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MEDICARE ADVANTAGE MARKETING AND SALES: WHO HAS THE ADVANTAGE?

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UNITED STATES SENATE

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MEDICARE ADVANTAGE MARKETING AND SALES: WHO HAS THE ADVANTAGE?

WEDNESDAY, MAY 16, 2007

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 11:49 a.m., in room SD–106, Dirksen Senate Office Building, Hon. Herb Kohl (chairman of the committee) presiding.

Present: Senators Kohl, Wyden, Whitehouse, and Smith.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. I thank you all for being here today, and I apologize for having kept you waiting an hour. As you know, there were a series of votes on the floor of the Senate, which delayed the beginning of this hearing.

Nevertheless, we would like to welcome you all here today. We particularly want to thank our witnesses for taking time out of their busy schedules in order to be with us.

Today, we will examine the sales and marketing practices involving Medicare Advantage plans. I want to make it clear at the outset that we are not taking any position on the benefit or relative cost of Medicare Advantage. These plans may be appropriate and beneficial for many individuals under the right conditions.

Rather, this focus and our concern today is with the numerous and widespread complaints involving the sale and marketing of Medicare Advantage plans, which are being aggressively promoted all around our country.

For those of you not familiar with Medicare Advantage plans, they are private-plan options ranging from managed care to private fee-for-service plans, which are offered to Medicare beneficiaries as an alternative to traditional Medicare.

While they have been in existence for some time, Medicare Advantage plans are now the fastest growing segment of the Medicare world and are an increasingly profitable enterprise for many plan sponsors. Unfortunately, widespread confusion and, in some cases, outright misrepresentation and even fraud, have been associated with the sale of these plans. Complaints appear to be nationwide and a troubling pattern has emerged.

So today we will hear from two distinguished State insurance commissioners, Sean Dilweg of Wisconsin and Kim Holland of Oklahoma. They will outline the problems associated with Medicare Advantage plans and tell us what some States, as well as the

National Association of Insurance Commissioners, are doing to address them.

Our investigation has revealed a disturbingly consistent picture, one which only seems to be growing. Countless seniors purchasing Medicare Advantage plans have been preyed upon and unwittingly taken advantage of by insurance agents.

Seniors have been removed from traditional Medicare without their knowledge, signed onto plans that they cannot afford, mislead regarding coverage and told that their doctors accept these plans when, in reality, they do not. This, of course, is not acceptable.

One of the most troubling problems that we have seen involves insurance agents misrepresenting and marketing Medicare Advantage plans in inappropriate manners in place such as within nursing homes. We will hear more about that from Sherry Mowell, an investigator from Georgia.

Just as seriously, many insurance-sales agents simply do not understand the important differences between traditional Medicare and the multitude of other plans available to seniors, including the Medicare Advantage plans that they are peddling. Too many of our seniors are paying a terrible price for those frauds, misunderstandings and outright ignorance.

We will also be learning about the sales training received by the insurance agents selling Medicare Advantage plans. At our request, plan sponsors have provided the Committee with an array of well-developed and impressively written training manuals and programs required for those who sell Medicare Advantage. Sadly, what is on paper does not always translate into the real world. In this case, not by a long shot.

Last, we will examine the details of the Federal-State oversight partnership, as it concerns Medicare Advantage sales and marketing. Based on current law, CMS has exclusive authority to investigate and discipline plans marketing and selling Medicare Advantage products.

The States have been permitted to investigate and enforce violations against insurance agents only. This unusual arrangement, which some might call a "preemption of authority," seems to have left a sizable enforcement gap that has exacerbated the problems found by the Committee.

To address this, I have begun working with the National Association of Insurance Commissioners and other stakeholders to develop legislation that would give States expanded authority to oversee plans and agents.

We are not suggesting today that CMS has done nothing to address these problems or that CMS officials are unconcerned about them. According to some State officials, CMS regional offices have made legitimate efforts to lend a hand, as they should, particularly when fraud and confusion have left our seniors with health-insurance gaps and unnecessary additional costs. Nevertheless, it is clear that a major disconnect in oversight exists; one that needs to be addressed immediately.

I am pleased that today's hearing is already having a positive effect. In the last weeks, Medicare Advantage plans announced initiatives to reform their marketing-and-sales practice guidelines.

The Americas Health Insurance Plans, AHIP, is here today to discuss its new initiative to strengthen training for its member agents and brokers. This is a good start, but it is only a start.

As we know, the number of Medicare Advantage plans being offered to beneficiaries is growing rapidly. So we must remain vigilant in our oversight of these plans, and I intend to do so.

If more hearings are necessary to hold feet to the fire, then we will do that. Cleaning up these marketing-and-sales practices is a high priority of mine. So let me be clear: This issue will not go away after this hearing; and, of course, neither will I.

We look forward to hearing from our witnesses today, with whom we will work to identify and address and shortcomings in the marketing and selling of Medicare Advantage plans.

At this time, we would like to call our first panel witness, who is Abby Block. She is from the Centers for Medicare and Medicaid Services, CMS. Ms. Block is the director of the Center for Beneficiary Choices at CMS. Prior to assuming her current responsibilities, she was a senior advisor to the CMS administrator.

She has worked extensively with the States' health plans and beneficiary advocacy groups on Medicare Advantage plans and the issues we are discussing today. She is a very well-versed, very knowledge expert.

We are very pleased to have you with us today, Ms. Block, and we would be pleased to receive your testimony.

STATEMENT OF ABBY L. BLOCK, DIRECTOR, CENTER FOR BENEFICIARY CHOICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), BALTIMORE, MD

Ms. BLOCK. Thank you for inviting me to discuss Medicare Advantage and, in particular, marketing compliance.

Medicare Advantage is a valued, important option for millions of people with Medicare. Working closely with Congress, we have refined Medicare Advantage over the years to promote strong plan participation across the country.

With a vibrant marketplace of plans for 2007, beneficiary enrollment is now at an all-time high. I am proud of these successes and stand committed to work with you in the days ahead to preserve choice for people with Medicare.

I am pleased to report that this year, beneficiaries selecting a Medicare Advantage plan are receiving, on average, an estimated $86 per month in benefits over and above what original Medicare provides. Such additional benefits vary by plan, but can include: lower cost-sharing, enhanced Part D prescription drug coverage, Part B and D premium reductions; and, access to items and services like hearing aids, routine physicals or vision exams that original Medicare does not cover.

Regardless of the programs' successes, CMS takes recent reports of aggressive marketing of some products very seriously. We have stepped up supervision. I want to talk today about some of the ways that CMS is building upon lessons learned and information gathered during 2006.

CMS enforcement for marketing violations ranges from issuing a warning letter or corrective action plan to suspending enrollment and even, ultimately, terminating a plan from the program. This

year alone, we have fined plans more than $400,000 in civil monetary penalties for failing to provide information to beneficiaries in a timely manner. Also, at present, 98 Medicare plans are on a corrective action plan to fix identified problems and allow CMS to monitor their progress.

Our experience shows that, on occasion, private fee-for-service plans have not been clear about what they offer our beneficiaries and what they don't provide. Therefore, for 2008, we will require plans to include specific, unambiguous language in all marketing materials, enrollment materials and sales presentations laying out what a beneficiary can expect if he or she signs up for a plan, and call all new applicants to confirm that they do, in fact, understand the features of the plan and wish to enroll. In fact, in some of our corrective actions underway now, we already have those requirements in place.

Our utmost concern is to aid and protect the beneficiary. Therefore, beneficiaries and enrollees mislead by a plan are given an opportunity to switch to another plan. In addition, during the first quarter of every year, all enrollees already have the opportunity to switch out of private fee-for-service plans or any other MA plan for any reason and select another option.

Marketing complaints are handled differently, depending on the nature of the issue. For example, CMS handles violations of our marketing guidelines. Issues involving fraud and abuse go to the medics, our program integrity contractors. Allegations of fraudulent marketing and enrollment go to the OIG. Finally, States handle complaints about licensed agents and brokers.

CMS is taking many steps to identify organizations in need of compliance intervention, including monitoring complaints by conducting secret shoppings of sales events across the country. In addition, stressing relationships with State regulators are key to ensuring that marketing is conducted appropriately.

Specifically, CMS works cooperatively with the National Association of Insurance Commissioners and State departments of insurance to develop a model compliance and enforcement Memorandum of Understanding. So far, 20 States and Puerto Rico have signed the MOU that will enable us to share information about non-compliant marketing activities.

CMS plans to issue soon a proposed rule that will facilitate oversight for Medicare Advantage plans and Part D prescription drug plans. The rule proposes new provisions to strengthen and reinforce Medicare's compliance provisions for detecting, preventing and correcting fraud, waste, and abuse.

These are only the initial steps we are taking to ensure that Medicare beneficiaries are not being misinformed, misled or defrauded. We are holding plans responsible for the actions of both employed and independent agents selling their products. This includes requiring documented training of marketing agents and brokers.

Finally, I want to assure you that the vast majority of seniors who bought Medicare Advantage products are satisfied with their plans and the services they are receiving. I am confident we will see continued high levels of plan compliance with marketing re-

quirements, along with significant improvements where necessary on this critical front.

Thank you again for the opportunity to speak with you today. I look forward to answering your questions.

The CHAIRMAN. Thank you, Ms. Block.

Before we get to questions for you, we would like to hear from our Ranking Member, Senator Smith, as well as Senator Whitehouse.

Senator SMITH. Thank you, Senator Kohl, for calling this important hearing on a very vital issue.

I want to apologize to our witness. You have heard me complain in the past that the leadership of the Senate should check with the Aging Committee before they schedule votes. We apologize to the witnesses. We thank you for your indulgence and your time. We respect it deeply, especially this particular issue.

I want to make a distinction, which I hope folks who are interested will understand. I find abhorrent the stories which I have recently read, particularly, in the New York Times, that talk about marketing and abuse. These things must be routed out. All stakeholders who would like to see this program continue need to understand that, if left unchecked, this will undermine confidence in the program.

Having said that, I want to make clear my belief that Medicare Advantage and Medicare Part D are not bad simply because they are private delivery systems. These programs are working. They can work better. But to all who have an interest in the continued success of these programs, it comes to each of us individually to do all that we can to fix the problems and to fix them fast.

What I did when I was Chairman and now, as Ranking Member—and I share the Chairman's concern—what I began to do in the 109th Congress is to provide oversight. Some of what I am learning, I don't like. It needs to change. So we will continue that oversight with the view, at least, from my view, to preserving and strengthening these programs that do so much good, help so many people, particularly, in rural places.

So any company with an interest in either prescription drugs or Medicare Advantage: Get on top of this and get on top of it fast.

The CHAIRMAN. Thank you very much, Senator Smith.

Senator Whitehouse.

Senator WHITEHOUSE. Mr. Chairman, I just want to say thank you for holding this hearing. I think it is very important. I am glad that you and the Ranking Member are leading on this issue.

As an attorney general in Rhode Island, I saw over and over again how seniors were targeted for all sorts of scams and fraud and abuse; how lists of seniors were traded among people who played in this arena. I saw firsthand how easy it is to target the senior population.

The other thing that I have seen is a senior population that depends on the provision of healthcare services—any risk to that is extraordinarily frightening for them. When you combine those two together—the fear that so many seniors have related to their continued provision of healthcare coverage, and their vulnerability as well, this kind of marketing hits in a particularly dangerous area.

So I think it is really important that we are doing this, and I appreciate the testimony of all the witnesses.

The CHAIRMAN. Thank you very much, Senator Whitehouse.

Ms. Block, in a front-page article in the May 7th New York Times, you were quoted as saying, concerning Medicare Advantage sales and marketing, that, quote, "Providers and people with Medicare clearly do not understand this product," unquote.

I would like to ask you what you meant by that comment and what is CMS doing to ensure that beneficiaries and insurance-sales agents do understand the Medicare Advantage product before they purchase it.

Ms. BLOCK. Well, the comment was addressed specifically to the private fee-for-service product and not the Medicare Advantage product, in general. I truly believe that many people, including providers, as well as beneficiaries, have found the private fee-for-service product confusing. Some of that confusion, unfortunately, has been perpetuated in the way that product has been marketed.

So we are taking a number of very meaningful steps, including and in addition to the specific things that we have specific plans doing, under Corrective Action Plans (CAPS) that are already in place because of marketing violations that have occurred in 2006 and 2007.

But we have added some very specific requirements, including documentation of training programs by the plans and disclaimer statements. I even have some examples with me of drafts of what those statements will look like. These statements, which are for both beneficiaries and providers, explain very clearly what a private fee-for-service plan is and, more importantly, what it is not, which is what I think is what confuses beneficiaries.

We are going to require all of the plans in every presentation in all of their materials to include these statements—these very clear statements—for both beneficiaries and providers so that there will be true transparency, true accuracy of information.

