Testimony by
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Mr. Chairman, Senator Smith, Committee members, I appreciate the opportunity to testify about marketing and sales activities related to Medicare Advantage products. I am Heidi Margulis, Senior Vice President, Government Relations for Humana Inc. Humana, headquartered in Louisville, Kentucky, has contracted with the Centers for Medicare and Medicaid Services (CMS) for over twenty years to offer Medicare beneficiaries, affordable, comprehensive health plan coverage through a variety of products. We currently offer three stand-alone prescription drug plans in 50 states, the District of Columbia and Puerto Rico, private fee-for-service plans in 50 states, regional preferred provider plans in 23 states, local preferred provider plans in 17 states and HMOs in 8 states and Puerto Rico. We also offer a Medicare Supplement product in 36 states. In addition, Humana offers private health plan options through the Department of Defense's TRICARE program to military families and plans to government employees through the Federal Employees Health Benefits Program. We offer Medicaid plans in Florida and Chicago, and a reforma plan in Puerto Rico. Finally, we offer health insurance coverage and related services to employer groups, other government-sponsored plans and individuals. In total, we provide medical insurance to over 11 million members.

Before I address issues related to the marketing and sale of Humana's Medicare Advantage products, I want to make three points at the outset:

1. We have served Medicare beneficiaries for over twenty years and recognize the vulnerability and needs of this population. Our marketing, sales and administration practices affect how beneficiaries view our company and the success of our products. Satisfied customers build great businesses. Our high retention rates are testament to that.
2. Humana takes very seriously our responsibility to meet federal AND state regulatory requirements as well as our Medicare contract obligations.
3. We have zero tolerance when we find violations of our Marketing Code of Ethics by both Humana employees and contracted agents. The 75 sales agents we terminated last year indicate we're serious about wrongdoing.

Here are some of the key components of and lessons we learned in our Medicare marketing licensure, training and oversight program as they relate to issues you, state and federal regulators and the press have expressed. I will also share some recommendations.

EMPLOYED CAREER AGENT LICENSURE, TRAINING AND OVERSIGHT

Humana sells its MA and PDP products through employed sales representatives (career agents) and through contracted, independent brokers (delegated agents), most of who are affiliated with large managing general agencies. These agents market to individuals by appointment only, in a variety of settings depending on their choice—through seminars, at home or other approved settings.

Humana currently employs about 2,000 career field agents who are licensed, appointed[1] and certified to sell our MA product and about 600 telesales agents. Those employees account for approximately **82%** of Humana's agent-assisted MA sales in 2007 (approximately 76% in 2006). Humana conducts a background check on all its employees. For Medicare sales employees, we also require a credit check, criminal background check, and we check these employees against the National Insurance Producer Registry.

All Humana Medicare sales employees or career agents are required to take a three week training course approved by CMS that encompasses the following subjects:

- Humana orientation (Successful Beginnings)
- Humana history & background
- Ethical sales practices and compliance [Sales & Marketing Code of Ethics review/signature[2] *(Attachment #1),* HIPAA policies, etc.]
- Original Medicare (utilizing "Medicare & You")
- Medicare Advantage products
- Medicare Part D
- Humana's enrollment process (proper completion of forms)

[1] The Medicare Modernization Act of 2003 provided that federal law preempted all state laws and regulations with regard to Medicare products with the exception of licensure and solvency. CMS Marketing Guidelines also preempt Medicare plans from state requirements to appoint agents to sell their products. However, it is Humana's policy to appoint licensed agents with their respective Departments of Insurance to sell our products.

[2] The Humana Code of Ethics includes seventeen (17) policies to which the agent must attest including: how they are to comport themselves, no door-to-door solicitation, not identifying themselves as representing the government, using only CMS-approved materials, fairly and accurately presenting sales materials, not using false or misleading statements, not disparaging competitors, not forging a signature, ensuring to the best of their ability, the beneficiary is of sound mind and is capable of understanding the product, etc.

