Testimony on

Medicare Advantage Marketing and Sales

by

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I. Introduction

Mr. Chairman, Senator Smith, and members of the committee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members serve most beneficiaries in both the Medicare Advantage and Medicare Part D prescription drug programs. They also participate in other public programs and offer a broad range of products in the commercial marketplace.

We appreciate this opportunity to testify on the Medicare Advantage program and issues surrounding the marketing and sales of Medicare Advantage plans to beneficiaries. Our members are committed to the long-term success of the Medicare Part D and Medicare Advantage programs, and to providing clear and accurate information to beneficiaries about these important benefits in an effort to assist them in making the most informed decision possible about their medical and prescription drug coverage. We recognize that concerns have been raised about the practices of certain brokers and agents, and today we will be announcing a new initiative that we will be working side by side with the Centers for Medicare & Medicaid Services (CMS) to implement to give beneficiaries additional peace of mind.

As you know, the Medicare Advantage and Part D programs generally open up enrollment for a limited time each year, which also limits the time periods during which plans are allowed to actively market their benefit packages to beneficiaries. As a result, plans recognized the need to develop a new means of marketing these products to serve the Medicare population. Many plans have accomplished this goal by using a contracted sales force to supplement the activities of their directly employed sales force, and by implementing new approaches to ensure that their sales force interacts appropriately with those they seek to serve.

In February 2007, we met with our Beneficiary Issues Advisory work group, which includes beneficiary advocates, to discuss various priority issues, including marketing practices. We went to work designing specific steps to address areas of concern. We did not approach these concerns as isolated events. Rather, we sought to establish a series of systematic initiatives that could be broadly adopted. I will review the elements of that plan in my testimony today.

Our testimony will outline aggressive new measures AHIP member organizations are undertaking to ensure that brokers and agents and plan marketing staff meet specific qualifications and follow appropriate standards of conduct when providing information to Medicare beneficiaries. These measures differ from the existing policies and requirements in several important respects, including the following:

- Requiring core competency training that meets standards we are urging CMS to establish;
- Requiring achievement of threshold scores on the core competency training;
- Ensuring that continuing education credits are available for the core competency training;
- Requiring achievement of threshold scores on plan-specific training;
- Requiring annual recertification through achievement of threshold scores on tests;
- Requiring targeted retraining on topics requiring special sensitivity throughout the year;
- Requiring beneficiary attestation on the enrollment application and outbound post-enrollment calls to verify the beneficiary's intent to enroll and understanding of key plan benefits and structure;
- Requiring plans to systematically and proactively track and analyze broker, agent, and staff marketing performance in such areas as beneficiary satisfaction, rapid disenrollments, and complaints;
- Requiring inbound pre-enrollment verification calls if broker, agent, or staff complaints surface to ensure beneficiary intent to apply for a plan; and

- Establishing uniform processes and criteria for reporting broker, agent, and staff misconduct to state agencies.

In addition to discussing these important issues relating to marketing and sales of Medicare plans, our testimony also will review the success the Medicare Advantage program has achieved in providing high quality, comprehensive, affordable coverage options to beneficiaries and the rapid growth the program has experienced in recent years.

II. Improving and Monitoring Medicare Marketing Practices

AHIP's Board of Directors has issued a statement outlining seven principles for ensuring that safeguards are in place to provide appropriate information to beneficiaries, that they intended to enroll in Medicare Advantage or Part D plans, and that appropriate steps are put in place to ensure that contract agents and brokers and internal plan sales teams are appropriately trained and regularly recertified.

Ensuring Best Practices

In each of the following areas, AHIP members are working on an accelerated basis to promote marketing practices that assist beneficiaries in making informed decisions about their health care options.

Establishing Qualifications for Brokers and Agents and Plan Marketing Staff:

Plan sponsors will specify the qualifications that brokers and agents and plan marketing staff must meet to market Medicare Advantage and Part D plans, clearly communicate these qualifications, and consistently apply them. Plans will use multiple strategies for accomplishing this, including:

- Performing background checks, including verification of required state licensure;

- Checking applicable databases for documentation of prior serious misconduct;
- Obtaining documentation substantiating that threshold test scores have been achieved on core competency training and ensuring that continuing education credits are available for licensed brokers, agents, and plan marketing staff. We are urging CMS to establish standards for training that requires that specific topics must be addressed in detail including:
    - Medicare fee-for-service eligibility and benefits;
    - Medicare Advantage and Part D plan types and structure, including the key differences between HMOs, PPOs, PFFS plans, and SNPs; and
    - Permissible and prohibited marketing practices, including non-discrimination rules and the prohibitions against door-to-door marketing; and
- Requiring brokers and agents and plan marketing staff to obtain threshold test scores on plan-specific training that provides detailed information about the plan types and benefits offered by the plan sponsor.