We are also requiring all of the plans to do callbacks to people who enroll in one of the private fee-for-service plans to make sure that, in fact, they, first of all, actually chose that plan—that they actually signed the application—and then, second, that they truly understand the provisions of the product they have purchased and that they truly intend to be in that plan because they believe it meets their needs.

The CHAIRMAN. Thank you.

Senator SMITH.

Senator SMITH. Thank you, Mr. Chairman.

Ms. Block, thank you again for being here. I believe we will hear from members of the second panel that States are frustrated by the preemption provision in the Medicare Modernization Act. This prohibits them from taking action against Medicare plans in their States that may be engaged in inappropriate and often-illegal marketing and enrollment actions.

I believe we will also hear from the second panel that CMS is not living up to its responsibilities to police these plans. So with this in mind, is there value in considering rolling back the preemption policies, creating a better partnership between the States and

CMS; or, at a minimum, reestablishing the State appointment laws?

Ms. BLOCK. Well, I can't tell you how critical I believe it is that CMS and the States work closely together. We are strong advocates of a partnership between CMS and the States on this issue. We understand that we share the concern for the well-being of Medicare beneficiaries.

For that reason, we worked with the National Association of Insurance Commissioners to develop the Memorandum of Understanding, which, now, will help us to communicate better, to share information, to make sure that each of us is holding up our end in terms of what needs to be done to make 100 percent sure—and you will hear again and again today—and I said it at the last hearing that I was at—there is zero tolerance for Medicare beneficiaries being deceived in any way about the products that they are being sold.

We are in total agreement on that.

Senator SMITH. But does the Medicare Memorandum of Understanding—is that sufficient, or do we need to roll back this preemption provision?

Ms. BLOCK. I think that the Memorandum of Understanding needs to be given a chance to work. We have 20 States that have signed the memorandum so far, and Puerto Rico. I would like to see the rest of the States do that as well.

We have a group working closely with the NAIC to work through how this is going to work in terms of processes, procedures and so on. I think that, clearly—and I know the comparison has been made to Medigap and the State supervision of Medigap. However, Medigap is something that beneficiaries purchased with their own money.

The Medicare Advantage plans are heavily federally funded. So I believe it is critical that the Federal Government maintain supervision and oversight of those plans. They are our contractors. There are huge amounts of Federal funds going into that program. It is a Federal program. I think we need to work as closely as possible with the States, and I can't emphasize that enough. But I think the Federal Government, rightfully, has the supervisory authority.

Senator SMITH. Would there be value, then, in reestablishing the State appointment laws in the interim?

Ms. BLOCK. Well, I think that is something that we could go back and think about. I understand that there has been some confusion about the appointment laws and, also, I understand that some of the plans actually do appointments voluntarily. So that is something that we could, certainly, go back and look at and talk with NAIC and the States and the Committee about.

But the critical point, I think, is that this is a Federal program and we want to work as closely as possible through the mechanisms that we have developed to do this jointly with the States in a way that, basically, achieves our common goal, which is to protect the beneficiaries.

Senator SMITH. Well, one plan that I believe is testifying today has an excerpt from a document that reads, "Now is the time to sell aggressively. Use the urgency of the impeding deadline to drive decisions with a 'Buy now or miss out' sales proposition." I am won-

dering if, in your view, Ms. Block, this is standard-operating sales pitch. Is this common: "Buy now or miss out"? Are their agents unable to answer beneficiaries' questions? Does any of this violate CMS guidelines?

Ms. BLOCK. Well, certainly, agents are required to be able to answer beneficiaries' questions, and that is the point of the documented training.

It is absolutely critical that everybody who is out there selling this product—whether the agent is actually employed by the plan or whether it is a contract broker or agent—first of all, understands the Medicare rules clearly and, second, fully understands the product that they are marketing. So that is something we are monitoring very, very carefully.

Again, we stepped up our supervision of the training programs for the coming year to make sure that the people who are out there selling know the product that they are selling.

Senator SMITH. Does CMS have a sense of urgency that some of the unscrupulous things that may be going on may be undermining the whole effort?

Ms. BLOCK. Absolutely. We share the sense of urgency. We believe very strongly that we need to get this under control, that we need to make sure—and I do want to say I think we are talking about some bad apples. Bad apples cannot be tolerated. I don't want to see the whole program disparaged as a result of the really unacceptable behavior of——

Senator SMITH. Well, I don't either. I don't want to see that happen either.

Ms. BLOCK [continuing]. Some actors.

Senator SMITH. I think we we will see it succeed.

Many of the beneficiaries who were enrolled in policies that don't meet their needs, they are going to end up returning to traditional Medicare. Doing so, I am wondering what the unanticipated impact might be on the Medicare program; that is, if beneficiaries, who have been stuck in an unsuitable MA plan for an entire year due to lock-in provisions, go without needed medical care due to lack of provider access and/or cost and then return the Medicare during the next enrollment cycle, are we going to be dealing with a sicker and more costly patient—a patient population that is just cycling back in?

I mean, this is the danger. We are not making it better. We are making it worse if the bad apples aren't harvested real quick and thrown out.

Ms. BLOCK. Senator, just let me say about that if any beneficiary has enrolled in a Medicare Advantage plan because they have, in any way, been misled or deceived, they can immediately request that they be returned either to original Medicare or have the option of electing a different Medicare Advantage plan. That is in place. We give a special enrollment period to any beneficiary in that situation.

Senator SMITH. Great. Thank you.

The CHAIRMAN. Just one additional question, following up on one of Senator Smith's points—later on this morning, one of our State insurance commissioners will testify that a letter on the Medicare Advantage sales and marketing practices, representing the views of

the National State Commissioners Association, took 10 months to be answered by CMS. This was during a period when the sales problems were growing rapidly in the States.

How do you account for that fact that it took almost a year to respond to a complaint regarding sales practices, when, at the same time, you are saying that you attach a great sense of urgency to prevent these kinds of practices?

Ms. BLOCK. Well, Senator, let me say that you all are aware—and we have stated repeatedly that we had some startup issues at the beginning of the program, mostly systems issues, that needed to be addressed.

So during the initial period, probably the time that you are talking about, we were very much focused on those issues and those issues that involved enrollment and making sure that we got the enrollments right and that people ended up in the plan that they had selected and so on.

Much of that, of course, was connected with the new prescription drug program and the fact that we were moving about 6 million from Medicaid coverage to Medicare coverage, so my apologies for any delay in responding to correspondence. Believe me. I hope we are doing better now. I think we are.

But if there was an inordinate delay at one point in time, I am sure it was because we were caught up in trying to solve a lot of problems that, fortunately, in 2007, have diminished dramatically so that we are not in that situation now.

That is one of the reasons that we can now turn our attention to these marketing issues and focus on them with the same attention that we gave to the systems issues that we had at the beginning of last year.

The CHAIRMAN. Well, we thank you very much, Ms. Block. You have been a very good witness. Obviously, you are more than willing and eager to cooperate in improving the program. We look forward to working with you.

Ms. BLOCK. Thank you, sir.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Block follows:]

Testimony of
Abby L. Block, Director
Center for Beneficiary Choices
Centers for Medicare & Medicaid Services
Before the
Senate Special Committee on Aging
On
Medicare Advantage Sales and Marketing Oversight
May 16, 2007

Good afternoon Chairman Kohl, Senator Smith and distinguished members of the Committee. I am pleased to be here today to discuss the oversight of sales and marketing by Medicare health plans – Medicare Advantage (MA) organizations and Medicare Part D prescription drug plan sponsors.

Building on lessons learned and information gathered during 2006, the Centers for Medicare & Medicaid Services (CMS) has strengthened its oversight of MA organizations and Part D sponsors this year. For example, CMS has improved its method for identifying companies for compliance audits, making more efficient use of the resources available for ensuring compliance, and developing a closer relationship with State regulators.

CMS has developed a contractor risk assessment methodology that 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 central to this oversight strategy, regularly scheduled and

focused/targeted program compliance and program integrity audits will be necessary to ensure program compliance and document the Agency's program oversight responsibilities. CMS anticipates the risk assessment tool to be ready for implementation and use 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 enables 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.

CMS also has strengthened relationships with State regulators that oversee the market conduct of health insurers, including MA organizations and Part D sponsors. Specifically, CMS worked cooperatively with the National Association of Insurance Commissioners (NAIC) and State Departments of Insurance to develop a model Compliance and Enforcement Memorandum of Understanding (MOU). This MOU enables CMS and State Departments of Insurance to freely share compliance and enforcement information, to better oversee the operations and market conduct of companies we jointly regulate and to facilitate the sharing of specific information about marketing agent conduct. To date, nineteen states and Puerto Rico have signed the MOU. The nineteen states are: Arkansas, Indiana, Florida, Kentucky, Maryland, Montana, Minnesota, Missouri, Nebraska, New Jersey, North Dakota, North Carolina,

Oklahoma, South Dakota, Utah, Virginia, Washington State, Wisconsin and West Virginia.

More fundamentally, before a plan sponsor is allowed to even participate in Medicare Advantage or the Part D program, it must submit an application and secure CMS approval. CMS performs a comprehensive review of the application to determine if the plan meets program requirements. Annually, plans also must submit formulary and benefit information for CMS review prior to being accepted for the following contract year. For each plan sponsor, CMS establishes a single point of contact (Account Manager) for all communications with the plan. The Account Managers work with plans to resolve any plan problems, including compliance issues.

CMS continually collects and analyzes performance data submitted by plans, internal systems, and beneficiaries. CMS has established baseline measures for the performance data and has been tracking results over time. Plans not meeting the baseline measures are contacted by CMS and compliance actions are initiated. Actions range from warning letters all the way through civil monetary penalties and removal from the program, depending on the extent to which plans have violated program requirements. All violations are taken very seriously by CMS, with beneficiary protection the foremost concern.

The recently-released 2008 Plan Call Letter highlights CMS' ongoing commitment to strong oversight, announcing new policies and procedures to improve compliance with

critical program requirements. Oversight of MA marketing activities is a major theme in the Call Letter, as described in detail below.

CMS uses several mechanisms to ensure that MA organizations conduct marketing activities that are compliant with the regulations and marketing guidelines. Organizations are responsible for the actions of sales agents and brokers whether they are employed or contracted. They must ensure that agents/brokers are properly trained in both Medicare requirements and the details of the products being offered. Part D sponsors also must provide strong oversight and training for marketing activities. Employees of an organization or independent agents or brokers acting on behalf of an organization may not solicit Medicare beneficiaries door-to-door for health-related or non-health-related services or benefits. Employees, brokers and independent agents must first ask for a beneficiary's permission before providing assistance in the beneficiary's residence, prior to conducting any sales presentations or accepting an enrollment form in person.

CMS continues to make significant progress in overseeing MA organizations and Part D plan sponsors. With ongoing effort and vigilance, I am confident we will see continued high levels of plan compliance with program requirements, along with significant improvements where necessary on this critical front. Thank you again for the opportunity to speak with you today. I look forward to answering your questions.

The CHAIRMAN. We would like to call the second panel at this time.

Our first witness on the second panel will be Commissioner Sean Dilweg, who is from my homestate of Wisconsin. Commissioner Dilweg heads up the Wisconsin Office of the Commissioner of Insurance.

Following Mr. Dilweg, our second witness will be Commissioner Kim Holland of the Oklahoma Insurance Department.

Following Commissioner Holland, we will hear from Special Agent Sherry Mowell, of the Georgia Office of the Commissioner of Insurance.

Finally, we will hear from Mr. Albert Sochor, who is the vice president and director of marketing for Old Surety Life Insurance.

We welcome you all here this morning.

We will commence with your testimony, Mr. Dilweg.

STATEMENT OF SEAN DILWEG, WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE, MADISON, WI

Mr. DILWEG. Senator, thank you for the opportunity to appear before you today. I am happy to see you in the Chairmanship and look forward to working with you and your Committee on this very important issue.

My name is Sean Dilweg, and I am commissioner of the Wisconsin Office of the Commissioner of Insurance. I also currently serve as the Chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners, which represents chief insurance regulators from 50 States, the District of Columbia and five U.S. territories.

Although I am not testifying in my NAIC capacity today, I will be supplementing some of my views with the collective views of the Nation's insurance commissioners on today's topic. We are still working this issue through our organization, but we have been surveying our States on the number of complaints that we have seen over the last year.

Today, I will touch upon those marketing complaints. We have surveyed all of our members and have responses from 43 States and find a pervasive similarity in what we are seeing throughout the Nation.

In addition, I would like to focus on one potential solution, which was mentioned earlier, in order to solve the problems that seniors are facing today with the program. That is the Medigap solution. As I turn and look as to what model might be on the shelf to take off and look at, I turn the Medigap.

This is a program where the States work very well with CMS and the plans and the consumers. We worked well with CMS to develop minimum standards for Medigap. That was delegated to the States to meet those minimum standards. It allowed seniors stability—something that they seek.