- Senior awareness and senior sensitivity training
- Humana sales system, sales materials, use of suitability and needs assessment
- Selling skills
- MA & PDP sales presentations [these presentations have been updated to address issues identified through trends in beneficiary complaints and regulator concerns—issues that cause beneficiary confusion, e.g. an MA product is not a Medicare Supplement policy; ensuring that the beneficiary's provider accepts the particular MA product]
- Seminar selling and small group sales presentation role-playing
- Computer training

At the end of the session, all career agents must successfully pass a "certification test" in order to be authorized to sell Humana's MA and/or PDP plans. Employees who fail to successfully pass the test in two attempts are terminated.

Annually, career agents must successfully pass a recertification test to demonstrate ongoing knowledge and competence related to the sale of MA and/or PDP plans. Career agents who fail to successfully pass the recertification test in two attempts are terminated.

Career agents are trained extensively on the use of our CMS-approved sales presentations. The sales presentations were created to help ensure that all beneficiaries received consistent information and that beneficiaries (and/or their designee) can make informed decisions. One week of the aforementioned training is devoted to proper delivery of the sales presentation.

Upon completion of classroom training, career agents return to their local market and are to be evaluated in the field on their sales presentation to ensure they are accurately presenting it. Local field sales management is to conduct at least three evaluations initially before the agent is released to sell unsupervised. These evaluations are followed by an additional two evaluations for a total of five in the first month of selling. Career agents are then to be evaluated once every six months thereafter. Sales management completes an evaluation form for each visit and provides feedback, coaching and counseling.

Local sales managers provide ongoing training as needed on various topics based on local market issues, trends, new policies, procedures or regulatory requirements. Training may take the form of conference calls, face-to-face meetings, etc.

Sales reports are issued monthly to sales management to apprise them of the source of sales in their markets. We have recently begun to distribute early voluntary disenrollment reports which are designed to identify trends in unsatisfactory rates that could be a sign of inappropriate selling practices. Humana's policy dictates that agents are not paid commission for members who disenroll within the first 90 days of membership. This process is called a "chargeback" and serves as an incentive to ensure proper selling techniques.

Field sales management tracks and identifies trends in agent complaints and investigation findings. All complaints related to alleged agent misconduct or misrepresentation are investigated by a special unit outside of the sales area and follow a specific policy and procedure related to prohibited marketing and sales activities. Investigations include:

- Beneficiary statement.
- Agent statement.
- All supporting information, such as the customer service records of member conversations, claims and if applicable, the verification recording review.

Determinations are reported to local sales management and based on the investigation determination, corrective action is taken. Corrective action ranges from coaching and counseling, to additional agent training to agent termination, including, if applicable, reporting to the relevant state Department of Insurance. Humana has taken such actions every year since this process began in 1991.

DELEGATED AGENT LICENSURE, TRAINING & OVERSIGHT

Humana contracts with approximately 11,000 delegated agents (through managing general agencies) who are licensed, appointed and certified to sell our MA products and approximately 3,800 State Farm and USAA agents who are licensed, appointed and certified to sell our MA and PDP products. In 2007, delegated agents accounted for approximately 18% of Humana's agent-assisted MA sales (approximately 24% in 2006). Further, Humana's contract with managing general agencies includes an Agency Compliance Agreement that specifies certain compliance requirements and activities to which the agency and its agents must adhere, including the attributes of individuals best suited to market MA products, required background checks, training requirements, certification and recertification testing, requirements for agency management oversight of agent sales activity, privacy policy requirements, etc. Failure to comply with this Agreement may result in agency termination. *(Attachment #2)*

Humana requires a background check for all delegated sales agents at the time of contracting, including a credit check, criminal check and check against the National Insurance Producer Registry. While not required, Humana appoints each delegated sales agent with the respective state Department of Insurance.

Delegated agents are required to take sixteen hours of training. Delegated agents complete four hours of pre-work and a test online prior to attending classroom training. The content of training includes:

- Ethical sales practices and compliance—Sales & Marketing Code of Ethics review and signature, HIPAA policies, etc.
- Original Medicare (using "Medicare and You").
- Medicare Advantage products.
- Medicare Part D.
- Humana's enrollment process—proper completion of required forms.
- Humana sales system and sales materials, including emphasis on suitability and needs assessment.
- MA & PDP sales presentations [these presentations have been updated to address issues identified through trends in beneficiary complaints and regulator concerns—issues that cause beneficiary confusion, e.g. an MA product is not a Medicare Supplement policy; ensuring that the beneficiary's provider accepts the MA plan].

