

Testimony of Sean Dilweg,
Wisconsin Insurance Commissioner

Before the
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Regarding:
Medicare Advantage Marketing & Sales

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Wisconsin Insurance Commissioner

Good morning Chairman Kohl, Ranking Member Smith, and members of the Committee. My name is Sean Dilweg and I am Commissioner of the Wisconsin Office of the Commissioner of Insurance. Like Commissioner Holland, I am here to share with you my perspective as Insurance Commissioner of my home state, and I would like to build upon Commissioner Holland's remarks and share with you the experiences of my department in Wisconsin. I also currently serve as chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators from 50 states, the District of Columbia, and five U.S. territories, and although I am not testifying in my NAIC capacity today, I would like to supplement some of my views with the collective views of the nation's insurance commissioners on today's topic.

Marketing Complaints:

The primary objective of state insurance regulation is to protect consumers and promote healthy insurance markets. State insurance commissioners and regulators are also on the front lines of consumer protection when it comes to private health insurance and our departments receive complaints every day from our citizens. In about one-third of the states, the State Health Insurance Assistance Program (SHIP) is housed within the department of insurance.

In this role insurance departments receive the whole spectrum of consumer complaints about the Medicare program. In many instances, the consumer complaints are routine, and to be expected for a program as large and complex as Medicare Advantage and Medicare Part D. But increasingly we are getting consistent complaints from consumers about the marketing and sales of Medicare Part D and Medicare Advantage plans that too often fall along familiar lines. The NAIC has surveyed the experiences of departments across the country, and the striking similarity to problems I have seen in Wisconsin indicate troubling patterns.

37 out of 43 states have reported receiving complaints about inappropriate or confusing marketing practices leading Medicare beneficiaries to enroll in a Medicare Advantage plan without adequately understanding their choice to remain in traditional Medicare or without adequate understanding of the consequences of their decision. Beneficiaries believed they were signing up for a Medicare Part D stand-alone drug plan or a Medigap plan to supplement their traditional Medicare, but

instead they were enrolled into a Medicare Advantage plan. Too often we find that the beneficiary did not know that he or she made this choice, or that he or she was not made aware of the implications of this decision, such as the fact that they would be giving up traditional Medicare, their Medigap policy, and also potentially restricting their access to doctors and other providers. We have heard instances when a beneficiary continues to send in their Medicare supplement premium for several months after they've signed up for a Medicare Advantage plan. In the most troubling of these cases, unscrupulous agents have enrolled beneficiaries with dementia into an inappropriate plan.

39 out of 43 state insurance departments have also reported received complaints about misrepresentations and inappropriate marketing practices. This includes instances where a plan or an agent provides inaccurate or misleading information about the provider network associated with a certain plan, or the benefits that the plan offers, or the beneficiary cost-sharing involved. This seems to be a particular problem with Medicare Private Fee-for-Service plans where seniors are being told that they can go to any provider without being told that they may only go to a provider that accepts Medicare, and also a provider that has agreed to accept the plan's payments. States have also reported that agents are describing Medicare Advantage plans as a "supplement" plan with extra benefits, thereby confusing the beneficiary into believing they are buying a Medigap plan to supplement traditional Medicare, when in fact they are enrolling in a Medicare Advantage plan.

31 out of 43 states have also reported cross-selling, where insurance agents and brokers use Medicare Part D as a pre-text to get in the door with a senior, a situation that is not prohibited by the Medicare marketing guidelines.¹ Once inside, agents instead sell the senior an unrelated and sometimes unsuitable insurance product -- including Medicare Advantage plans, annuities, life insurance policies, funeral policies, and other types of products. These other products are often much more lucrative to the agent than a Medicare Part D plan.² In Wisconsin, one insurer paid agents a commission of \$50 for a Part D sale, whereas the commission for a Medicare Advantage sale was \$250. With these types of incentives, inappropriate steering of beneficiaries to Medicare Advantage is difficult to avoid.

¹ CMS Medicare Marketing Guidelines, pages 112-113.

² CMS Medicare Marketing Guidelines, pages 131-132.

States have consistently reported other types of complaints of high-pressure sales tactics and tactics that could be considered unethical, at best, and fraud at worst:

- door-to-door sales;
- sales by unlicensed agents/brokers;
- agents improperly portraying that they were from "Medicare" or from "Social Security" in order to gain people's trust;
- seniors who merely asked for more information about a plan, or filled out a "sign-in sheet" at a health fair, and later discovered that they had been disenrolled from their old plan and enrolled in a new plan without their consent;
- mass enrollments and door-to-door sales at senior centers, nursing homes, or assisted living facilities;
- inappropriate use of gifts or gift cards as enrollment incentives;
- forged signatures on enrollment forms;
- improper obtainment or use of personal information.