Right now, under the Medicare Advantage plans, we have changes that occur from year to year. You have the potential for almost product-dumping in one year, where a plan has zero cost and gets ramped up in the next year. That is not the type of continuity that we like to see in our world of insurance.

To start out, the primary objective of State insurance regulation is to protect the consumers. My office was vested in our State constitution because consumers throughout our State were facing very complicated products. Let me say that the Medicare Advantage is one of the most complicated products we have seen to date. All health-insurance products are very complicated. These are not, simply, term-life policies that we wrestle with.

Annually, in Wisconsin, we receive over 8,000 complaints. We take all of those seriously. Senator, I have a family with two young children. If I were to sit down and fill out a three-page complaint, I would hope that that would be taken seriously by the agency that handles it.

In our complaint process in our State, the company is required to respond in 10 business days to the consumer. An average case in Wisconsin lasts 40 days before it is resolved. I would say that about 50 percent of those—this is across the board—this is not only in health plans—but I would say that, on average, 50 percent of those go in favor of the consumer and 50 percent in favor of industry.

In this role across the Nation, insurance departments receive the whole spectrum of consumer complaints about the Medicare program. As I stated before, the NAIC has surveyed the experience of all department across the country and we have found a common theme as it relates to high-pressure sale tactics and tactics that, under our State laws, are considered unethical at best, and fraud at worst.

We have seen sales by unlicensed agents and brokers; agents improperly portraying that they were from Medicare or from Social Security to gain people's trust, seniors who were merely asked for information about a plan or filled out a sign-in sheet at a health fair and later discovered they were dis-enrolled from their old plan and enrolled in a new plan without consent, mass enrollments and door-to-door sales at senior centers, nursing homes or assisted-living facilities.

Under other circumstances, these types of marketing practices I have described are either prohibited by State laws or 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, our hands are tied as it relates to the companies. We obviously have oversight of the agents.

But when my Governor turns to me and says, "What do we need in our regulatory toolbox to handle these issues?" I say that, as a State regulator, we have all the tools that we need. We are simply preempted. We do not have the authority over the companies.

You and the Federal Government need to decide if the Medicare Advantage plans are either insurance products or, simply Federal contracts with a number of vendors. I would argue that these should be treated as insurance products. As I stated before, when I look at a potential solution, I turn simply to the Medigap solution as a model.

You have a number of seniors in our State—over 800,000 seniors—who are wrestling with very complicated products. As I go through my complaints, I see sons and daughters of these seniors

who have PhDs and legal degrees who are having trouble navigating these products.

In conclusion, in order for these programs to be successful and valuable to the marketplace, this issue needs to be resolved as soon as possible. The baby boomers will hit the market in full force by 2010, and the fastest growing segment of our senior population is over 85.

I look to you for action and I hope that we can all work together—Congress, State regulators, CMS, the insurance industry, agent groups and consumer advocates—to provide products that our seniors can utilize.

Chairman Kohl, thank you again for this opportunity to testify today.

[The prepared statement of Mr. Dilweg follows:]

Testimony of Sean Dilweg,
Wisconsin Insurance Commissioner

Before the
United States Senate Special Committee on Aging

Regarding:
Medicare Advantage Marketing & Sales

May 16, 2007
10:30 a.m.
Dirksen Senate Office Building
Room 106

Testimony of Sean Dilweg
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.

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[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.

State 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.

Below are the amounts you would have to pay with:

Benefits 2007 Benefits	Medicare Advantage VS	Original Medicare
Part B Premium	$93.50/month There is no extra premium other than your part B for Medicare Advantage.	$93.50/month
Annual Out of Pocket Maximum	The most you would pay **$3000** in 1 year for co-payment. (Worst case scenario)	There is **NO Annual maximum** on what you would pay
Primary Care Physician Office Visits	**$15 per visit** No Annual Deductible	You pay 20% of the Medicare approved amount, after the $131 annual deductible
Specialist Office Visits	**$30 per visit** No Annual Deductible	You pay 20% of the Medicare approved amount, after the $131 annual deductible
Inpatient Hospitalization	$180/day co-pay for days 1-5 $0/day co-pay after 5 days (unlimited days) No Annual Deductible	$992 deductible- days 1-60 $248 per day- days 61-90 $496 per day- days 91-150 YOU pay all costs after day 150
Routine Vision & Hearing There is a $100/year hearing aid benefit and $100/year eye wear benefit with medicare advantage.	$30 co-pay for annual exam	Generally YOU pay 100% for vision and hearing
Preventive Dental Cleanings & Checkups Semi-annual	50% co-insurance	Generally YOU pay 100% for dental

The plan will pay for your medical bills except the co-pays above.

If you ever spend $3000 out of your pocket in co-pays, you will not have to pay anymore co-pays for the remainder of the year.

Plans are available that include drug coverage for $0/month. You must continue to pay your Part B premium.

For enrollment instructions and more information

CALL 1-800-657-1460

$0 Medicare Advantage Information

You currently live in a county which qualifies for the $0 Medicare Advantage benefits.

- Anyone who lives in your county with part A&B of Medicare can enroll.
- There are no health questions.
- Medicare pays a private insurance company which pays your medical bills except for some small co-pays that are listed on the back of this card.
- This plan eliminates the need for an expensive Medicare supplement that you may never use.
- You will still be on Medicare with all its benefits.
- Medicare Advantage eliminates most of original Medicare's HIGH deductibles and 20% co-insurance.
- Your part B premium and tax dollars pay for Medicare Advantage.

See the reverse of this post card for a comparison.

For enrollment instructions and more information CALL 1-800-657-1460.

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U.S. POSTAGE
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Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

November 22, 2005

Dear Dr. McClellan:

I am writing on behalf of the National Association of Insurance Commissioners (NAIC) to express further concerns we have regarding implementation of the new Medicare prescription drug benefit. The NAIC represents the insurance regulators in all 50 states, the District of Columbia, and five territories. Our primary mission is to protect consumers.

The Senior Issues Task Force of the NAIC recently held a meeting in Overland Park, Kansas. The states and interested parties present at the meeting expressed unease over several issues regarding implementation of Medicare Part D that concern your agency:

Waivers of State Licensure. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) provides several grounds for waiver of the state licensure requirement for prescription drug plan (PDP) sponsors, including a special three-year waiver in the initial startup of the program. In the final rule regarding Part D, issued Jan. 28, 2005, it states "CMS grants a waiver upon a demonstration that an applicant to become a PDP sponsor has submitted a fully completed application for licensure to the State." 70 Fed. Reg. 4551, sec. 423.410(d).

Several states expressed concern that CMS granted waivers to certain entities, in some cases entities that were not licensed as insurers in any state, without performing any due diligence and first checking with a state to see whether an application had been filed, and if so, whether it was complete, in accordance with the rule. It is our understanding that CMS accepted the face page from a PDP sponsor showing it had filed an application, with no further documentation required. The states related that certain PDP sponsors had filed an application, but that the applications were returned because they were "woefully inadequate." The states did not hear from the PDP sponsors again. When CMS announced the approved PDP sponsors in late September, the proposed domiciliary states learned for the first time that a waiver had been granted to an entity that did not have an application for licensure pending in that state. Needless to say, the affected states found granting a waiver under these circumstances troublesome.

I hope that there can be greater cooperation in the future between CMS and affected states when a waiver application is received. Any absence of due diligence in reviewing these requests creates a risk of insolvency that is in both our interests to avoid.

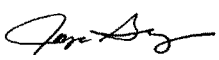
Website Issues. Multiple parties expressed concern at our recent meeting about the medicare.gov website. These concerns focus on two areas: security and plan comparison ability. Interested parties expressed that when using the website, after keying in personal information such as name and Medicare number, the person is redirected to an insecure website. If true, this is an obvious concern.

Cross-selling. Multiple parties also expressed concern that CMS has expressly blessed cross-marketing in its final Marketing Guidelines. Given the problems states already have experienced in the seniors market in general (for example, unsuitable sales of annuities to seniors), state regulators are fearful of what will happen since the time frame for open enrollment is so short and the federal government is aggressively pursuing the enrollment of individuals into Part D. Since the potential market is so large, it will be virtually impossible to monitor all situations involving cross sales and ensure that only suitable sales are made.

Silverscript. Silverscript is a national plan that has been granted a waiver from state licensure for three years to operate as a PDP sponsor. Silverscript does not have a license as an insurer in any state. Silverscript is a subsidiary of CareMark, a company engaged in, among other things, pharmaceutical benefits management. State regulators find it disconcerting that CMS would grant a waiver to an entity's subsidiary when the entity is embroiled in litigation in which several states allege various frauds, some related to the administration of pharmaceutical benefits. NAIC recommends that CMS pay particularly close attention to the operations of Silverscript given the vulnerability of the population being served.

I would be happy to discuss these issues with you at any time. I look forward to our continuing cooperation as we work together to implement Medicare Part D.

Sincerely,



Jorge Gomez
Chair, NAIC Senior Issues Task Force
Insurance Commissioner, State of Wisconsin

NAIC
making progress . . . together
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

October 7, 2005

Dear Dr. McClellan:

I am writing on behalf of the National Association of Insurance Commissioners (NAIC) to express some concerns we have regarding implementation of the new Medicare prescription drug benefit. The NAIC represents the insurance regulators in all 50 states, the District of Columbia, and five territories. Our primary mission is to protect consumers.

The Centers for Medicare & Medicaid Services (CMS) has issued final "Guidance for Organizations Providing Personalized Assistance for Medicare Prescription Drug Coverage." (*Guidance)* CMS is contemplating that volunteers provide "enrollment assistance" to Medicare beneficiaries – that is, provide information about the benefit and available plans, and help the beneficiary fill out the enrollment form. We have some concern with volunteers with unspecified, if any, training, helping a vulnerable population enroll in a complicated new insurance benefit:

- **Licensure as Producers.** The *Guidance* lists four steps in the process: ask questions about the person's specific situation; explain the options for coverage and decisions that must be made; explain how to compare plans; and help with necessary forms. We are aware that the majority of states have interpreted their laws to allow enrollment assistance as described without requiring a producer license. However, state laws vary and some states may not allow those activities without a license.
- **Conflicts of Interest.** The *Guidance* states that organizations that provide assistance cannot have an arrangement with a PDP that remunerates based on the number of enrollees into the plan. However, other monetary relationships are not prohibited. The *Guidance* does not provide that these relationships must be disclosed. Steering, unintentional or not, is a real possibility.
- **The Real Potential for Impermissible Activity.** Historically, SHIP volunteers have never assisted beneficiaries in enrolling in an insurance product. Once someone decided to enroll in a Medicare Advantage plan, or to buy Medigap or some other insurance product, the counselor referred the person to the plan or to a producer. Now, they are expected to cross a line never before crossed and help with enrollment into an insurance product. Given human nature and the complexity of this endeavor, it is easy to imagine scenarios where volunteers (particularly those less well-trained than SHIP volunteers) cross the very fine line contemplated by the *Guidance* that they only help people compare plans and to enroll, but do not make recommendations.

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We also have more general concerns with other aspects of the Part D program:

- **Nontraditional Carriers.** The list of approved PDPs contains several entities that are not licensed in any state. These entities have no working relationship with any department of insurance, and no history of delivering benefits to Medicare beneficiaries. Given their lack of experience in insurance, a complicated business that has many arcane technical aspects, we recommend that CMS pay particular attention to oversight of these entities. Further, we recommend that CMS direct these carriers to file their marketing plans with the insurance commissioner in states in which they plan to do business.

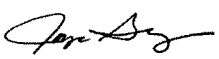
- **Formulary Changes.** The *Guidance* referenced above, educational materials developed by CMS, and CMS messaging in general almost completely ignore the fact that PDPs can change formularies during the contract period. The Medicare Prescription Drug Plan Finder will ask beneficiaries what drugs they currently take. What the beneficiary is not told is that a drug on the formulary today may be removed from the formulary in the future. Certainly, the Part D rule provides for a 60-day notice period. This does not vitiate the fact that consumers can be horribly misled about coverage. Since the Plan Finder asks what drugs they take, and plan options appear in response to this question, a beneficiary can reasonably assume the drug is covered by the plan. Our experience with major medical health plans tells us that formularies can change often, and not reminding beneficiaries of this fact does a tremendous disservice to them. We further recommend that CMS seek a statutory change that will allow beneficiaries to switch PDPs when a change in a formulary makes the PDP a nonviable option for the beneficiary.

- **Incomplete Information.** Because of the tremendous focus on the new Medicare prescription drug benefit, beneficiaries may well lose sight of planning for the full range of Medicare options. In addition to Part D, new beneficiaries in particular need to plan for Part A and Part B, consider Medicare Advantage, and decide if Medicare supplement insurance, a guaranteed renewable product, is appropriate for their needs and financial circumstances. The online enrollment tool only focuses attention on prescription drugs, to the detriment of overall planning.