Humana requires that delegated agents must successfully pass a certification test in order to be authorized to sell Humana's MA and PDP plans. Agents who fail to successfully pass the test in two attempts are not allowed to sell our MA plans.

Delegated agents must also pass a recertification test annually to demonstrate ongoing knowledge and competence related to the sale of MA and/or PDP plans. Agents who fail to successfully pass the recertification test in two attempts can no longer sell our MA plans. Recertification testing is administered online and takes place just prior to the next annual enrollment period.

Delegated sales agents are trained extensively on the use of our CMS-approved sales presentations that were created to help ensure all beneficiaries receive consistent information. Agents must commit to using only the standardized presentation for all selling opportunities to ensure that beneficiaries (and/or their designees) are able to make informed decisions.

Humana has provided and received signed acknowledgements from all contracted managing general agencies of their obligations with regard to compliance oversight of their contracted agents. That Agreement requires the agencies to conduct one field evaluation the first week after the agent's successful certification. A second field evaluation must be completed within ninety days of certification. A subsequent field evaluation must be conducted at a minimum of once every six months. Further, in some Humana markets, our sales management team has reached out to delegated agents to provide assistance, additional coaching and some have conducted evaluations and have secret-shopped sales presentations.

We have recently begun to distribute early voluntary disenrollment reports to agencies that are designed to provide identify trends in unsatisfactory rates that could be a sign of inappropriate selling practices.

All complaints related to alleged agent misconduct or misrepresentations are investigated by a special unit outside of the sales area. Investigations include:

- Beneficiary statement.
- Agent statement.
- All supporting information, e.g. customer service records of member conversations, claims, verification recording review, if applicable.

Determinations are reported to local sales management and based on the investigation determination, corrective action is taken. Corrective action ranges from coaching/counseling, to additional agent training to agent termination, including, if applicable, reporting to the relevant state Department of Insurance. Sales compliance staff tracks and trends agent complaints and investigation findings and confers with field management on necessary actions.

Finally, field sales managers provide ongoing training as needed on various topics based on local market issues, trends, new policies, procedures or regulatory requirements. Training may take the form of conference calls, face-to-face meetings and other activities.

ENROLLMENT VERIFICATION SYSTEM

With over 20 years of serving Medicare beneficiaries, Humana understands the special needs and vulnerability of this population, including adversity to change and cognitive disparities. Since 1991, Humana has had an enrollment verification system in place. This verification system was established as a final check to ensure that the beneficiary (or his/her authorized representative) understood (s)he was enrolling in a

Medicare Advantage plan and understood the basic rules of the plan. The system has been enhanced on a regular basis since then to include the lessons learned from customer service calls, regulator input, beneficiary advocate input and our experience over time with this process. The last major improvements were made just prior to the 2007 annual enrollment period.

Verification is conducted outside the sales area by a trained customer care representative or by an interactive voice response (IVR) system, the choice of which resides with the beneficiary. For employed career agents, prior to the beneficiary's executing the application, the agent phones our toll-free verification line. The plan representative/IVR asks the beneficiary a set of questions designed to ensure the beneficiary (or his/her authorized representative) has made an informed decision. The script is approved by CMS. Questions range from ensuring that the beneficiary understands that (s)he in enrolling in a plan with medical and prescription drug benefits and is not a stand-alone PDP to ensuring beneficiaries understand that the plan is not a Medicare Supplement plan. Beneficiaries are told to confirm that their providers will accept the plan. Beneficiaries are also asked whether their agent compared their current coverage to the new coverage to ensure suitability to their coverage needs.

If the beneficiary chooses the IVR option and hesitates to reply, fails to reply or answers negatively, the beneficiary is transferred to a live customer care representative. Any hesitation or negative response halts the verification process and the agent is advised to further review the sales presentation with the beneficiary. When the beneficiary fully understands the plan and desires to enroll, the agent is instructed to call back. If for whatever reason, an enrollment is not verified upfront, an outbound call is made

following our enrollment center's processing of the application.[3] If we are unable to reach the beneficiary, a letter is sent. Less than 1% of enrollments are stopped as a result of verification. Verification recordings are used in investigations of sales practice allegations.