Annual Recertification and Targeted Retraining:

Plan sponsors will establish requirements for brokers and agents and plan marketing staff to achieve threshold scores on annual recertification tests and repeat core competency training, as needed. Plan sponsors also will require targeted retraining addressing topics requiring special attention that may arise throughout the year and provide updated information through e-mails, websites, or other means on an ongoing basis.

By setting threshold scores for annual training, our objective is to ensure that brokers and agents and plan marketing staff regularly update their knowledge or expertise so that they can fully and clearly inform beneficiaries about the details of their coverage options. Moreover, the additional requirement for targeted retraining ensures that brokers and agents and plan marketing staff will promptly receive in-depth information on specific issues that arise during the year.

Enrollment Safeguards:

Plan sponsors will include steps in their marketing and enrollment processes to verify beneficiaries' intent to enroll and understanding of the plans they are electing. Strategies for verification include:

- adding to the plan's enrollment application attestations by the beneficiary or his/her legal representative or guardian and the broker, agent, or plan marketing staff that address the beneficiary's understanding of the plan structure and benefits; and
- conducting oversight such as post-enrollment outbound calls from the plan sponsor to the beneficiary or his/her legal representative for face-to-face enrollments or systematic monitoring of recorded telephonic enrollments.

We understand that beginning this fall CMS will require that private fee-for-service plans make calls to beneficiaries who have enrolled to verify their intent to enroll and to ensure that they understand the coverage they have chosen. We will be working with CMS to add a safeguard to all plans' enrollment applications: an attestation to be signed by the beneficiary and the broker/agent/plan marketing staff that addresses the beneficiary's understanding of the plan structure and benefits and how they compare to the beneficiary's previous Medicare coverage. We also support requiring post-enrollment outbound calls from the plan sponsor to beneficiaries selecting all products. These measures will help to avoid misunderstandings about whether beneficiaries actually intended to enroll in a plan and to reaffirm that beneficiaries understand the coverage offered by the plan they choose.

Monitoring Compliance:

Plan sponsors will establish processes for tracking and analyzing individual broker and agent and plan marketing staff performance in such areas as beneficiary satisfaction, rapid disenrollments, and complaints. This ongoing process of evaluation allows plan sponsors promptly to identify conduct that merits urgent investigation, such as provision of incorrect, misleading, or inaccurate

information; unauthorized contact or home visit; fraudulent enrollment submission; or intimidation.

Protecting Beneficiaries:

Plan sponsors will establish processes for rapidly investigating complaints and taking immediate and decisive action when complaints are verified, including requiring inbound calls by the broker, agent, or plan marketing staff and beneficiary before each application is completed, re-qualification, suspension, or termination. We strongly urge CMS to work with the National Association of Insurance Commissioners (NAIC) to develop a uniform process and criteria for plan sponsors to report serious misconduct by licensed brokers, agents, and plan marketing staff in a timely fashion to state agencies overseeing broker and agent licensure.

These processes will give plans the information they need to move quickly in taking corrective measures – including requiring pre-enrollment inbound calls by the broker and beneficiary before the application is completed or dismissal, if warranted – when brokers or agents engage in inappropriate conduct while marketing Medicare Advantage or Part D plans to beneficiaries.

Compensation:

Compensation arrangements must comply with CMS Medicare Marketing Guidelines, including withholding or withdrawing payment for rapid disenrollments.

We have strongly supported compensation requirements in the CMS Medicare marketing guidelines which are designed to reward brokers and agents when beneficiaries are satisfied with their choices and penalize brokers and agents who use marketing tactics that result in beneficiaries signing up for a product that they do not fully understand – and then disenrolling a short time later after learning more about the plan. We will take additional steps to ensure that beneficiaries understand the program they have joined and that brokers and agents have correctly answered their questions.

Provider Outreach:

Plan sponsors will make available to physicians, hospitals and other providers detailed information about plan structure, benefits, rules and payment terms of the plans they offer. Plan activities will include strategies to educate providers prior to market entry and ongoing efforts to build and maintain relationships to serve plan members. CMS should increase outreach to educate providers about the types of Medicare Advantage plans and expand availability of CMS materials for providers.