- **Statutory Fix for Part D Enrollment.** To try to educate and enroll 40 million beneficiaries into the new prescription drug benefit in a period of six months seems unattainable at best and ludicrous at worst. The beneficiary should not be penalized for not figuring it all out so quickly. We should encourage CMS to pursue a statutory amendment to extend the initial open enrollment period through all of 2006.

I would be happy to discuss these issues with you at any time. I look forward to our continuing cooperation as we work together to implement Medicare Part D.

Sincerely,



Jorge Gomez
Chair, NAIC Senior Issues Task Force
Insurance Commissioner, State of Wisconsin

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG - 4 2006

Mr. Jorge Gomez
Chair, Senior Issues Task Force
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64 108-2662

Dear Mr. Gomez:

Thank you for your letter conveying your concerns with the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), including the role of volunteers in assisting beneficiaries with enrollment. The Centers for Medicare & Medicaid Services (CMS) understands your concerns and provides continuing support to the State Health Insurance Assistance Programs (SHIPs) and other community-based organizations through ongoing training and sharing current information.

We have listened carefully to your concerns about licensure, conflicts of interest and impermissible activity. As you noted, among the steps we have taken is the development of the "Guidance for Organizations Providing Personalized Assistance for Medicare Prescription Drug Coverage" (Guidance) to help SHIP counselors, paid and volunteer, as well as those in the AAAs and other community-based organizations understand the new benefit, compare plans, and assist beneficiaries enrolling in prescription drug plans. To ensure those assisting beneficiaries are as informed and equipped as possible, we have urged these organizations to follow the guidance carefully and have maintained ongoing activities to disseminate information and provide technical support.

With passage of the MMA, and the many new benefits it offers to beneficiaries, CMS recognized SHIPs would need additional support, including training and technical information and materials, to enhance their ability to reach out and support beneficiaries in their local communities including hard-to-reach populations. In response, in January 2005, CMS launched a National SHIP Training Strategic Plan providing information, training, and support tools in advance of key dates for beneficiary mailings, media events, and other milestones in Part D implementation. Additionally, CMS increased funding to the SHIP Resource Center, which provides technical support to SHIPs, enabling deployment of trainers in the field to assist in training counselors on providing enrollment assistance and using the web-based Prescription Plan Finder and Online Enrollment Center. Built upon their long established role as unbiased providers of information, the training provided to SHIPs, as well as to other counselors, stresses the importance of impartiality and objectivity and the need to ensure that beneficiaries are aware of all of their options to enable them to make informed decisions for prescription drug coverage and other benefit choices.

Mr. Jorge Gomez

Regarding non-traditional carriers, those entities received a Federal license waiver in all states in which they operate, met all Federal requirements, and were approved for contracts with CMS after successfully completing a rigorous process. Entities that received a Federal license waiver must ultimately be state licensed or moving towards state licensure. CMS is monitoring the performance of these entities and will continue to do so even after the entities are state licensed. If a state has issues with the marketing practices of a plan sponsor, the state should forward its complaint to CMS via the email address it established specifically for state regulators at Medicare_PartC&D_Complaints@cms.hhs.gov. As you know, CMS is working with the NAJC to draft standard operating procedures for the sharing of information between CMS and states.

As for formulary changes, the MMA allows for drugs within plan's formularies to change during the benefit year. However, except for formulary maintenance changes such as the replacement of a brand name drug with the equivalent generic, negative formulary changes will not affect enrollees who have been taking an affected drug. Further, the law does not allow for therapeutic categories and classes to change. Beneficiaries affected by a formulary change must be provided at least 60-day notice when a drug is being removed from a formulary or moved to a higher cost-sharing tier. Any proposed changes in the plan's formulary must be reviewed and approved by CMS. CMS will be tracking changes across formularies in order to identify any plans that may be performing a bait-and- switch operation. Beneficiaries can request an exception or appeal a drug if a formulary change affects them.

To ensure beneficiaries receive comprehensive comparison information, CMS has developed multiple online tools. CMS has launched the online Prescription Drug Plan Finder to assist Medicare beneficiaries and counselors in their efforts to identify the drug plan that best meets their needs and enroll in a prescription drug plan. The Prescription Drug Plan Finder is one of the tools individuals and organizations can use to facilitate enrollment. Also available on www.medicare.gov is the Medicare Personal Plan Finder, which is a tool for assisting new and current Medicare beneficiaries with detailed information about original Medicare coverage, Medicare Advantage Plans, and Medicare supplemental insurance options. CMS is also looking beyond the initial prescription drug coverage enrollment period to implement additional features that support new beneficiaries.

Finally, CMS did not believe it necessary to extend the drug benefit initial open enrollment period. The open enrollment period this year began on November 15, 2005, and ended on May 15, 2006, which gave beneficiaries 6 months to decide and enroll in a Medicare prescription drug plan. CMS worked diligently in its outreach and education efforts throughout this period to inform Medicare beneficiaries about enrolling in the drug benefit and the importance of joining a Medicare drug plan before May 15. In fact, as of June 14, more than 38 million Medicare beneficiaries are receiving comprehensive prescription drug coverage, with over 16 million enrolled in stand alone and Medicare Advantage prescription drug plans thanks to many of your local organizations. About three quarters of the remaining four million plus beneficiaries who do not have drug coverage, are estimated to be eligible for extra help and can enroll throughout the year with no late enrollment penalty. CMS is working closely with the local organizations to continue to reach these remaining beneficiaries

- Mr. Jorge Gomez

Again, we appreciate the concerns you have brought to our attention and assure you we will continue to do all we can to support beneficiaries in making informed and appropriate decisions in selecting their health benefits.

Thank you for working closely with us on these important issues

Sincerely,

Mark B. McClellan, M.D., Ph.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore MD 21244-1850

OCT 16 2006

Mr. Jorge Gomez
Chair, Senior Issues Task Force
Commissioner, Wisconsin Department of Insurance
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-3600

Dear Commissioner Gomez:

Thank you for your letter to Dr. Mark B. McClellan expressing the concerns of the National Association of Insurance Commissioners' (NAIC) Senior Issues Task Force. He asked me to respond to you directly.

The Centers for Medicare & Medicaid Services is working diligently to implement the new Medicare drug benefit as Congress intended. Enclosed you will find discussions of the concerns that the Senior Issues Task Force raised.

I look forward to working with the Senior Issues Task Force and the NAIC as we continue to implement the Medicare drug benefit.

Sincerely,

Abby L. Block
Director
Center for Beneficiary Choices

Enclosure

ENCLOSURE

Waivers of State Licensure.

The Task Force expressed concern about the process by which Centers for Medicare & Medicaid Services (CMS) granted Federal license waivers and alleged a failure, on CMS's part, to perform due diligence in granting Federal license waivers. We do not agree with this assertion. CMS acted with the diligence required by the Social Security Act. The Congress authorized the Secretary to waive state licensing requirements for risk bearing entities in order to expand choice for Medicare beneficiaries if the Secretary determined, based on a potential plan sponsor's application and other evidence presented to the Secretary, that the applicant was entitled to a waiver. 42. U.S.C. §1395w-112(c)(Supp. 2004). The Congress provided several grounds upon which a waiver could be approved, one of which is the special 2006/2007 waiver that the Senior Issues Task Force references in its letter. For the special 2006/2007 waiver, the statute requires that a substantially complete application have been submitted to the state. 42. U.S.C. §1395w-112(c) [which refers to the applicable Part C provision that establishes the standard]. CMS required in the Solicitation for Applications from Prescription Drugs Plans an explanation of why the applicant was entitled to a particular waiver, a description of the organization requesting the waiver and a copy of the cover letter to the appropriate state authority that accompanied the applicant's licensure application. If an applicant provided adequate documentation to CMS, the waiver was approved. All entities that received a federal license waiver did submit adequate documentation.

In addition to the requirements stated in the Solicitation, CMS required applicants to produce proof of delivery, which generally included a signed receipt with a tracking number. On August 16, 2005, CMS put the states on notice that it was reviewing applications and that it would identify for the states plan sponsors that entered into contracts with CMS and of those plan sponsors, which ones received license waivers. On September 23, 2005, CMS provided to each state and the NAIC information identifying the plan sponsors, whether licensed or waived, that would be operating in each state. Included in the information provided were the names of each plan sponsor, a list of other states in which each plan sponsor would be operating, whether the plan sponsor was licensed or waived in each of those states, and a contact name, telephone number and email address for each plan sponsor. Throughout the process, any state that contacted CMS was updated on the status of any particular waiver request. (For 2007 waiver applications, states were advised by CMS when a licensure waiver application was received and asked states to notify CMS if a state licensure application had not been received.)

On November 7, 2005, CMS further notified all state insurance departments and the National Association of Insurance Commissioners (NAIC) that there were several prescription drug plan (PDP) sponsors that received waivers in the states where they would be operating, and that would not be licensed in any state. The applicants that intended to operate in more than one state had applied in one state for a domestic license and in the other states had applied as a foreign corporation. CMS advised the states that it was aware that the applications for foreign status could not include a copy of the applicant's domestic license because the domestic license application was submitted at the same time as the expansion applications were submitted to the non-domestic states. The applicants were advised to notify the non-domestic states that they

were applying for a domestic license in their domiciliary state and that they were applying to the non-domestic state for the purpose of receiving a federal license waiver. The applicants were also advised to notify the non-domestic states that the applicants would provide their domestic license and other available information as soon as the domestic license was granted. In these cases license applications in non-domestic states were considered adequate for the purpose of granting a waiver without presenting a copy of the domestic license because it was impossible for the applicant to do so.

In cases where an applicant was advised by a non-domestic state that its application was being returned as incomplete due to not being licensed elsewhere or not meeting the seasoning requirements, the applicant was able to withdraw the state application after CMS granted its waiver. Applicants were also allowed to withdraw the state application after CMS granted a waiver when the state would have been forced to start processing the application within mandatory timeframes and would have failed the applicant for not being licensed in another state or not meeting the state seasoning requirements. This was allowed in order to avoid a denial which would be viewed unfavorably when attempting to reapply, and because it could also negatively impact the effort to become licensed in other states. All states and the affected PDP sponsors were reminded that these plan sponsors are expected to resubmit complete expansion applications as soon as the underlying reason for potential failure is resolved.

We agree that it is in the best interests of CMS and the NAIC, as well as beneficiaries, that plans do not become insolvent. This is why CMS exercised due diligence when contracting with plan sponsors and granting waivers. This is also another reason why CMS is continuing to work cooperatively with the states and plan sponsors to move plan sponsors towards state licensure. Once plan sponsors are state licensed, the plan sponsor must comply with state solvency requirements. CMS continues to monitor plan sponsors' efforts to become state licensed to ensure good faith efforts. Generally, all plan sponsors must become state-licensed or cease operating in any state where they are not licensed 36 months after the effective date of the waiver.

Because plan sponsor solvency is important, CMS worked closely with the NAIC on developing, not only the Federal solvency guidelines relating to entities that have no state license in any state, but also in developing the notification strategy for addressing entities that are licensed in at least one state and received a waiver in at least one other state. Because CMS was advised by the NAIC that a state would adjust the reserve requirement for a licensed entity that expanded into additional states, CMS provided each state with participation information for every plan sponsor in the state. In this way, licensing states were made fully aware of a licensed plan sponsor in the state expanding into other states so the plan sponsor's reserve requirements could be adjusted by the licensing states. Because CMS relied upon the NAIC's advice in developing the Federal solvency guidelines and the notification strategy for plan sponsors that are licensed in at least one state and waived in at least one other state, CMS is confident that the guidelines and strategy are adequate to minimize the risk of plan sponsor insolvency.

If any state believes that a plan sponsor did not file an application with the state or a state has any other question about a license waiver, please advise the state to contact Mr. Joe Millstone of the Division of Finance and Operations, Medicare Drug Benefit Group, CMS, at (410) 786-2976 or

e-mail him *at **joseph.millstone@cms.hhs.gov***. CMS looks forward to continuing to work cooperatively with the states and the NAIC.

Website Issues.

The Task Force expressed concern about the capabilities and security of the Medicare.gov website. CMS agrees with the Task Force that website security is of paramount importance. That is why when individuals query the Medicare Beneficiary Database using the personalized search option, the individual's information is transferred over a secure connection. Transfer over a secure connection protects the individual's information, particularly their health insurance claim number. After the authentication, there is no need for the website to remain secure because no personal information is passed or displayed on the following pages. The Online Enrollment Center, where an individual completes an online enrollment form, is also secure.

It is unclear what concerns the Task Force has with respect to the website's plan comparison ability.

Cross-selling.