These marketing concerns compound the difficulty Wisconsin consumers already face with these confusing programs. I have attached three Wisconsin Medicare Advantage complaints to this testimony to illustrate some of the especially troublesome sales activity we are experiencing. In Wisconsin, we had many seniors sign up for a Medicare Advantage plan one year, as beneficiaries were attracted to the generous benefit package and very low or no additional premium. The next year, however, the company decided to significantly scale back on these benefits, and many seniors were left not fully understanding the changes that had occurred to their plan and without the benefits they believed they originally signed up for. I will discuss this in more detail later in my testimony. These troublesome scenarios Wisconsin seniors have to sort through, which are inherently acceptable under the Medicare Modernization Act of 2003 (MMA) are exacerbated by troublesome and aggressive marketing tactics.

Limited State Regulatory Authority:

Under other circumstances, the types of marketing practices I've described are either prohibited by state law as unfair or deceptive practices in the business of insurance or would be questioned by watchful state regulators and controlled by the state regulatory structure. However, since these cases involve Medicare Advantage and Medicare Part D, the hands of state regulators are often tied, as states are largely pre-empted and marketing guidelines are established by CMS.

Prior to MMA states shared some regulatory oversight over Medicare Advantage plans, but the MMA scaled back on the ability of state insurance regulators to set or regulate marketing and sales standards for Medicare Advantage plans, and instead limited state regulation of Medicare Advantage plans to licensing and solvency. State regulation of insurance agents and brokers was retained. The MMA also established the same limited boundaries of state regulation for Medicare Part D plans.

This means that, unlike Medicare Supplement insurance or other types of state-regulated health insurance, the state insurance commissioner has regulatory authority over insurance agents and brokers, but has very limited authority over the actual insurance company. In Medicare Advantage and Medicare Part D a state insurance department has no say in whether a marketing strategy or practice (such as permitting cross-selling or cold-calls) or advertisement is appropriate for this often-vulnerable population. They have limited ability to monitor companies in the marketplace and limited ability to take corrective action against a company for misconduct. I have attached a Medicare Advantage marketing piece received by a Wisconsin resident to my testimony to illustrate how misleading these pieces of advertising can be by failing to provide certain relevant information.

In the absence of such constraints imposed by the MMA, states could avoid and react to such consumer problems by effective state regulation. A good example is Medicare Supplement insurance, which is also a Medicare-related product. States typically require companies to file their marketing plans and strategies with state regulators so that they can be reviewed prior to their use in the marketplace. State insurance commissioners also conduct market conduct reviews to ensure that consumer needs are being protected and they order corrective action if necessary. These are tools that are not fully available to us under Medicare Advantage and Medicare Part D.

States' Regulatory Authority

	Medigap	Medicare Advantage	Medicare Part D
Evaluation of Market Conduct of Plans	YES	NO	NO
Enforcement of Benefit requirements, Enrollment, Eligibility, consumer protections, claims practices	YES	NO	NO
Evaluation of Network Adequacy	YES (select plans)	NO	NO
Review and Approval of Policy Forms, rates, loss ratio compliance	YES	NO	NO
Regulation of Company Marketing, Sales, Advertising	YES	NO	NO
Regulation of Agent Conduct	YES	YES	YES
Ability to Address Consumer Complaints	YES	LIMITED	LIMITED

The preemption of state authority over the operations of Medicare Advantage and Medicare Part D plans - except licensure and solvency - means that consumers must go to CMS for assistance, regardless of the fact that state regulators have a closer connection to their citizens, more dedicated resources, and greater expertise in dealing with consumer complaints than CMS. However, states continue to receive and assist to the best of their ability with these types of issues.

Collaboration and Information Sharing with CMS:

Now that I have laid out many of the problems, I would like to spend some time focusing on ways to improve the situation, some of which is already occurring. I agree with Commissioner Holland that the best step forward is to work in a more collaborative fashion with CMS. State departments of insurance have worked to try to improve the situation with CMS.

Since December, over 20 states have signed a separate Memorandum of Understanding (MOU) with CMS, and plans to share compliance related information concerning agent activities between state and federal regulators are developing. Additionally, states may be reluctant to sign on to something before they see how it will be implemented. I hope that CMS will continue to make implementation of the MOU a high priority, and get states the information we need in a timely way so that we can act quickly to protect consumers against unscrupulous agents and brokers.