The seven principles outlined above reflect our members' commitment to zero tolerance for broker and agent misconduct in carrying out Medicare marketing and sales activities and a comprehensive approach to improving the performance of brokers and agents and plan marketing staff. At the same time, the initiatives represented by these principles will help beneficiaries receive the clear and accurate information they need to make informed choices that meet their particular needs.

III. The Success of the Medicare Advantage Program

The success of the Medicare Advantage program is highlighted by the findings of a recent survey[1], released by AHIP in March 2007, regarding the important role Medicare Advantage plans play in providing health security to Medicare beneficiaries. This survey found that 90 percent of beneficiaries enrolled in Medicare Advantage are satisfied with their coverage overall. Other findings show that a large majority of beneficiaries are satisfied with the quality of care they receive (93 percent), the number of doctors from which they can choose (92 percent), the benefits they receive (89 percent), the coverage they receive for preventive care (87 percent),

[1] Ayres, McHenry & Associates, Inc. and The Glover Park Group, *National Survey Of Seniors Regarding Medicare Advantage*, February 26 - March 2, 2007

their out-of-pocket costs (80 percent), and the coverage they receive for prescription drugs (76 percent).

Additionally, 35 percent of seniors – including 62 percent of low-income seniors – enrolled in Medicare Advantage say they would skip some of the health care treatments they currently receive if the option of choosing a Medicare Advantage plan was taken away. Another 42 percent say they would pay higher out-of-pocket costs if the option of choosing a Medicare Advantage plan was taken away.

The creation of the Medicare Advantage program has provided valuable opportunities for seniors and Americans with disabilities to benefit from the innovations developed and implemented by private health insurance plans. Approximately 8 million beneficiaries currently receive high quality coverage through the Medicare Advantage program, reflecting a more than 50 percent increase in Medicare health plan enrollment since 2003. As a result of this rapid growth, nearly 20 percent of all Medicare beneficiaries nationwide currently are enrolled in Medicare Advantage plans.

The participation of private health insurance plans in Medicare has enabled millions of seniors and persons with disabilities to benefit from chronic care initiatives and other innovations that are improving their health care and enhancing their overall quality of life. Recognizing that many Medicare beneficiaries suffer from multiple chronic conditions – such as diabetes, heart disease, cancer, asthma, and depression – Medicare Advantage plans meet a critical need by offering care coordination and management for diseases that commonly afflict the elderly.

Health insurance plans are playing a leadership role in developing strategies and programs to improve patient care for persons with chronic conditions. Our members are focused not only on ensuring that patients with chronic conditions live longer – but also helping them live healthier lives, with fewer symptoms, so they can fully participate in the activities they enjoy. This requires a strong emphasis on preventive care, personal responsibility for healthy lifestyles, and early intervention to promote care strategies that are effective in improving the patient's quality of life.

Health insurance plans have a strong track record of encouraging prevention and evidence-based care for individuals with chronic conditions. Our members also are working on an ongoing basis to continue to develop new tools and greater expertise to help physicians customize care strategies to meet the unique needs and circumstances of individual patients. Building upon the success of early innovations in disease management, they are taking personalized service to a new level through a new generation of chronic care initiatives. These efforts reflect four interconnected trends:

- Plans are offering health coaching to change patient behavior. Using nurses and other health professionals who are trained to serve as health coaches, health plans are helping enrollees make lifestyle changes to improve their health, understand and follow their doctors' treatment plans, and address other health and social service needs.

- Plans are using advances in information technology – including moving toward personal health records (PHRs) for health plan enrollees – to improve the delivery of care, enhance health care quality, and increase productivity. In November 2006, AHIP's Board of Directors endorsed a set of recommendations calling for the industry to implement steps to standardize health plan-based PHRs. These recommendations, developed in partnership with the BlueCross BlueShield Association, will facilitate both information-sharing between consumers and caregivers and portability when a consumer changes health plans.

- Plans are recognizing that patients are well-served by a comprehensive strategy that addresses the needs of each person as a whole, rather than a narrow approach that targets individual diseases. Accordingly, our members are using nurse case managers to identify barriers to effective treatment – including financial, transportation, or social support issues – and helping individuals overcome these barriers.

- Another trend is the increased focus health insurance plans are placing on the continuum of health care services that people need throughout their lives. By providing a full spectrum of services – ranging from wellness and prevention to acute, chronic, and end-of-life care – our

members are improving health outcomes and addressing the unique needs and circumstances of each individual patient.