The Task Force expressed concern that CMS "expressly blessed" cross-selling in the Medicare Marketing Guidelines and generally notes that states have experienced problems in the seniors' market. In discussions subsequent to the November 22, 2005 letter, the Task Force contended that beneficiaries may be confused or intentionally misled by marketing representatives if cross-selling is allowed. While CMS appreciates the Task Force's concerns, we do not agree that the Medicare Marketing Guidelines permit inappropriate marketing activities that might confuse beneficiaries or that would allow plans sponsors, through their marketing representatives, to intentionally mislead beneficiaries.

The Marketing Guidelines generally address inappropriate behavior of marketing representatives by requiring plan sponsors to use only state licensed, registered or certified marketing representatives, if a state has such a requirement. The Marketing Guidelines discuss marketing multiple lines of business via direct mail, television advertising and the Internet, which were not raised as concerns by the NAIC. Marketing multiple lines of business is briefly mentioned in relation to CMS-sponsored health information fairs as well, which we are reviewing for possible clarification. To the extent allowed by HIPAA, if a Medigap issuer chooses to sponsor a Medicare Advantage plan that includes Part D coverage or a stand-alone "PDP", the issuer is allowed to use its existing enrollment information to market its Part D plan(s) to its Medigap enrollees, which may or may not involve cross-selling.

Because marketing representatives are licensed at the state level, the Medicare Marketing Guidelines do not expressly address the types of marketing representative behaviors about which the NAIC is concerned, which, based upon our discussions with the NAIC subsequent to the November 22, 2005 letter, seem to be face-to-face interactions where a marketing representative gains access to a potential enrollee under the premise of selling a Part D plan, in order to market additional products.

In fact, in conducting marketing activities, plan sponsors are not allowed to participate in activities that could mislead or confuse Medicare beneficiaries. If there is a specific plan sponsor at issue or a marketing representative that is believed to be misleading or confusing Medicare beneficiaries, please forward the specifics of the complaint to CMS and we will investigate the allegation and take appropriate action against the plan sponsor. 42 C.F.R. §423.50.

Pursuant to the NAIC's request, CMS considered requiring plan sponsors to place restrictions on how plan sponsors allow marketing representatives to market non-Medicare products in conjunction with Medicare products, otherwise referred to as "cross-selling". After considering the positions of multiple stakeholders, CMS believes that it is inappropriate to place requirements on plan sponsors with respect to the cross-selling of products by marketing representatives, for the following reasons:

1. CMS does not want to restrict beneficiary access to information for those beneficiaries who may want complete access to information on all products in one contact. This position is consistent with the position CMS stated in the Preamble of the final Part D regulations, which states that "[w]e do not want to restrict beneficiaries from receiving materials about [sic] health-related and non-health-related services that may be of benefit to them in managing their health or payments for health care." *Voluntary Medicare Prescription Drug Benefit, 70 Fed.Reg. 4194, 4224 (2005).*

2. It is unclear how separate contacts would guarantee that a potential beneficiary would not be confused. Conversations during the separate contacts are likely to cross back and forth between Medicare products and non-Medicare products; therefore to limit the discussion may actually contribute beneficiary confusion.

3. It is not clear how requiring plan sponsors to require marketing representatives to make separate contacts would address the issue of marketing representatives gaining access to Medicare beneficiaries to sell other products. Marketing representatives could still use the premise of selling a Part D and/or MA plan to gain access to a beneficiary, regardless of the number of contacts.

4. CMS does not regulate the sale of annuities, long-term care insurance, life insurance, or other non-Medicare insurance products. The creation of restrictions on cross-selling would be an indirect way of regulating products and activities that are regulated by other governmental entities and, therefore, it is inappropriate for CMS to create such restrictions.

5. It is unclear how separate contacts would address unscrupulous marketing representatives selling inappropriate products or inappropriately obtaining personal information. An unscrupulous marketing representative may ignore the separate contact rule or may sell inappropriate products or obtain personal information in multiple contacts, just as he or she might in one contact.

6. As stated above, marketing representatives are regulated at the state level. Although there may be issues that the Department of Health and Human Services' Office of Inspector General may enforce against a marketing representative, generally if there are issues with respect

to the conduct of a specific marketing representative it is the state marketing representative licensing body that must take action. Instead of placing restrictions on beneficiary access to product information, a better approach would be for the states and CMS to share timely information on the conduct of plan sponsors and individual marketing representatives. This is why CMS is working with the NAIC to develop a standard operating procedure for the ongoing sharing information relating to possible violations of state and federal law.

7. It is important to note that all beneficiaries who were already enrolled in one Part D plan had one opportunity to change plans until May 15, 2006. Until May 15, 2006, if a beneficiary enrolled in a plan during the beneficiary's initial enrollment period, but then wanted to change to another plan, for any reason, the beneficiary could have done so using his or her annual enrollment period election. *See* PDP Guidance-Eligibility, Enrollment and Disenrollment.

8. In addition to the initial enrollment and annual enrollment election period protections, there are additional protections allowed for instances where a marketing representative materially misrepresents the provisions of a plan. If an individual can demonstrate that the prescription drug plan or its agent materially misrepresented the plan's provisions in the marketing of a plan, a special enrollment period may be allowed for the beneficiary to enroll in another plan. 42 C.F.R. §423.38. *See also* PDP Guidance-Eligibility, Enrollment and Disenrollment.

Therefore, based on the above analysis, it is CMS's position that the Medicare Marketing Guidelines should not be revised to place requirements on plan sponsors that require their marketing representatives to make separate contacts when selling Medicare and non-Medicare products. CMS does require that if a marketing representative is meeting with a potential enrollee, a plan sponsor must require that the marketing representative clearly identify the types of products the marketing representative will be discussing, before the marketing representative markets to a potential enrollee. *See* page 131, Medicare Marketing Guidelines (July 25, 2006). CMS looks forward to continuing to work with the NAIC to ensure that Medicare products are marketed in an appropriate manner.

Waiver/Contracting.

The Task Force expressed concern about a specific plan sponsor that received a license waiver from CMS because the plan sponsor may be involved in litigation in several states. If a plan sponsor meets the requirements established in the Medicare Modernization Act and its implementing regulations and guidance, there is no reason why CMS should not grant a license waiver and contract with the plan sponsor. It is only when an entity cannot meet the requirements to become a PDP sponsor, which includes a state license or a license waiver, or is on the Department of Health and Human Services' Office of Inspector General's Exclusion List that CMS cannot contract with an entity. The plan sponsor noted in the NAIC's letter met the requirements to receive a waiver and become a PDP sponsor. Furthermore the plan sponsor is not on the Exclusion List. The Office of General Counsel has made it clear that CMS does not have the legal authority to deny a contract application based upon allegations of wrong-doing or pending legal actions.

To deny a license waiver or contract based on an investigation or the filing of a complaint against an entity would not be prudent because disputes may be resolved in favor of such an entity, or parties may settle a dispute with no admission of wrongdoing. CMS will take action against a PDP sponsor if the sponsor is found to have violated, or is violating, the law. Additionally, at such a time as the entity is placed on the Exclusions List, CMS will move to terminate its contract with the entity or it would not contract with such an entity.

CMS has been in contact with the state in which the noted plan sponsor was seeking a domestic license and the state advised that it awarded a certificate of authority, effective May 22, 2006.

Social Security Act: Certification of Medicare Supplemental Health Insurance Policies

Section 1882 (p)(1)

(A) If, within 9 months after the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the "Association") changes the revised NAIC Model Regulation (described in subsection (m)) to incorporate— (i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection, (ii) uniform language and definitions to be used with respect to such benefits, (iii) uniform format to be used in the policy with respect to such benefits, and (iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990, subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the "1991 NAIC Model Regulation").

(B) If the Association does not make the changes in the revised NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the "1991 Federal Regulation".

(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the 1991 NAIC Model Regulation or 1991 Federal Regulation or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier. (ii) In the case of a State which the Secretary identifies, in consultation with the Association, as— (I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1991 NAIC or Model Regulation or 1991 Federal Regulation but (II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered, the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(E) If benefits (including deductibles and coinsurance) under this title are changed and the Secretary determines, in consultation with the Association, that changes in the 1991 NAIC Model Regulation or 1991 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

The CHAIRMAN. Thank you very much, Mr. Dilweg.
Ms. Holland.

STATEMENT OF KIM HOLLAND, OKLAHOMA INSURANCE DEPARTMENT, OKLAHOMA CITY, OK

Ms. HOLLAND. Mr. Chairman, thank you for allowing me to be here today, Senator.

My name is Kim Holland, and I am the Oklahoma State insurance commissioner, an elected office I have held since January of 2005. The primary obligation of my agency is to protect the consuming public. I and my staff of over 150 dedicated individuals take this obligation very seriously, and this is the main reason I am here today.

The Oklahoma Insurance Department is responding to an unacceptable number of complaints caused by the inappropriate and sometimes fraudulent marketing of Medicare Part C and Part D products by certain insurance companies and their sales producers.

Over the past year, we have received hundreds of complaints from our citizens, who have been misled or deceived during a sale.

The Medicare Modernization Act of 2003's preemption of States' authority to oversee the licensure, market conduct and financial solvency of Medicare Part D agents and carriers and the marketing practices of Medicare Advantage carriers has led to virtual lawlessness in Oklahoma.

Unlicensed agents are setting up shop in pharmacies and Wal-Marts and nursing home lobbies to prey upon seniors' confusion and concern over their medical-care coverage. Certain insurers are exploiting their exemption from regulatory oversight with aggressive and frequently misleading advertising, agent financial incentives that encourage high-pressure sales tactics, lack of responsiveness, if not outright neglect, of a vulnerable population caught in the middle of an unbridled free market.

As insurance commissioner, I currently have greater authority to address a consumer's problem with pet insurance than I do ensuring the protection of the 500,000 Oklahoma senior citizens covered under a PDP or Medicare Advantage plan.

Since the rollout of Medicare Part D in November 2005, we have communicated with CMS on numerous occasions, attempting to forge a partnership in educating and protecting our senior citizens. Yet, at the earliest stages of the program rollout, we found ourselves challenged by the inadequacy of CMS's resources in providing the necessary support to our seniors and by further attempts to preempt our authority over agent licensure.

Senators, I am grateful to Congress for the passage of the MMA, as it has made access to affordable medications possible for 20 percent of my population, a large measure of whom depend solely on Social Security for their livelihood.

The creation of new and affordable programs under Medicare Part C and D means that many of our seniors no longer have to choose between a meal or their medication. But it is this reality—a pressing demand for coverage and a growing supply of available plans—that necessitates adequate regulatory oversight to ensure what insurance commissioners across the Nation strive for: a

healthy marketplace, wherein robust competition and vigorous consumer protections are balanced to create choice and value.

While I can offer you many examples of how our seniors are now dangling on the short end of this teeter-totter, I would like to use my remaining few moments to focus on a recent targeted examination we conducted on one of America's largest providers of Medicare Advantage plans, which will illustrate clearly the inadequacy of Federal oversight.

In June 2006, we initiated a targeted examination of Humana, due to the escalation in number and nature of unresolved complaints involving the sales tactics of agents selling their product. The examination report, submitted with our written testimony, provides numerous examples that illustrate the scope and gravity of the types of complaints made against this company.

When finally completed, the examination exposed chronic and blatant disregard for State regulation and for senior policyholders. Advantage plan products were sold throughout our State by untrained, unlicensed individuals, in violation of Oklahoma law and similar laws enforced in every State in the U.S.

Our appointment process, which creates a critical accountability link between insurer and agent was consistently circumvented by guidelines promulgated by CMS prohibiting States from enforcing this important consumer protection. The examination illustrated the company's indifference to complaints and concerns registered by senior consumers, leaving some Medicare beneficiaries waiting months for any kind of response.

It is important to note that throughout the past year and a half, we—Oklahoma, individually and collaboratively, through the NAIC—have made numerous requests of CMS to act to address company sales-and-marketing issues.

We have made beneficiary-complaint referrals, as required, provided information, negotiated and entered into a Memorandum of Understanding for information sharing—whatever we could do to encourage a swift and appropriate response to these unnecessary and unlawful activities. The senior citizens of my State are still waiting for that response from CMS.

In August of last year, we made a Freedom of Information request to CMS regarding a company selling Part D products under a CMS waiver, without having been licensed in their homestate or any State, as required by Federal law. We are still waiting for that information from CMS.

Due to the gravity of the findings from the Humana exam, I traveled to DC to meet with CMS officials in March of this year. I provided a copy of the examiner's draft report and voiced my concerns and frustration over our ongoing and unresolved issues. I left CMS with no assurances and with the impression that they are more concerned with protecting the program than the people. I am still waiting for a response from CMS.

So now I appeal to you, sir. Allow me to do the job I do every day to ensure the financial solvency of companies selling health plans in my State. Allow me to fully deploy the substantial and immediate resources of my office to protect the interests of all policyholders, regardless of their age and regardless of the private health plan that they have purchased.