For delegated agents who use Humana's telephonic enrollment/signature technology, virtually 100% of their enrollments are verified as part of the enrollment process and the beneficiary is automatically connected to a verification option. All telephonic signature calls are digitally recorded. Delegated agents who use laptop technology to enroll beneficiaries where the beneficiary digitally signs the application and those agents who use paper enrollment call the toll-free verification line to begin the process as described above. Regardless of verification form, Humana seeks to ensure that beneficiaries understand and intend to enroll in an MA plan.

SALES ALLEGATIONS

As mentioned previously, Humana takes seriously any and all specific sales allegations brought to our attention. Our company's reputation and brand promise is inextricably tied to best sales practices and agents the public can trust. We have an established unit, process and procedure outside the sales area to individually investigate each issue. This program has been in place since 1991 and has been enhanced on a regular basis to address trends and current issues. During 2006, we received and investigated approximately 1,612 allegations. That represented .0008% of our total MA sales in 2006. Of those allegations, approximately 304 were "founded" and corrective

[3] Under current CMS rules, we must process an executed application. We cannot stop an application after it has been signed.

action was taken. We terminated 75agents and reported the relevant agents to state Departments of Insurance according to their laws. We have a zero tolerance policy for violations of our Sales Code of Ethics. We can only investigate those complaints where we have specific information such as identifiable beneficiary information. When we receive a complaint, whether from a beneficiary, CMS, the Department of Insurance, the State Health Insurance Assistance Program (SHIP), consumer advocate or whomever, we will investigate that complaint and report the findings to the appropriate parties. If there is a marketing violation, we will take immediate action up to and including termination and will report terminations for cause as outlined in state law to the relevant Department of Insurance.

REGULATORY OVERSIGHT

The MA program is subject to regulation and oversight by CMS and, as previously discussed, MA plans are subject to state regulatory oversight for issues related to licensure and solvency. As required by law, Humana has undergone regular and special reviews by both federal and state regulators. When issues are identified that were not already identified by Humana and corrected, Humana has taken necessary corrective action. These actions have improved program operations.

In 2005, CMS identified issues related our verification script, filing of marketing materials and increased complaints related to sales and marketing practices. Humana implemented (prior to the report of findings) and CMS accepted, several corrective actions including: revised sales training materials, revised verification script, revised sales presentation, increased management oversight, increased delegated agent training

and oversight, increased staffing for complaint resolution, revised marketing review and approval processes. Humana began biweekly reporting of sales complaint investigations and analysis of complaint trends as well as biweekly calls with CMS central and regional office staff. That reporting process continues today.

The Oklahoma Department of Insurance conducted a modified Market Conduct Examination covering the 2006 open enrollment period and found issues related to agent licensure and appointment. Even though it is preempted by federal law, it is Humana's policy to appoint each agent who sells our product in a state. While we maintain that all of our agents were appointed pursuant to Humana policy and not subject to the Oklahoma appointment law, we did have issues related to non-resident licensing for 68 of 950 agents (7%) reviewed. We have taken corrective action as follows:

- For those Humana employed telesales agents whose job is to complete enrollment forms, we are seeking licensure in all jurisdictions. We are also enhancing our call management system to alert staff as to licensure status needed in order to accept a routed call. (Our call system misrouted certain calls and call queues caused 26 telesales agents to enroll beneficiaries in states in which they were not licensed.)
- For 2 employed career agents without a non-resident license in Oklahoma, they were both counseled and applications for non-resident licenses are underway. The commissions have been charged back to Humana.
- For 40 delegated agents, no commission was ever paid to them for these sales as our commission management system checks for delegated agent licenses for each sale. Those agents who remain with us have been counseled and

applications for non-resident licenses are underway. One agent has been terminated.