Legislative Suggestions:

In addition, I would like to continue to work with this Committee and other Members of Congress, as well as CMS to improve things. In particular, I encourage the Committee to look at the Medicare Supplement Insurance (or Medigap) regulatory approach as a potential model for these products. From the Medicare beneficiary standpoint, Medigap is a proven successful example of shared state-federal regulation of a Medicare-related product that works well, and is popular with Medicare beneficiaries.

As you might know, the standardized benefits for Medicare Supplement insurance plans are set by CMS, in conjunction with the NAIC through a unique delegation from Congress. Given the opportunity by federal law, the NAIC worked with CMS, industry representatives, consumer advocates, and other interested parties to establish a Model regulation that includes benefit, benefit design and regulatory standards for all Medigap plans. The NAIC model regulation was then promulgated at the

federal level and became the federal minimum standard, which then needed to be promulgated by each state in order for the state to enforce the standards.

One of the significant benefits of using Medigap as a model regulatory approach for the MMA products is that states will be again be able to regulate both the agents and the companies in the marketing and sales of these products. Companies will be held responsible for the acts of their agents as they currently are for all other insurance products. Eliminating this current critical regulatory gap, state insurance commissioners will have a greater authority and thereby greater ability to serve and protect their Medicare-eligible population. Under the Medigap model, consumers will also be able to go directly to their state insurance departments to resolve problems, rather than having to call CMS who seems to have neither the manpower nor the expertise to deal with many of these types of complaints.

Now, I admit that I am speaking for my own state of Wisconsin on this recommendation. At the same time I know that every insurance commissioner is concerned with the current situation concerning these products that have caused all these problems in every state. But, some commissioners may be wary of an unfunded mandate on the states to have a more active role in the regulation of these federally developed insurance products.

In addition, to take this a step further, I would suggest that you consider looking at the Medigap regulatory model for another reason, which is to consider the concept of simplification of the benefits and benefit plan designs, especially for the Part D PDP's and the Medicare Advantage Private Fee-for Service Plans. Currently, many of the problems have occurred because these programs are simply too confusing for people to understand. Medigap plans were simplified so that beneficiaries are able to compare plans and costs, and thereby make educated buying decisions. Under the Medigap model, beneficiaries have many choices of coverage. Yet, with simplified and consistent benefits and benefit plan designs amongst the plans, beneficiaries are able to truly compare plans when making their buying decisions.

Earlier in my testimony I referred to a Medicare Advantage plan significantly changing its benefits and premium in 2007 compared to 2006. In 2006, this major Medicare Advantage company offered several Private Fee-For-Service plans in Wisconsin. One of those plans, as an example, provided Medicare Part A and Part B coverage along with prescription drug coverage at no additional premium to the enrollee. The plan had a \$180 per day hospital co-pay for the first 3 days of a hospital stay. After the third day the plan picked up all hospital charges. That same plan in 2007 now charges \$39 per month additional premium and has changed its hospital cost-share to a \$550 deductible for any hospital stay

whether it is for one day or 30 days. The company informed its enrollees through the CMS approved plan amendment document. The plan document did not significantly highlight these reductions in coverage and increased premium in any way. In addition, to my knowledge, the company did not hold informational meetings with its beneficiaries to go over the changes to their plan during the open enrollment period. For many beneficiaries, the way they found out about the changes is when they got their premium payment coupons and if they went to the hospital.

That is one of the major problems with the Medicare Advantage plans. They can change the cost-share provisions and the premium annually so that the stability in coverage expected by the beneficiary is really not there. People are used to stability and consistency in their health insurance plans from year-to-year. Medicare Advantage does not provide that stability. This could not happen under the Medigap regulatory model.

Another concern is the number of PDPs available in Wisconsin. For a relatively small, rural state like Wisconsin, we have over 50 PDP's offered by 22 companies. Each plan has different benefit options, cost shares and formularies. I have heard from our Medicare-eligible seniors that they or their children, some of whom are attorneys or PhD's, are unable to figure out all the various option so that they can make a good decision for their coverage. Today, I have provided you with suggestions as to how to solve these problems.

In order for these programs to be successful and valuable to the market place, these issues need to be addressed with all dispatch. The baby boomers will hit the market in full force by 2010. The fastest growing segment of the population is the 85+ segment. I look to you for action and I hope we can work together; the Congress, state regulators, CMS, the insurance industry, the agents' groups, and the consumer advocates to provide our Medicare-eligible population with products they can compare, with marketing and sales standards that provide protection, yet allow for innovation, and an enforcement structure that provides assurance that they are protected.

Thank you again for this opportunity to testify today.