For the safety and security of all Oklahomans, I have not failed to act. I have not failed to respond. Yet, I am encumbered by unproductive, unnecessary and dangerous preemptions that expose my citizens to the neglect and abuse I have described.

Please allow me to do my job. Thank you.

[The prepared statement of Ms. Holland follows:]

Senate Special Committee on Aging Testimony for 5/16/07
Commissioner Kim Holland

Good morning Mister Chairman and members of the Committee. My name is Kim Holland and I am the Oklahoma State Insurance Commissioner, an elective office I have held since January 2005. The primary obligation of our agency is to protect our consuming public. I, and my staff of over 150 dedicated individuals, take this obligation very seriously. Our office fields over 60,000 calls to our consumer assistance division each and every year, plus an additional 12,000 calls to our federally funded Senior Health Insurance Counseling Program (SHIP). We license and regulate the activities of over 80,000 agents, monitor the financial solvency and market conduct of over 1,600 insurance companies and my twelve member law enforcement team responds to more than 700 insurance fraud allegations each year. We investigate all complaints thoroughly then act swiftly and aggressively against any carrier, agent or broker that has acted inappropriately in our marketplace.

This is the main reason I am here today. The Oklahoma Insurance Department is responding to an unacceptable number of complaints caused by the inappropriate and sometimes fraudulent marketing of Medicare Part C and Part D products to Medicare beneficiaries by certain insurance companies and their sales producers. Over the past year we have received hundreds of complaints from our citizens who have been mislead or deceived during a sale. [1]

The Medicare Modernization Act of 2003's (MMA) [2] preemption of states authority to oversee the licensure, market conduct and financial solvency of Medicare Part D agents and

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[1] For examples see Oklahoma Insurance Department Limited Market Conduct Report of Examination of Humana Insurance Company for the period as of September 15, 2006, pages 6-15.

[2] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. 108-173, 117 Stat. 2066 (codified as amended in scattered sections of 42 U.S.C.).

carriers by MMA and the marketing practices of Medicare Advantage carriers has led to virtual lawlessness in Oklahoma. Unlicensed agents are setting up shop in pharmacies, Wal-Marts, and nursing home lobbies to prey upon seniors' confusion and concern over their medical care coverage. Certain insurers are exploiting their exemption from regulatory oversight with aggressive and frequently misleading advertising; agent financial incentives that encourage high pressure sales tactics; and a lack of responsiveness, if not outright neglect, of a vulnerable population caught in the middle of an unbridled free market. As Insurance Commissioner, I currently have greater authority to address a consumer's problem with Pet Insurance than I do ensuring the protection of the 500,000 Oklahoma senior citizens covered under a PDP or Medicare Advantage plan.

Since the roll-out of Medicare Part-D in November of 2005, we have communicated with The Centers for Medicare and Medicaid Services (CMS) on numerous occasions in an attempt to forge a partnership to educate and protect our senior citizens. Yet at the earliest stages of the program roll-out, we found ourselves challenged by the inadequacy of CMS's resources in providing the necessary support to our seniors and by further attempts to pre-empt our authority over agent licensure.

The Oklahoma Insurance Department has been aggressive in our attempts to grapple with the myriad of issues that have arisen since Part D enrollment began a year and a half ago. From requiring special licensure of enrollers[3] to threatening problematic PDP providers with cease and desist orders, to field investigations by our fraud unit to target market exams of insurers, we have pushed the boundaries of our authority to respond to our citizens in need because CMS has not done so - leaving many of our aged vulnerable to those whose interests are strictly their own.

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[3] See Oklahoma Insurance Commissioner General Order, Case No. 05-1417-PRJ, In Re: Temporary Licensing – Medicare Prescription Drug Plan Enrollment, October 11, 2005.

Senators, I am grateful to Congress for the passage of the MMA as it has made access to affordable medications possible for twenty percent of our population, a large measure of whom depend solely on Social Security for their livelihood. Fully 70,000 of our seniors live at or below the federal poverty limit and, due to the creation of new and affordable programs under Medicare D and C, are not having to choose between a meal or their medication. But it is this reality – a pressing demand for coverage and a growing supply of available plans – that necessitates adequate regulatory oversight to ensure what Insurance Commissioners across the nation strive for: a healthy marketplace wherein robust competition and vigorous consumer protections are balanced to create choice and value.

While I can offer you many examples of how our seniors are now dangling on the short end of this teeter-totter, I would like to use my remaining few moments to focus on a recent targeted examination we conducted on one of America's largest providers of Medicare Advantage plans which will illustrate clearly the inadequacy of federal oversight.[4]

Humana Insurance Company has been licensed in Oklahoma since 1987 and is currently authorized to market some eleven different life and health products. Historically a group health insurance provider in our state, they embraced the opportunity created by MMA and began an aggressive marketing campaign for the private fee for service Advantage plans. Of note, Humana consistently priced their Medicare products the lowest in our state.

In monitoring calls through our Senior Health Insurance Counseling Program (SHIP) office we were alerted to a number of complaints from seniors indicating they were confused and/or mislead by assertions made by agents representing Humana. We learned that the

[4] See Oklahoma Insurance Department Limited Market Conduct Report of Examination of Humana Insurance Company for the period as of September 15, 2006.

company had set up kiosks staffed by insurance agents at local Wal-Marts to sell Medicare prescription drug plans. Their location within Wal-Mart pharmacies caused us concern that consumers could be given the misleading impression that they had to be insured with that particular company in order to purchase their medicines from Wal-Mart. In many small communities throughout Oklahoma, the nearest Wal-Mart may have the only conveniently located pharmacy operation. And, indeed, seniors seeking information from these kiosks stated that they felt pressured to buy and were not made fully aware of all of the options available. We asked Humana corporate representatives to come to our offices to explain their marketing strategies and allow us to share our concerns. We were particularly concerned over complaints from seniors who stopped by the kiosk to obtain information on Part D and were pressured to change from their current program and enroll in one of the carrier's Advantage plans, not understanding the consequences of their decision – either in terms of benefits or physician choice. During this meeting, Humana assured me that they had an extensive agent training program. Their senior executives asserted that sales associates (both company employees and independent brokers) were required to go through a lengthy forty-five minute presentation with each senior that explained fully all available options. However, when I questioned them about their ability to enforce this requirement or even monitor their agent performance within Wal-Mart, they confessed their inability to do so indicating that they had underestimated the volume created by their marketing campaign and were not adequately staffed – but, while continuing to run full-page advertisements for their products in our local newspapers. I asked the company to discontinue the arrangement with Wal-Mart and challenged them to act more responsibly in accounting for the activities of their independent agent population. Subsequently, we proposed

an agreement with Wal-Mart to allow our SHIP volunteers to co-locate in their larger stores to ensure seniors received objective program information.

In June of 2006, we initiated a targeted market examination of Humana due to the escalation in the number and nature of unresolved complaints involving the sales tactics of agents selling their products.[5] The examination report submitted with our written testimony provides numerous examples that illustrate the scope and gravity of the types of complaints made against the company.

Let me provide you one such example, the story of Malcolm who lives in the small Oklahoma town of Claremore. He was solicited by a salesman representing Humana while visiting his local Wal-Mart Pharmacy. The salesman aggressively encouraged Malcolm to purchase the Humana Gold Choice plan, a Private Fee for Service Advantage product. Malcolm told him that he merely wanted the stand-alone drug plan and submitted paperwork for what he believed to be that plan. However, when his card and information arrived in the mail he discovered he was in fact enrolled in the Advantage product.

Malcolm had been enrolled in a private insurance plan with rich benefits to which he was entitled as a result of his retirement from a major corporation. This plan served as his Medicare supplement plan. By law, an individual can have only one Medicare supplement plan. Therefore, the enrollment in Humana Gold Plan caused him to be automatically disenrolled from his more comprehensive plan. He and his family spent weeks restoring his original insurance and disenrolling from the Humana plan. After restoration of his original insurance coverage, Humana continued billing Malcolm for months. His circumstance is unfortunately typical of the complaints we heard and which prompted our targeted exam.

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[5] *Id*

I sent an independent examiner to Humana to review the files of their Oklahoma agents who had been paid for the sale of the company's Advantage products.[6] Throughout the examination, the company attempted to hinder the examiner's access to information, claiming federal preemption.

When finally completed, the examination exposed chronic and blatant disregard for state regulation and for senior policyholders. Advantage plan products were sold throughout our state by untrained, unlicensed individuals in violation of Oklahoma law and similar laws in force in every state in the US. Our appointment process was consistently circumvented by guidelines promulgated by CMS, prohibiting states from enforcing this important consumer protection.[7] [8] An appointment creates a critical link between an insurer and the agent, ensuring that regulators can hold insurers accountable for the conduct of an agent. The examination illustrated the company's indifference to complaints and concerns registered by senior consumers, leaving many Medicare beneficiaries waiting months in some instances for any kind of response.

It is important to note that throughout the past year and a half Oklahoma, individually and collaboratively through the NAIC, has made numerous requests of CMS to act to address company sales and marketing issues. We have made beneficiary complaint referrals as required, provided information, negotiated and entered into a Memorandum of Understanding[9] for information sharing and whatever we could do to encourage a swift and appropriate response to

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[6] *Id.*

[7] "Because CMS, through its Medicare Marketing Guidelines, explicitly addresses the use of marketing representatives, state marketing agent appointment laws will not apply to organizations." Centers for Medicare and Medicaid Services Medicare Marketing Guidelines for Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans and 1876 Cost Plans, page 130.

[8] 36 Okla.Stat. tit § 1435.15.

[9] Memorandum of Understanding and Agreement Concerning Regulatory Cooperation and Information Sharing Between The Centers For Medicare and Medicaid Services and the Oklahoma Insurance Department, signed by CMS on February 5, 2007.

these unnecessary and unlawful activities. The senior citizens of my state are still waiting for that response from CMS.

Even in instances where we believe CMS could take action to address a clear problem, we have been frustrated by their inaction. For example, we had a foreign company selling Medicare Part D products that had an identical name to an Oklahoma domestic health carrier selling Part C and D products. This situation created widespread confusion among consumers, causing many to be disenrolled in their local Medicare Part C plan when they enrolled in the other company's (with the identical name) Part D plan by mistake. CMS provided no assistance in resolving this problem which was ultimately corrected by our domestic's legal action and our efforts to mediate the dispute for the benefit of consumers.

Another challenge for states was the granting of three year waivers by CMS from state licensure and financial solvency requirements. The MMA provides for waivers if a company had filed a "substantially complete" application each in which the applicant seeks licensure. However, CMS proceeded to grant waivers to companies who had not fulfilled the most basic requirements of licensure in their home states, as required by state law and NAIC guidelines. In fact, CMS would grant waivers if a company simply showed that it had applied for state licensing and been turned down.

These unlicensed upstarts are not subject to the prelicensing scrutiny or triennial examinations that are performed on licensed insurers, nor are they covered by state guaranty funds in the event of insolvency. If such a company were to fail, consumers and medical providers would be left holding the bag.

In August of last year we acted upon our concerns over one particular company doing business in Oklahoma under such a waiver by initiating a Freedom of Information Act request to CMS.[10] We are still waiting for that information from CMS.

Due to the gravity of the findings from the Humana exam, I traveled to Washington, D.C. to meet with CMS officials in February of this year. I provided a copy of the examiner's draft report and voiced my concerns and frustration over our ongoing and unresolved issues. I left with no assurances and feeling that CMS had no sympathy for the victims. I am still waiting for a response from CMS.

I now appeal to you – allow me to do the job I do every day to assure the financial solvency of companies selling health plans in my state. Allow me to fully deploy the substantial and immediate resources of my office to protect the interests of all policyholders in my state regardless of their age and regardless of the private health plan they purchase. For the safety and security of all Oklahomans, I have not failed to act; I have not failed to respond. Yet I am encumbered by unproductive, unnecessary, and dangerous preemptions that expose my citizens to the neglect and abuse I have described. Senators, allow me to do my job. Thank you.

[10] See Freedom Of Information Request by the Oklahoma Insurance Department dated August 9, 2006; also see letter from CMS with CMS reference number C06FOI2682 (VEH) received by the Oklahoma Insurance Department on September 15, 2007.

EXHIBITS

A Oklahoma Insurance Department Limited Market Conduct Report of Examination of Humana Insurance Company for the period as of September 15, 2006, pages 6-15.

B "Because CMS, through its Medicare Marketing Guidelines, explicitly addresses the use of marketing representatives, state marketing agent appointment laws will not apply to organizations." Centers For Medicare and Medicaid Services Medicare Marketing Guidelines For Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans and 1876 Cost Plans, page 130.

