disenrollment is not required?

Did a pharmacist change the amount that you were supposed to pay out-of-pocket to help you get through the coverage gap?

Did the pharmacist illegally substitute a drug that your doctor said couldn't be substituted?

Please refer the caller to the MEDIC contractor.
READ: You will need to report this complaint to the Medicare Integrity Contractor who handles Medicare drug coverage complaints. They are handling all issues related to potential fraud, waste and abuse in the Medicare Prescription Drug program. You can call them at 877-7SAFERX or (877) 772-3379.

I also need to get some information from you.

****Enter the caller's information into the CSR feedback tool under the functional area of "AEP Issues".**

Please enter the following information:

- Broker's name and company
- Beneficiary's name
- Location of incident
- Date of call to 1-800-Medicare
- Plan name, if applicable. **For example**, if the broker is selling a particular plan.
- The incorrect or misleading information. **For example**, if the broker was marketing a Medicare Advantage Prescription Drug Plan and misleading the beneficiary to think it was a Medigap policy.

TIP = A broker is an independent agent who markets health plans or health systems.

(End of script)

Verify the caller's plan enrollment/disenrollment status in the MA PD Tab or in the CSR Plan Finder Tool.

CSR NOTE: If the caller agrees with what is in the system, provide the plan phone number if necessary.

If system is not showing the correct enrollment status, offer plan name/phone number so the caller can follow up. If caller refuses to contact plan or has tried unsuccessfully to resolve the issue with the plan, click here to file a complaint.

If the system is not showing a disenrollment:

1. Verify that the caller does intend to disenroll versus enroll in a different plan.
2. Ask caller how they disenrolled previously (called plan or 1-800-Medicare).
3. Ask when they previously disenrolled.

If the prior disenrollment action was done more than 30 days ago, and the system still shows the enrollment in that plan, transfer to Tier 2 for disenrollment. (End of script)

Complete the PDP Plan Referral.

READ FOR COMPLAINTS: I will need to get some information from you in order to log your complaint. When I am finished, your complaint will be forwarded to your plan for resolution. Someone from the plan will work to resolve your complaint as soon as possible. Please call the plan for more information or to see if the issue has been resolved.

READ FOR RETROACTIVE DISENROLLMENTS (RD): I will need to get some information from you. When I am finished, your request for an adjustment to the disenrollment date will be forwarded to your plan for resolution. Someone from the plan will work to resolve the issue as soon as possible. Please call the plan for more information or to see if the issue has been resolved. Once your disenrollment information has been updated in our system, your provider should resubmit the claim to Medicare for processing.

CSR NOTE: If caller asks how long it will take to resolve the complaint, READ:
Your issue is important to us and it will be given serious attention. Unfortunately, I am unable to give you a specific time frame. Please call the plan for more information or to see if the issue has been resolved.

If they already filed a complaint and it has been less than 48 hours for urgent complaints or less than 5 business days for non-urgent complaints, READ:
I see that you have already filed a complaint. It is being worked on and we appreciate your patience. Please call the plan for more information or to see if the issue has been resolved.

If they already filed a complaint and it has been longer than 48 hours for urgent complaints or longer than 5 business days for non-urgent complaints, file another complaint.

****CSR NOTE: Click "Next" below to enter complaint.**

- **Be sure to enter the correct Contract number provided by the beneficiary. (It is case-sensitive.)**
- **Do not enter your personal commentary or your opinions in the complaint form.**
