Senate Committee On Aging
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Testimony of

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Senator McCaskill, thank you for inviting me to testify regarding Medicare Advantage Sales & Marketing Oversight.

I am Robb Cohen, the Chief Government Affairs Officer for XLHealth. We are headquartered in Maryland, and operate Chronic Special Needs Plans, including 1 in Maryland and 3 Regional PPOs in the Southeast and South Central United States. These are areas with a high prevalence of chronic disease, including throughout Missouri. We serve 64,000 members, of which 3,500 are in Missouri, including in 113 of 114 counties, offering a valuable choice with added and disease-tailored benefits to chronically-ill seniors who have historically had limited Medicare options.

Other than a soon to end Medicare project in Tennessee, our sole business is as a Chronic Special Needs Plan. Our Company was founded as a disease management organization, focused on Diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and End Stage Renal Disease. Our goal is to offer the most beneficial Medicare product option to Medicare beneficiaries with one or more of the qualifying conditions, and to deliver improved quality and satisfaction at a reduced cost, through a targeted care model and benefit design.

My testimony will focus on issues related to, and efforts to improve, beneficiary education and marketing.

Beneficiary education

We believe each beneficiary should make a well-informed choice, and that it is our responsibility to do everything possible to ensure that occurs. We believe our care model and benefit design offer the most possible value for disease qualified beneficiaries, and that over time our care model will result in beneficiaries experiencing better quality and outcomes. Special Needs Plans, because they care for Medicare's most needy beneficiaries, must be required to be special.

An important component of beneficiary education is our work with Area Agencies on Aging, State Health Insurance Plan counselors, and other members of the Aging Services Network. We want to inform educators as well as beneficiaries to make appropriate Medicare coverage choices.

Medicare marketing issues

We acknowledge that there have been problems with Medicare Advantage sales and marketing , including with Care Improvement Plus. Also, we agree with proposed increases in regulation and oversight so that seniors are able to make well-reasoned Medicare choices.

Since starting our RPPOs in January 2007, and becoming the second largest Chronic Special Needs Plan in the country, we have experienced growing pains, including beneficiary complaints.

We understand that given the nature of the product and sales method, there are and will be complaints and misunderstandings. Our goal is to address every single complaint in a manner that resolves the complaint, and use the knowledge gained to fix root causes to eliminate future complaints.

Our efforts to address marketing issues include a pre-enrollment verification call, mandatory agent testing, and, thorough investigation of all member complaints with agent discipline where warranted:

Pre-enrollment verification. Beginning in November 2007, we required completion of a pre-enrollment verification telephone call with each applicant. We record each verification call. The verification call asks the applicant very specific questions, including whether the applicant understands they are enrolling in a Medicare Advantage plan, and that they are leaving Medicare fee-for-service or any other Medicare Advantage or Part D Plan. As a result, disenrollments within 90 days after enrollment have been reduced.

Mandatory agent testing. We instituted mandatory testing in 2007 and all agents who sell our plans must pass a written test. We support proposed regulations to require agents to pass a written test.

Internal sales management, complaint investigation and agent discipline. We employ Sales Managers in each market, including Missouri, who manage the broker network, and our compliance department investigates all member complaints, including ones that allege agent misconduct.

We have improved our complaint management processes, including growing our compliance staff from three employees in early 2007 to over 20 employees today. Our number of complaints is within CMS expected industry benchmarks and we strive to process complaints within CMS expected timeframes. In addition, we do not tolerate unacceptable broker practices and implement various levels of discipline, including suspensions while investigations are occurring, and terminations for serious misconduct as the result of an investigation.

Marketing oversight

We believe there is much work that can be done by Care Improvement Plus and the state and federal regulatory authorities to improve how we market our health plan. We support proposed changes in regulation of Medicare advantage marketing, including the following:

* Regulation of broker commissions;
* Appointment of agents through state insurance departments; and,
* Creation of a national registry of agents who have been disciplined, so that all Medicare companies can benefit from each other's efforts to eliminate agents with confirmed violations.

Additionally, we are active with the Association of Health Insurance Plans and the Special Needs Plan Alliance, including to contribute to efforts to address Marketing concerns.

Conclusion

Finally, while we are highly respectful of the need to reduce and respond to complaints, we are pleased about the following statistics from Member Surveys conducted in 2008 by an independent research firm. These are just a couple statistics from the survey, which demonstrate that across the board, our members are satisfied with their benefits and services:

* 94% of members were satisfied with the plan;
* 91% of members would recommend the plan;
* 96% of members were satisfied with the enrollment process; and,
* 91% of members said their health status was the same or better since joining the plan, with 30% saying they had gotten better, and 97% of those saying XLHealth's support contributed to their improvement.

In summary, every complaint is one too many. We want to improve beneficiary education, agent oversight, and other aspects of our health plan to eliminate complaints. To the extent there are complaints, we want to protect beneficiaries and handle complaints appropriately and efficiently.

As a new Company that has grown tremendously, we believe we have improved significantly in the past 18 months, and that we constantly strive to be responsive to all member comments and concerns.

In addition to myself, I am here with Tom Mapp (Corporate Compliance Officer) and Tracy Beavers (Community Outreach Representative, St. Louis, Missouri), and we would be pleased to answer any questions today and in the future. Thank you.