Hello, I am Mary Kempker, Consumer Affairs Director for the Missouri Department of Insurance, Financial Institutions and Professional Regulation. I appreciate the opportunity to testify on the Medicare Advantage solicitation abuses and participate in ensuring consumer protections are strengthened to protect our most vulnerable population.

In my capacity as Director of Consumer Affairs, I actively participate with investigations involving Medicare Advantage solicitation abuses, participate on the National Association of Insurance Commissioners Senior Issues Task Force and am a member of Missouri's SHIP Advisory Board.

Investigating Medicare Advantage abuses involves interviewing the elderly, subpoenaing the agent to appear before us and, if necessary, subpoenaing the company to appear before Consumer Affairs. While the Centers for Medicare and Medicaid Services (CMS) retain jurisdiction over the actual product, marketing of the product and the training and certification of the agents, the states are allowed to pursue agent solicitation abuses.

Through investigating solicitation abuses, Consumer Affairs identified three areas of concern: agent solicitation; insurance company responsibilities and call or marketing centers.

Agent complaints brought to light the following abuses:

1. Agents representing themselves from Medicare or Medicare Advantage
2. Agents sponsoring a bingo event at a senior center and as one agent called bingo, the other agent was asking seniors to sign forms or set up appointments as they played bingo
3. Agents churning the dual eligible. Since CMS guidelines allow dual eligibles to switch plans on a monthly basis, agents take advantage of dual eligible seniors. The seniors, however, find themselves unable to purchase prescriptions or procure medical care because of the time required to process the changes in CMS' and the insurance company's systems.
4. Agents asking consumers to sign a form just as proof to their boss that they met. However, signature on the form enrolled the unsuspecting senior into a MA plan.
5. All of the agents appearing before us didn't know that Missouri's Medicaid program did not cover copayments leaving these financially vulnerable individuals with even greater out of pocket expenses and facing the choice of purchasing their prescriptions or food.
6. Agents fail to provide information on PFFS participating providers. PFFS plans do not have a standard network. The insured receives the benefit provided in the policy if the provider "agrees to accept the plan". The provider's agreement can change on a daily basis. Because the network requirements were not disclosed, one elderly, disabled consumer went 1 ½ months without his 18 prescriptions.

While the states can pursue Unfair Trade Act violations against the agents and can take action to suspend or revoke the license, our hands are tied when pursuing violations against the insurance company on Medicare Advantage plans. CMS retains authority over approving the benefit plans filed by the company, the marketing materials, the training and certification of agents, and investigating any claim or provider complaint from the senior. While investigating complaints against the agents, Consumer Affairs will request marketing materials from the company to ensure appropriate training. However, the states do not have the authority to police the content of the training, the continued training and certification, premium billing, policy content nor claim adjudication issues.

Another issue is the Federal Waiver granted by CMS to those companies lacking a certificate of authority to do business in the states in which their products are marketed. The Federal waiver allowed the company rights to conduct business without the Certificate of Authority for three years but required the companies to pursue a Certificate of Authority before the end of the three years. By forgoing the state's Certificate of Authority process, CMS further restricted the states ability to apply any appropriate regulatory pressure on the company. The states lacked a certificate of authority to revoke if concerns were not resolved and/or financial solvency secured. Missouri's experience is that the plans with Federal Waivers generate the most complaints.

And finally, companies and/or insurance agencies hire call or marketing centers to initiate contact with the consumer and set up appointments. I have two examples here today from call centers. The first call you will hear is from fall 2007.

Listen to call.

What's wrong with the call?

1. They identify themselves as from Medicare.
2. The caller appears to suggest he/she mailed out the "red, white, and blue" book.
3. The caller intrigues the consumer by stating it involves "changes to their Medicare benefits."
4. The caller never identifies the company or the product.
5. The caller indicates it will only take 15 minutes.
6. And finally, the product being solicited is a PFFS SNP for duals or those with specific medical conditions.

Missouri called the insurance company using this call center to appear before us and after hearing the call, the company agreed to ensure the CMS script would be adhered to. Here's a call from February 2008 from a call center of this same insurance company.

Listen to the call.

Notice any changes?

The only change I noticed was that the caller stated they were calling from Medicare Advantage instead of Medicare. Other than this, the caller

1. Indicates it's an entitlement program.
2. Fails to identify the company or the product.
3. Again states it will only take 15 minutes.
4. Keeps questioning the consumer on her health conditions until he finds anything that may qualify her for a SNP plan. It sounds like the member may have sleep apnea, not COPD, the required diagnosis for a SNP.
5. The caller rejoices at setting the appointment, whether appropriate or not.

While CMS requires the call center scripts to be filed and adhered to, oversight through site visits and on-site audits to ensure compliance appear to be lacking.

During the 2008 legislative session, legislation was introduced to thwart the abuses by requiring the agent encourage the consumer to contact their provider to ensure participation, contact their SHIP program for general unbiased information and require 48 hours before the application became effective. CMS indicted the requirements were more strict than MMA so, even if the legislation were to pass, the states still lacked the authority to enforce.

The National Association of Insurance Commissioners, in collaboration with CMS, advocacy groups, states, and insurance companies, is producing a white paper identifying the issues nationally and providing suggestions for strengthening consumer protection.

I will be glad to answer any questions.