Testimony of Sean Dilweg
Wisconsin Insurance Commissioner

Before the
United States Ways and Means Subcommittee on Health

Regarding:
Medicare Advantage Private Fee-For-Service Plans

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Good morning Chairman Stark, Ranking Member Camp, and members of the Subcommittee. My name is Sean Dilweg and I am Commissioner of the Wisconsin Office of the Commissioner of Insurance. Thank you for inviting me here to share with you some observations on Medicare Advantage Private Fee-for-Service Plans as Insurance Commissioner of my home state of 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 and experiences 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 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 private Medicare programs, including Medicare Advantage and Medicare Part D. In many instances, the consumer complaints are routine, and to be expected for these large and complex programs. However, I would like to share with you an issue that has become of growing concern to me and other state insurance regulators, which is abuse in the marketing and sales of Medicare Advantage plans.

Although this issue is not limited just to Medicare Advantage Private-Fee-For-Service plans, the problems that insurance commissioners have seen in the states are often most evident when it comes to this product because of the tremendous rate of growth in the sales and enrollment in these plans. It has been reported that Private-Fee-For-Service Plans made up 46% of the total enrollment growth from 2005 to 2006.

Since January 1, 2006 my department has received approximately 400 complaints from consumers about marketing and sales involving Medicare Advantage plans. This is an extraordinarily

high number. The complaints I have heard from Wisconsin consumers and in insurance departments across the country too often fall along familiar lines. The NAIC has surveyed the experiences of departments across the country, and the striking similarities to problems I have seen in Wisconsin indicate troubling patterns.

37 out of 43 state insurance departments 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 reported that they have 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 who accepts Medicare without being told that, in order to be covered by the plan, the provider must have also have agreed to accept the plan's payments. States have also reported that agents are describing Medicare Advantage plans as "supplement" plans 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 state insurance departments 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

[1] CMS Medicare Marketing Guidelines, pages 112-113.

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 financial incentives, inappropriate steering of beneficiaries to Medicare Advantage is difficult to avoid.

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 consumers already face with these confusing programs, but are inherently acceptable under the Medicare Modernization Act of 2003 (MMA), and 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 plans, or Medicare Part D, the hands of state regulators are often tied, as

[2] CMS Medicare Marketing Guidelines, pages 131-132.

states are largely pre-empted from regulating Medicare Advantage plans. The marketing guidelines are established by CMS, and, thus, a large regulatory gap exists in the regulation of these plans.

Since MMA, state regulators have lost all of their regulatory authority over Medicare Advantage plans, except for licensure and solvency. 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. 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 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. We have limited ability to monitor companies in the marketplace and limited ability to take corrective action against a company for misconduct.

In the absence of such constraints imposed by the MMA, state regulators could prevent 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 available to us under Medicare Advantage and Medicare Part D, and I believe that there is a direct link to this inability for states to regulate and monitor this marketplace and the types of rampant abuses we are seeing today.

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

State Efforts:

To be clear, states do have regulatory oversight and authority over insurance agents and brokers, including those that sell Medicare-related products, including Medicare Private-Fee-For-Service plans. With this authority, I and my colleagues are acting as aggressively we can, with our limited resources, against rogue agents and brokers to the best of our ability. However, without the ability to regulate the plans themselves, state regulators are very limited in their ability to prevent the abuses that I've described earlier, and we can only act on the extraordinarily high number of complaints that result from these abuses. Most state regulators do not have the resources to track down and respond to every inappropriate agent action. In order for me to do that I would have to increase my staff. In traditional insurance, I can deal with inappropriate agent action by holding the insurance company responsible for the acts of its agents and thereby having it supervise and discipline its agents. Under the Medicare Advantage regulatory model, I cannot hold the companies responsible for the acts of their agents thereby severely crippling my ability to respond to inappropriate agent conduct. It's like trying to protect our seniors with our arms tied behind our backs.

Additionally, our regulatory authority over agents and brokers has been limited by CMS' interpretation that states' appointment laws are preempted by the federal law. We were very encouraged to hear at last week's hearing held by the Senate Special Committee on Aging that CMS is willing to re-examine its interpretation of its position of agent appointment laws. By not allowing states to enforce their appointment laws, it becomes virtually impossible for state regulators to track which agents sell Medicare Advantage products for the Medicare Advantage plans.

Also, due to the regulatory gap in oversight, in many instances state departments of insurance have not always received consumer complaint information about agent or broker misconduct. To remedy this situation, the NAIC has negotiated and finalized a Memorandum of Understanding (MOU) to be signed by state departments of insurance and CMS, so that they can share compliance related information between state and federal regulators. Since December, over 20 states have signed a separate MOU, and the NAIC is working with CMS to develop implementation procedures. In addition to agent/broker complaints, state departments of insurance and federal regulators hope to exchange information about enforcement actions, corrective actions, and other compliance related information. 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.

Even once the MOU is fully operational, state regulators are still very limited in their ability to prevent marketing and sales abuses. The preemption of state authority over the operations of Medicare Advantage 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 insurance consumer complaints than CMS. Despite these limitations, states continue to assist consumers to the best of their ability.