In addition to improving patient care for chronic illnesses, the Medicare Advantage program also provides many additional benefits that are not included in the Medicare fee-for-service benefits package. 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.[2] This translates into aggregate savings of approximately $8 billion annually. Examples of the additional benefits Medicare Advantage plans provide to beneficiaries include:

- **Protection against out-of-pocket costs:** Ninety-three percent of all beneficiaries nationwide have access to Medicare Advantage plans that provide protection against out-of-pocket costs for Medicare-covered (non-drug) benefits of $2,500 or less. This protection is not available in the fee-for-service program.

- **No cost sharing for preventive screening:** All Medicare beneficiaries have access to a Medicare Advantage plan that does not require cost sharing for screenings for breast cancer, cervical cancer, and prostate cancer.

- **Extra benefits not available in FFS:** Medicare Advantage plans are widely available that provide hearing, vision, and other benefits that the Medicare program does not offer. For example, all Medicare beneficiaries can choose from a Medicare Advantage plan that covers hearing benefits. Over 98 percent of beneficiaries can enroll in a Medicare Advantage plan offering preventive dental benefits.

- **Comprehensive prescription drug benefits:** Almost every Medicare beneficiary can choose from a Medicare Advantage plan that provides protection in the Part D coverage gap.

[2] Keynote Address by CMS Administrator Mark McClellan before the AHIP Medicare Conference (September 11, 2006).

Almost 90 percent of beneficiaries can choose a Medicare Advantage plan that provides Part D benefits for no additional premium.

Research studies indicate that these additional benefits are particularly important to low-income and minority Medicare beneficiaries, especially those who fall just short of qualifying for Medicaid. In February 2007, AHIP published a new study[3] showing that financially vulnerable beneficiaries who do not have Medicaid or employer-based coverage are more likely to enroll in Medicare Advantage plans than other beneficiaries.

This AHIP study demonstrates that Medicare Advantage plans serve as an important source of support for beneficiaries who may not qualify for state Medicaid programs, but are still likely to need assistance paying for necessary health care services. This is why Medicare Advantage plans remain the most popular option for beneficiaries with incomes between $10,000 and $20,000 who are less likely to have access to Medicaid or employer-sponsored coverage. AHIP's study found that beneficiaries with incomes above this range are more likely to have employer-based coverage to supplement their Medicare benefits. However, beneficiaries in the lower income categories are less likely to have employer-based coverage. And those with incomes in the range of $10,000 to $20,000 generally are not eligible for Medicaid – meaning that Medicare Advantage is their only option for comprehensive, affordable coverage.

Other key findings of the AHIP study include:

- 49 percent of Medicare Advantage enrollees in 2004 had incomes below $20,000; and

- among minority (non-white) beneficiaries in Medicare Advantage, 68 percent had incomes below $20,000, while 70 percent of African-American and Hispanic Medicare Advantage enrollees had incomes below $20,000; and

[3] AHIP, *Low-Income and Minority Medicare Beneficiaries in Medicare Advantage Plans,* February 2007

- in areas where Medicare Advantage plans were offered, 40 percent of low-income Medicare beneficiaries not enrolled in Medicaid or employer-based coverage chose a Medicare Advantage plan.

These findings demonstrate that Medicare Advantage plans play an important role in providing health coverage to many minority beneficiaries and many low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program. For many beneficiaries who do not receive supplemental coverage through Medicaid or a prior employer, the Medicare Advantage program serves as a crucial health care safety net by providing comprehensive, affordable coverage that is not available under the Medicare fee-for-service program.

In discussing the value of Medicare Advantage, it also is important to recognize that the program includes incentives that generate high quality health benefits and savings for beneficiaries and the program. Under the program's competitive structure, Medicare Advantage plans return 25 percent of the savings to the federal government when they bid below the benchmark; the remaining 75 percent is used to provide beneficiaries improved cost savings and supplemental coverage. According to CMS, the 25 percent that plans return to the government total approximately $26 per beneficiary per month.[4] This translates into approximately $3 billion in aggregate savings for taxpayers in 2007 alone.

IV. Conclusion

Thank you for this opportunity to testify on these important issues. We look forward to continuing a dialogue with committee members regarding our members' ongoing activities to improve marketing practices and beneficiary information in the Medicare Advantage and Medicare Part D programs. We also stand ready to work with you to further strengthen these programs, building upon the competition, choice, and innovation that have played such a crucial role in delivering savings and value to our nation's Medicare beneficiaries.

[4] Keynote Address by CMS Administrator Mark McClellan before the AHIP Medicare Conference (September 11, 2006).