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E See Freedom Of Information Request by the Oklahoma Insurance Department dated August 9, 2006; also see letter from CMS with CMS reference number C06FOI2682 (VEH) received by the Oklahoma Insurance Department on September 15, 2007.

F Oklahoma Insurance Commissioner General Order, Case No. 05-1417-PRJ, In Re: Temporary Licensing – Medicare Prescription Drug Plan Enrollment, October 11, 2005.

The CHAIRMAN. Very good statement. Thank you very much, Ms. Holland.

Ms. Mowell.

STATEMENT OF SHERRY MOWELL, GEORGIA OFFICE OF THE COMMISSIONER OF INSURANCE, ATLANTA, GA

Ms. MOWELL. First of all, thank you, Senator, and the Committee for inviting me here.

My name is Sherry Mowell. I have been employed with the Georgia Insurance and Safety Fire Commissioner, John Oxendine, since 1994. During the last year—I am just going to give you some examples of the types of fraud and abuse that we have found in the State of Georgia.

Agents are allowing untrained sub-agents to sell the Medicare Advantage product. This is very problematic because the sub-agents have not been through the required training of CMS. By using the untrained sub-agents, the agents can later disclaim knowledge of any wrongdoing.

Agents have obtained personal, identifying information from the agencies that they are affiliated with, which have the information on record from previous Medicare Part D sales. This personal information is being transferred to a Medicare Advantage plan application, with clients unwittingly signing.

This is how it works: Agents ask potential clients to sign a form to prove to their boss that they have been to visit the client. When the client signs the form, they are unaware that they are signing the back page of a contract to purchase a Medicare Advantage product.

Agents without prior appointments solicit individuals that have not requested any information on a Medicare Advantage program. Agents are soliciting door-to-door in areas of high elderly population.

Agents have told potential clients that Medicare is closing down or running out of money, and if the customers do not sign up for the Medicare Advantage plan, they will lose all healthcare benefits. Some agents are even telling the potential customers that the Medicare Advantage product will not go into effect until Medicare actually closes down.

Agents are not clearly and concisely explaining the benefits of the Medicare Advantage program. Agents have misled prospective enrollees by telling them that they are going to receive free eye care and free dental care for signing up, and that enrolling in a Medicare Advantage plan will not change their benefits.

Individuals misrepresent that they are insurance agents. They have told prospective enrollees that they are from Medicare or that they are sent by the Georgia Department of Family and Children's Services. Agents in our State have signed up deceased individuals prior to the enrollment period using the deceased individuals' personal identifiers.

Agents call on patients in personal-care homes without prior approval of the patients or their guardians. Agents misrepresented their identity and affiliation to the staff in the personal-care homes. They have told staff members that they are from Medicare. On one occasion, two agents called on a personal-care facility out-

side the normal operating hours. Agents have asked staff of healthcare facilities to visit patients in their room and not in the common areas. They have also asked the staff members not to accompany them to the rooms.

Consumers have been signed up for Medicare Advantage Programs even though they have never met with an agent or they have never discussed signing up for the program. We showed a group of elderly victims' applications with their purported signatures and none of the victims had signed the application, nor had they met with an agent.

One agent who previously signed up individuals under Medicare Part D went to a mentally challenged facility and switched these patients, without their knowledge or their guardians' knowledge, onto a Medicare Advantage product. These individuals were also dual-eligible.

Agents signing up Medicare Advantage to the dual-eligible: They are already eligible for both Medicaid and Medicare. Under the Medicare Advantage, they are charged co-pays up to $30 and $40 per doctor visit. We are talking about individuals who make less than $300, $400, $500 a month.

Agents, on numerous occasions, have claimed that they were trained by the company to solicit customers in the manner in which they are operating or they were approved to conduct business in this manner by their field management office.

Since January 2006, our office has received over 300 written complaints from the public concerning the Medicare Advantage. This does not include the hundreds of telephone calls our office has received. Also, this office has received numerous complaints on the companies that offer the products, which allege the companies are not paying the claims, nor are they processing the cancellations that have been requested.

Our office is trying to work hand-in-hand with the Centers for Medicare and Medicaid Services, trying to get these individuals the help they need.

Our office has found, in some instances, the companies that have been contracted by Medicare to provide the coverage are not adequately prepared to handle the flow of business that has been written by the company. The State regulators do not have the authority to regulate the company or the product. The result is consumer frustration and dissatisfaction.

Commissioner Oxendine's staff has arrested three agents on these fraudulent acts within the past 6 weeks and we have more investigations that we are working on at the present.

[The prepared statement of Ms. Mowell follows:]

Remarks before the Senate Committee on Aging

Sherry Mowell, Special Agent
Georgia Insurance and Safety Fire Commissioner John Oxendine
May 16, 2007

I want to thank the Committee for inviting me to speak. My name is Sherry Mowell, and I have been employed by Georgia Insurance and Safety Fire Commissioner John Oxendine as a criminal investigator since 1994. My duties include the investigation of complaints of insurance fraud.

The Office of the Commissioner of Insurance licenses insurance companies and insurance agents operating in the State of Georgia and enforces Georgia law. However, with regard to the sale of Medicare Advantage products, the States retain jurisdiction over the insurance companies only as to "solvency and licensing" issues; once a license is granted, the state cannot take action against the insurer unless it faces solvency issues. (We are in the process of taking action against one insurer who has fallen below our minimum surplus standards.) As for agents, the states license agents who sell insurance products, including Medicare Advantage products, and retains authority over their actions.

In the past year, the Office of the Commissioner of Insurance has received numerous complaints related to the Medicare Advantage product. These complaints have come from both consumers, CMS, and other related government agencies. Based on complaints received, we have investigated numerous agents acting in our state as well as one insurer. Our investigations have found numerous instances where consumers have been taken advantage of.
Specifically, we have found the following:

- Georgia licensed insurance agents contracted with various Medicare Advantage Program Providers to market their products during open enrollment periods in 2006. These insurance agents receive on average a commission of $200 to $250 for each enrollee they signed up. Some agents began soliciting enrollees before the open enrollment period. This violated federal guidelines.

- Agents allowed untrained sub-agents to sell the Medicare Advantage product. This is problematic because the sub-agents have not been through the required training. (Further, by using these untrained sub-agents, the agent can later disclaim knowledge of wrongdoing by the sub-agent.)

- Agents obtained personal identifying information from the agency they are affiliated with, which had the information on record from previous Medicare Part D sales. This personal information was transferred to Medicare Advantage Plan

applications which clients unwittingly signed. Here's how it worked -- agents asked potential clients to sign a form, stating that the form was to prove to the agent's boss that the agent had been to visit with the client – however, the client was unaware that they were signing the back page of a contract to purchase a Medicare Advantage product. This is fraudulent.

- Similarly, agents told prospective enrollees that they were visiting them to verify that they were covered under Medicare Part D. The agents had the prospective enrollee sign a form that they said would show that they had verified their choice of Medicare Part D, when, in fact, the form was a Medicare Advantage enrollment form. This was fraudulent.

- Agents, without prior appointments, solicited individuals that had not requested any information on the Medicare Advantage program. Agents solicited door-to-door in areas with a high elderly population. This violated federal guidelines.

- Agents told potential customers that Medicare is "closing down" and "running out of money," and if the customers do not sign up for Medicare Advantage, they will lose all healthcare benefits. Some agents have told potential customers that Medicare Advantage coverage will not go into effect until Medicare "closes down." Of course, this is a false statement.

- Agents did not clearly and concisely explain the benefits of the Medicare Advantage Program. Agents misled prospective enrollees by telling them they would receive "free eye care and dental care" for signing up and that enrolling in Medicare Advantage would not change their Medicare benefits. This is not true.

- Individuals misrepresented that they were insurance agents; they told prospective enrollees that they were "from Medicare," or that they were "sent by the Georgia Department of Family and Children Services." This was untrue.

- Agents signed up deceased individuals prior to the enrollment period using the deceased individual's personal identification information which the agent had retrieved from insurance agency databases or Medicare Part D applications.

- Agents called on patients in personal care homes without prior approval of the patients or their guardians. Agents misrepresented their identity and affiliation to the staff in the personal care homes -- they told staff that they were from Medicare. On one occasion, two agents called on a personal care facility after normal hours of operation. This violates federal regulations.

- Agents asked staff of healthcare facilities to visit patients in their rooms rather than in common areas; the agents did not want staff members to accompany them to the rooms.

- Consumers were signed up under a Medicare Advantage program even though they had never met an agent and discussed signing up for the program. We showed these elderly victims applications which purported to contain their signature, and the victims denied ever signing the applications or meeting with anyone concerning the Medicare Advantage program.

- One agent, who had previously signed up individuals for Medicare Part D at a facility for the mentally disabled, switched those mentally challenged patients to a Medicare Advantage plan without the knowledge of the patient or their guardians.

- Agents have signed up individuals for Medicare Advantage who are dual eligible -- that is, they are already eligible for both Medicaid and Medicare. Under Medicare Advantage, they are charged co-payments that they would not be responsible for under their dual status. (Thus, for example, individuals whose income is $400 a month end up with $30.00 to $40.00 co-pay for each doctor visit – charges that would have been covered for them by Medicaid and Medicare.)

- Agents, on numerous occasions, have claimed that they were trained by the company to solicit customers in the manner in which they were operating or were approved to conduct business in this manner by their field management office.

Since January 2006, this office has received over three hundred (300) written complaints from the public concerning Medicare Advantage enrollment issues. This number does not include the hundreds of telephone calls that our office has received concerning problems with the Medicare Advantage program.

Also, this office has received numerous complaints on the companies that offer the Medicare Advantage Plan which allege the companies are not paying claims or are not processing their cancellations of the plan. Our Office has worked hand–in-hand with Centers for Medicare & Medicaid Services trying to get the individuals the help they need. Our Office has found, in some instances, the companies that have been contracted by Medicare to provide the coverage are not adequately prepared to handle the flow of business that has been written by the company. The state regulator does not have the authority to regulate the company or the product. This results in consumer frustration and dissatisfaction.

Commissioner Oxendine's staff has arrested two agents for fraudulent acts related to their sales of Medicare Advantage product as of the date these comments were submitted. We're working hard to investigate and prosecute insurance fraud in our state. Thank you.

The CHAIRMAN. Thank you very much, Ms. Mowell.
Mr. Sochor.

STATEMENT OF ALBERT SOCHOR, VICE PRESIDENT AND DIRECTOR OF MARKETING, OLD SURETY LIFE INSURANCE, OKLAHOMA CITY, OK

Mr. SOCHOR. Thank you, Senator Kohl, for having this meeting. I feel honored to be here.

I am vice president of Old Surety Life Insurance Company. Old Surety is an Oklahoma-based insurance company. It has been in business since 1932. We have been operating for 20 years in the Medicare arena—helping seniors make choices and helping to train agents about Medicare.

I have been invited to speak here because of my personal involvement with some of these problems and on behalf of companies and other agents out there that are running into problems with these Medicare Advantage plans and the marketing tactics that they are using to promote these plans.

I want to make it clear: I am not against the Medicare Advantage plans. But, I am against how they are marketing the plans and the tactics that they are using.

What I am going to share with you today is what is happening in the field and what beneficiaries and agents are dealing with on a day-to-day basis.

It has already been mentioned that seniors go to enroll in a prescription-drug plan; yet, they come to find out that they really didn't enroll in a prescription-drug plan only. They were actually enrolled in a Medicare Advantage plan. But frequently they find out too late. They don't find out what they have done until they go to a provider and then the beneficiary receives a claim several months later. That's when beneficiaries discover they were actually disenrolled from Medicare. That is when they find out. Sometimes, it is too late.

The senior, or the enrollee, will then contact CMS or the Medicare Advantage company and ask for help or assistance. CMS and the Medicare Advantage companies tell these seniors that they can't do anything and the are locked in until the next enrollment period.

I have helped many seniors resolve this problem by referring to page 60 of the "Guide to Medicare" supplement that CMS distributes. I tell CMS and these MA companies to "Look at page 60." These beneficiaries, in their trial period, have the right to try these plans and get out; but it is taking my intervention to get that done.

Some Medicare beneficiaries have been told by agents that with Medicare Advantage plans—"You can go to any physician," "It works the same as Medicare," "It works the same as a Medicare supplement," "You can use it and you won't notice any difference with your plan," but the beneficiaries can lose benefits.

Consequently, many Medicare recipients join the plans only to find out that their doctors don't accept the plan. Even if a doctor does accept the plan, he can opt out.

What happens, is that it leaves some people without coverage unless they want to travel a long distance, to where a provider is lo-

cated. Many doctors and facilities choose not to accept these Medicare Advantage plans. In rural areas, provider access is limited.

I am aware that CMS and the MA companies know that these beneficiaries can get out of the lock-in period but they aren't informing consumers. At no time in the history of Medicare have recipients been locked in any plan where they couldn't make a choice.