The Oklahoma Department has been concerned about sales allegations of misconduct and the use of delegated agents. We share their concern and, as previously discussed, have increased training and oversight. We have decreased the use of delegated agents. In addition to the 68 cases discussed above, with regard to sales allegations, during 2006, we received and investigated 30 specific beneficiary complaints in Oklahoma. Of those 30 complaints, 1 was founded, 19 unfounded and 10 were inconclusive. All resulted in remedial action and findings are contained in the agent's file. No trends were identified. Sales in Oklahoma in 2006 totaled over 31,200. Humana seeks to investigate each and every specific complaint or concern a beneficiary or his/her surrogate has. Founded complaints are one way we can identify weaknesses in our systems and ferret out bad apples. Regrettably, we cannot fully investigate issues and take focused action where we do not have specific beneficiary information.

LESSONS LEARNED

Outreach & Education: The Part D Medicare Prescription Drug benefit and the new products offered under Part C, Medicare Advantage (MA) represented the most fundamental change in Medicare since its inception. The new benefits brought new choices and coverage options for beneficiaries, their families and caregivers as well as for providers. Humana recognized the need to educate these individuals on the new benefits and options and on enrollment and post-enrollment processes. For both the 2006 and 2007 open enrollment periods, we conducted national education campaigns in places

where beneficiaries frequented, and we reached out to provider organizations, pharmacy associations, state health insurance counseling groups and regulatory agencies. One of the lessons learned from the first enrollment season was that our outreach failed to adequately reach state insurance departments, SHIPs and other beneficiary advocacy groups. For the 2007 open enrollment season, we reached out to **all** state insurance departments and SHIPs as well as beneficiary advocacy groups to orient them prior to November 15 about our products, how we sell—including copies of our sales presentations--and provided them with contact names and a special toll-free number to call with constituent issues. We have also been active members with our trade group, America's Health Insurance Plans, in a Beneficiary Advocates Working Group, to respond to concerns of consumer advocates and make improvements in our processes.

Agent Licensure: As a result of regulatory findings in a market conduct exam, we have strengthened our processes for ensuring non-resident licensure status. We implemented a new policy on confirmation of state licensure of agents to ensure that agents selling outside their primary state hold the relevant non-resident license. We also amended agreements and enhanced our training programs. Any willful violation will result in termination. We note that during the state's regulatory examination period, any delegated agent who sold a beneficiary in a state where (s)he did not hold a non-resident license, was not paid commission. Our system will not pay a commission without a license in the system. Further, we strengthened our in-house, non-resident licensing process for those employed telesales agents who enroll beneficiaries telephonically, but do not externally solicit sales. Previously, calls were system-routed to telesales agents with a license in the state of the caller. Due to misrouting of calls and call queue issues,

some enrollments were completed by agents not licensed in the relevant state. We have counseled management and have applied for licenses for all states for all these employees. Further, we are enhancing our systems to bring up additional flags to indicate the state of the caller and to screen agents' licensure status.

Investigation of Sales Allegations: In late 2006, we established a new unit (outside of our Medicare Sales operation) to investigate sales allegations to expedite our resolution of these cases. (The investigation of sales allegations has always been conducted outside our Sales operation. Previously, our Market Compliance Directors handled these cases.) Our field sales management keeps the findings of these investigations in the agents' files and continues to monitor for trends. Failure to comply with Humana's sales practice rules results in various corrective actions--from coaching/counseling and retraining to termination.

Verification Process: We reengineered our verification system based on issues related to system inadequacy during the 2006 open enrollment season. We were unable to verify some sales due to "hold" times for live representatives and length of calls or sales made outside the verification unit's hours of operation. Based on beneficiary, regulator and agent feedback, we revised all product scripts and made available both live and IVR options. The script was also modified as previously indicated.

Training/Certification Program: Mid-summer 2006, we implemented improvements to our comprehensive training program as a result of trends identified through beneficiary and regulator complaints/concerns and observations by training staff. We redesigned our delegated agent training program to bring it closer to our career agent training program. We doubled the length of training, added self-directed study prior to

classroom work, self-study competency testing and strengthened the process to ensure certification is completed. We gave increased emphasis to ethics and compliance, election periods, sales presentation skills, proper enrollments, needs analysis and suitability assessments and added follow-up phone calls to answer agent questions after they started selling. We know our program is extensive from comments made by delegated agents who chose not to sell for us based on our training and oversight programs and from those who chose to sell for us because they value and appreciate the focus we place on these issues.

