

**Statement of
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Before the
Energy and Commerce
Subcommittee on Oversight and Investigations
On
Marketing of Medicare Advantage Plans**

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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.