Financial Incentives:

Medicare Advantage plans are being reimbursed at an amount that is significantly higher than the cost of original Medicare. I have read of reimbursements between 111% to 113% or more of the cost of original Medicare with Medicare Advantage Private Fee-For-Service plans receiving 119% of the cost of original Medicare. In my opinion, these higher reimbursement amounts create financial incentives that may very well be a major cause for the marketing and sales abuses we are seeing today. Under the current reimbursement structure, companies have a very strong incentive to participate in the program and a very strong incentive to sign up as many enrollees as possible. In addition, because of the reimbursement structure, companies can provide generous remuneration to agents for enrolling as many people as possible.

It is my belief from what I have seen in my State and from many of my fellow commissioners these incentives have resulted in some significant harm to the Medicare-eligible as outlined earlier in my testimony. Some plans, and their agents and brokers, have used unacceptable sales and marketing techniques to sign up enrollees in their plans ignoring what is best for the enrollee. In the worst cases, marketing and sales tactics are used that are harmful to enrollees such as high pressure sales tactics, misleading and confusing marketing material, inappropriate sales, forged signatures, and more.

Another unintended result of these generous financial incentives is that plans may underestimate the utilization of the covered benefits so that they actually experience adverse financial results. This will occur if the bids submitted to CMS underestimate utilization and participation while at the same time include high expenses in acquiring business such as high agent commissions. The result is adverse financial performance forcing the plan to either get out of the market and thereby leaving its enrollees to find new and different coverage or change it's benefits and premiums so that the enrollees need to reevaluate whether the plan still meets their needs. Such a situation has recently been reported in Florida.

In order to address these problems, the incentives that cause them need to be addressed, along with leveling the playing field for the enrollee so that enrollee can make an educated buying decision. So long as the profit potential is as high as it is with these plans and the reimbursement to agents is so disproportionately high compared to Part D Prescription Drug Plans and Medigap policies, the marketing and sales abuses we are currently experiencing in Medicare Advantage, in my opinion, will continue.

Legislative Suggestions:

Chairman Stark, as you work to improve the Medicare Advantage program, I encourage this Subcommittee to closely examine this problem of the current regulatory gap over Medicare Advantage and Medicare Part D prescription drug plans. I believe that improving states' ability to exercise oversight over these plans is a key consumer protection that should be considered in any legislative efforts to improve this program, and I would like to offer a few specific suggestions.

Medigap as a model for improved plan regulation:

If Congress decides to continue to give seniors the choice to choose a private Medicare Advantage plan, including a Private Fee For Service Medicare Advantage plan, I would like to suggest that the Subcommittee look at the Medicare Supplement Insurance (or Medigap) regulatory approach as a potential model for improving these products. You may recall that federal action to standardize Medigap plans came about as a result of a history of rampant abuses targeting seniors in the marketplace throughout the 1980s. Many people have described the marketing and sales abuses that are currently occurring with Medicare Advantage plans as strikingly parallel to the abuses reported at that time before OBRA '90 was passed. 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.

The most important aspect I believe you can take away from Medigap is the strong state regulatory authority. With Medigap, states have the ability to regulate both the agents and the companies in the marketing and sales of these products, as well as in other areas. We need this same ability to hold companies responsible for the acts of their agents in Medicare Advantage as we currently have for all other insurance products. If you eliminate this current regulatory gap, state insurance commissioners will have a greater authority and thereby greater ability to serve and protect their Medicare-eligible population, and consumers would 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 virtually 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.

Medigap as a model for simplification:

I know that this Subcommittee is looking at a wide range of ideas to improve the Medicare Advantage program for beneficiaries. Therefore, I would like to take my suggestions one step further and suggest that you consider looking at the Medigap regulatory model for another reason beyond strong state regulation, which is to consider the concept of simplification of the benefits and benefit plan designs. As you might know, unlike Medicare Advantage or Medicare Prescription drug plans, the benefits for Medigap plans are standardized. This enables the consumer to make apples-to-apples comparisons so that they can make meaningful decisions.

Although Wisconsin is a relatively small, rural state, we have 92 Medicare Advantage plans 50 of which are Private Fee For Service Plans with premiums, in addition to the Medicare Part B premium, ranging from $-0- to $211 per month, and over 50 Medicare Part D prescription drug plans offered by 22 companies. Each plan has different benefit options, cost share, and formularies. Many of the problems I discussed earlier 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. 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 options under Medicare Advantage and Part D so that they can make a good decision for their 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.

Medigap is a good model, because as a result of federal legislation and a partnership of state and federal regulators, we have made the product simpler for the consumer to understand and to compare

plans, yet with many choices of coverage. The standardized benefits were 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.

Medigap as a model for improved consumer protections:

In 2006, a 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, as Medigap plans are guaranteed renewable which means plans cannot unilaterally change coverage from year-to-year except to adjust to original Medicare's changes of its deductibles and co-payments Although premiums might differ slightly, the benefits for an individual beneficiary would not change. Plans could decide to offer a different set of benefits or plans for new enrollees, but they would not be able to disrupt the coverage they are already providing to insureds. I urge you to consider these types of key consumer protections.

Finally, a major problem with Medicare Advantage plans is that they do not provide the stability beneficiaries have with original Medicare and a Medicare supplement policy. This is because the plans

have a one year contract with CMS which means that a plan can chose to leave a market at any time at the end of any year. This happened in the '90's when the then Medicare + Choice reimbursement formulae were changed. We have already seen it in 2007 when a major Medicare Advantage provider left certain markets forcing its enrollees to switch plans. Senior insurance consumers like stability. Under the current Medicare Advantage program they have none. Plans can change their benefits and cost shares every year and can abandon a market should they chose leaving their enrollees high and dry.

Summary:

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.