Further, we moved to an online method for delivering training and testing for recertification. Instructor-led training manuals and guides were created as an alternative to online learning/testing. The focus for recertification included changes to Medicare, CMS rule changes, election periods (what changed and what was new), ethics issues, compliance standards and expectations, and suitability assessments. We changed test questions to be more scenario-based rather than a recitation of facts.

Sales Presentations: We added a component to the sales presentation that requires the use of a CMS-approved Suitability Worksheet *(Attachment #3)* that is given to the beneficiary during the presentation. This Worksheet is left with the beneficiary (as it contains personal information and includes questions the agent is not permitted to ask). The Worksheet, designed in consultation with a former NAIC Health Insurance/Senior Issues Task Force staff director, compares the beneficiary's current coverage to the coverage being considered by the beneficiary. It also compares medical needs, providers and costs of coverage. It was designed to assist the beneficiary in determining whether or

not an MA plan is a good fit for their particular needs. This Worksheet augments the needs assessment the agent discusses during the presentation.

Management Oversight Reports: For the 2007 year, we designed early voluntary disenrollment reports to allow field sales management to track and trend any outliers among agents for beneficiaries who voluntarily disenrolled in the first 90 days of enrollment. Early voluntary disenrollment could be an indicator of a violation of sales practice policies.

CONCLUSION/RECOMMENDATIONS

Humana recognizes the trust that CMS has placed in us to provide affordable, comprehensive health care coverage options for Medicare beneficiaries. We understand the vulnerability of this population and their special needs. Our success over the past 20 years has come from the retention of beneficiaries who place their trust in us. None of us is advantaged when one of us is not.

Today, our trade association, America's Health Insurance Plans, has put forth Medicare sales and marketing practice principles that all its members will ascribe to, thus creating a national standard for plans. We wholeheartedly endorse those principles. Within those principles are provisions for CMS and state regulatory agencies to work together to ensure the best consumer protections for beneficiaries are in place and that those protections are uniform across the regulatory landscape. For example, state and federal regulators should work together to determine an appropriate reporting mechanism for agents who are not only terminated for cause (reportable under state law), but also for those who exhibit a demonstrable trend in complaints that result in inconclusive findings—a "watch list" registry. We believe that the current information-sharing model

for detecting health care fraud could serve as a model for such a registry. Under the auspices of a national fraud association, state, federal and company fraud investigators share information related to suspected fraudulent activities. This information-sharing model allows for early detection of potential violations. Further, we believe licensure and appointment rules should be uniform across the state and federal regulatory landscape. We encourage the states to work together with CMS to explore whether it is feasible to have a uniform definition of "for cause" reporting that addresses all parties' concerns. We encourage CMS to require plans to distribute CMS new product information to beneficiaries as part of the pre-enrollment process to ensure beneficiaries have additional information. There are others. Through public, private and partnership efforts, we all should work together to ensure as much uniformity in agent training and agent oversight requirements as possible.

Within our own organization, we continue to look for ways to improve our operational processes. At the top of that list are the formalization of secret shopping initiatives and call-backs to new members to solicit feedback on sales visits.

Finally, we recognize that consumer protection is among your most important concerns and that you have valid concerns about the marketing and sales of insurance products to Medicare beneficiaries. We share those concerns. We want you to know that Humana and our employees are working to earn the trust that consumers place in us when they select our coverage. If we do not work with the beneficiary to provide a product that best meets their needs, they will make a different choice. In doing so, we continue to work to ensure that we comply with all regulatory and contractual requirements.

Thank you for allowing me to present this testimony and I am happy to answer any questions.

Testimony Attachments

Attachment #1: Humana Sales & Marketing Code of Ethics

Shortcut (2) to medicarecodeofethics.pdf.lnk

Attachment #2: Delegated Sales Program Agency Compliance Agreement

Shortcut to delagencycomplagt.doc.lnk

Attachment #3: Humana Medicare Advantage Suitability Worksheet

Shortcut to SuitabilityWorksheet 2.pdf.lnk