I have actually called CMS and MA companies and spoken to their customer service and have been told that the beneficiaries were locked in. It has taken me an hour, in some cases, to get to the right person to be able to ask them to—"Look at page 60 of the Medicare guide."

I have talked with CMS customer service, which is actually outsourced. They are outsourced! They are not really employees of CMS. These service reps have a list of SEPs that CMS tells them they can use and I have argued with them about the Medicare guide. They do not even have the "Guide to Medicare" booklet available to them to look at.

Now, a 70-year-old senior is not going to be able to push the buttons that I can; to get to the right person; to find out that they need to submit a letter to the regional office to do a retroactive disenrollment or get dis-enrolled because of their trial period. Most seniors are afraid to push the buttons. If they are told, "No," they stop.

Many agents and companies are negligent they don't always take into consideration what is best for the beneficiaries, I feel. Agents do not fully disclose how the plans work. They fail to tell the beneficiaries about the downfalls of the plan and all the co-pays and coinsurance the beneficiaries will be required to pay. They fail to explain the potential out-of-pocket costs for many of the plans benefits and how much they could be at risk for, if the plan has no out-of-pocket max. They leave out the part that plans can, and probably will, change benefits, co-pays and premiums each year.

I have found that if agents give full disclosure to those who are interested in the plans, that many individuals choose not to enroll. Once they are told everything about the plan, they usually stay with original Medicare; not because the plans are bad, but because the plans do not fit their needs.

Medicare Advantage companies have training—a certification process—that agents have to go through to sell the plans. This meets the CMS requirements. The certification process covers laws, marketing practices and product knowledge. However, they tend to leave out a lot about ethics, about consumer interests and how to handle the problems that I have discussed.

I have been to these certification meetings. I am a licensed agent. I have sat there and been told that if I don't get onboard, that I will lose my Medicare-supplement business that we have with clients. It is more motivated by commissions than it is by compliance.

The driving force behind this confusion, I feel, is money; not the cost of the product, but what companies and agents can make selling the product. Almost every day, I receive solicitations to appoint with agencies to sell Medicare Advantage plans, telling me how much money I can make.

First-year commissions run as high as $700 per enrollee—and these agents are advanced these commissions every time they en-

roll someone in a Medicare Advantage plan. Agents have made hundreds of thousands of dollars in a very short time. Each year, these agents can enroll the beneficiaries in new plan to again gain access to that first year's commissions.

I never understood how much money could be made until we, as a company, started being solicited to sell our company at more-than-market value. There is a lot of money to be made by both the companies and the agents in this plan. We at Old Surety Life have not accepted any offers.

It brings back memories of why Congress established OBRA 1990. Companies would bring out new Medicare supplement products every year to try to "wine and dine" and have people to enroll in their plans. There wasn't any way to compare apples to apples it was very confusing for beneficiaries.

Agents would go out and move beneficiaries every year just to get those high first-year commissions. So Congress standardized Medicare-supplement plans. This stopped the confusion. They levelized commissions. Agents lost their motive to churn the business. The market became stable and complaints dropped considerably.

In conclusion, we all know—we looked in the newspaper this morning—in the Washington Post—there are problems going on with the Marketing of Medicare Advantage plans. The marketing concepts have seniors ending up in situations they weren't aware of. We can't keep saying things are going well when it seems like it is getting worse.

CMS, the industry and the industry sales force need to understand that they are dealing with one of the most vulnerable segments of our population—our seniors, our poor and our disabled. If we, as an industry, do not do our jobs in a professional and ethical manner, we are doomed. If CMS doesn't respond quickly to help Medicare beneficiaries, trust will diminish.

CMS should stand up and be an advocate for Medicare beneficiaries against these plans when they don't fit the client's needs or they didn't understand what they were getting into—not tell them they are locked in! Have 1–800–Medicare service reps ask questions to determine if this beneficiary is eligible for any of these enrollment options.

Get rid of the lock-in. Give beneficiaries freedom to choose. Make CMS be an advocate and help Medicare recipients who have made a mistake and need to change coverage do so!. Have them become more like counselors than they are, not just robots.

Hold companies and agents accountable for unlawful or deceptive sales practices. Standardize the Medicarae Advantage plans, the Medicare Advantage Prescription Drug plans and the Prescription Drug plans to help stop the confusion. Levelize commissions to stop the unnecessary churning of business.

These are our parents—our moms, our dads, our friends—is this how we want to treat them?

I thank you for your time. I appreciate it. Have a great day.

[The prepared statement of Mr. Sochor follows:]

STATEMENT OF ALBERT SOCHOR BEFORE THE SENATE SPECIAL COMMITTEE ON AGING MAY 16th 2007

My name is Albert Sochor, Vice President and Director of Marketing for Old Surety Life Insurance Company. Old Surety is an Oklahoma based insurance company that has been in business since 1932, operating in several states and dealing mainly in the senior market. We have over 20 years experience with Medicare and have thousands of clients and hundreds of independent licensed agents who rely on us to help them with their Medicare choices and training. I was invited to this meeting to speak on behalf of insurance professionals and companies who have expressed great concern about Medicare Advantage (MA) plans, their problems and the marketing tactics being used to promote these plans. I want to make it clear; I am not against Medicare Advantage (MA) plans. I am, however, against the tactics used to sell and promote these plans. What I am going to share with you today is what's happening in the field. What beneficiaries are dealing with on a day to day basis.

During the Part D enrollment period for 2006 and 2007 many seniors rushed to enroll in just a Prescription Drug Plan (PDP). Little did some of them know but they were actually being enrolled in a Medicare Advantage Prescription Drug Plan (MAPD). This means they were no longer covered by original Medicare, but by the MA plan. The enrollees didn't realize this until they went to a doctor and later received a bill. Angrily they called CMS and the MA company to get this resolved, but were told by both entities they were locked in and couldn't go back to original Medicare until the next enrollment period. It took my intervention and page 60 from CMS's 2006 "A Guide to Health Insurance for People with Medicare" to prove that these folks could indeed go back to original Medicare. In spite of this, the clients were still held responsible for their medical costs incurred while on their Medicare Advantage plan. At no time in the history of Medicare have recipients been locked into any plan, so why now? I have personally been told that beneficiaries are "Locked In' by CMS and companies when they had rights to disenroll from the plan but weren't informed of them.

Many Medicare beneficiaries have been told that with Medicare Advantage plans you can go to any doctor that accepts Medicare. Many were told the plans worked just like original Medicare and they wouldn't lose any benefits or that the plan would work just like a Medicare Supplement. Consequently, many Medicare recipients joined the plans only to find that their doctors didn't accept the plan. Even if the doctor does accept the plan he can opt out at any time, but the client is being told (as stated above) that they are "locked in" and cannot go back to original Medicare until the next enrollment period. If these beneficiaries are not told of their rights it can leave them at risk of not having any health coverage unless they travel long distances to a provider who accepts the plan. Many doctors and facilities choose not to accept MA plans. This can be a major problem in rural areas due to limited providers.

Here, in my opinion, are other problems with the plans. Many agents and companies do not always take into consideration what's best for the consumer. Agents are not fully disclosing how the plans work. They fail to tell the consumer about the downfalls of the plan and all the co-pays and coinsurance the consumer will be required to pay. They fail to explain the potential out of pocket costs for many of the plans benefits and how much they could be at risk for if the plan has no Out of Pocket max. They leave out the part that plans can and probably will change benefits, co-pays and premiums each year. I have found if agents and companies gave full disclosure to those who are interested in their plans that many may choose not to enroll. Once they're told everything about the plan they usually stay with original Medicare. Not because the plans are bad, but that the plan doesn't meet their needs.

MA companies have a certification process that agents have to go through to sell the plans. This meets CMS requirements. The certification process covers the laws, marketing practices and product knowledge. However they tend to leave out a lot about ethics, consumer interest and how to handle problems such as I've discussed. Most of these certifications are now done on line and have no personal training.

I believe the driving force behind the confusion and the misrepresentation is money. Not the cost of the product, but what companies and agents can make selling the product. Almost everyday I receive solicitations to appoint with companies who sell Medicare Advantage plans telling me how much money I can make. First year commissions run as high as $700 per enrollee. Agents have made hundreds of thousands of dollars in a very short time. Each year agents can enroll beneficiaries in another plan and receive high first year commissions again, even if it's not in the enrollees best interest. Agents can make a lot of money churning their business. Regularly I hear of blocks of Medicare business being bought by big companies who are heavily involved in the Medicare Advantage market. I never understood how much money could be made until our company started receiving offers to purchase us that were well over the market value. We found out then that these companies only wanted our company to get at our Medicare Supplement policyholders. We have not accepted any offers.

This brings back memories of why Congress voted in the OBRA 90 act. Prior to OBRA 90 companies would come out with new products that had new bells and whistles. There was no way to compare apples to apples. Agents would get Medicare beneficiaries to change policies each year, just for the high first year commissions. At that time hundreds of companies were in the Medicare Supplement business with agents and companies making a lot of money. When Congress standardized Medicare Supplement plans, it stopped the confusion. When Congress levelized commissions, agents lost their motive to churn their business. The market became stable.

I have spoken before groups of seniors who are very confused about what is going on with Medicare, Medicare Advantage Plans and PDPs and this concerns me, my company and our agents deeply.

CMS, the industry and the industries sales force need to understand that they are dealing with one of the most vulnerable segments of our population, our seniors, our poor and our disabled. If we as an industry do not do our jobs in a professional and ethical manner, we are doomed. Each state has an Insurance Department that is dedicated to be an advocate for the seniors and Medicare recipients that live in that state. CMS should stand up and be an advocate for Medicare beneficiaries against these plans when they don't fit the client's needs or they didn't understand what they were getting into, not tell them they are "Locked In"

Get rid of the "Lock In". Make CMS be an advocate and help Medicare recipients who have made a mistake and need to change their coverage. Hold companies and agents accountable for unlawful or deceptive sales practices. Standardize the MA and PDP plans. Levelize commissions to stop the unnecessary churning of business.

When the wrong doing that has taken place in our industry stop?

It's up to you.

The CHAIRMAN. It is pretty hard to do that after your testimony. Very good.

Before we call on Senator Wyden, I will ask just a couple questions.

Mr. Dilweg, CMS has informed the Committee that they consider the Memorandum of Understanding a working document; that the agency has already begun to supply additional information to States. As a result, is that your view of the status of this document? In fact, why haven't 30 States signed on as yet?

Mr. DILWEG. I think, Senator, when we look at it—obviously, this has arisen out of how we handle confidential information between CMS and the insurance commissioners as well.

But as we looked at it and surveyed our States, some simply don't have all the problems that Wisconsin may have seen or Oklahoma may have seen. They don't have the driving force to get involved or they are simply taking their time in getting around to it.

Part of the problem is we have been told that we would have a secure Web site that we could deal with and have not seen that Web site. So before you get involved in exchanging confidential information between State agencies and Federal agencies, you want to kind of see the environment you are going to be operating in. So it is a work-in-progress.

The CHAIRMAN. Many of the agents who are operating in the State of Wisconsin are operating in a manner which you would describe as scandalous, fraudulent? Is that true?

Mr. DILWEG. We have surrounding Medicare Part D and Medicare Advantage—we have about 400 complaints over the last year. To put that in perspective, when something like credit scoring came out for automobile or home insurance, we had 42 complaints. So this is quite high——

The CHAIRMAN. But you have the right to crack down on every one of them, right?

Mr. DILWEG. On every one of the agents.

The CHAIRMAN. You do?

Mr. DILWEG. Yes.

The CHAIRMAN. All right. I just want to make that—you know, understand so that we don't only look at the company or CMS. We all are involved in this together, including this Committee.

Mr. DILWEG. Right.

The CHAIRMAN. But in terms of the responsibility—clear responsibility—to deal directly with agents who are acting in ways which are fraudulent, misrepresentative or crooked, you have the opportunity, the right, if you had enough personnel. But the right to crack down on them is centered in your office?

Mr. DILWEG. Correct.

The CHAIRMAN. Ms. Holland, how would you respond? You have the right——

Ms. HOLLAND. We certainly have that right. As you can tell from my testimony, we have exercised that right immediately and deliberatively.

One of the challenges, however, Senator—first of all, in my State, what we identified from our examination is we had unlicensed agents—numerous unlicensed agents—selling product. I have no

way to track—unless I go to the company and demand that information, I don't know that there is an unlicensed person there.

As we discussed in testimony, we are dealing with folks, oftentimes, that are fragile and may not get all the information they need, may have gotten a business card that has misleading information or inadequate information. So it is very difficult for my office to track down someone who is an unlicensed agent.

Additionally, with the absence of an appointment, again, that creates that critical link where the agent is actually an agent for the company—he is not a freewheeling person out here. He may act like one, but he is an agent for the company.

That creates that tie that allows me to go back to the company and hold them responsible as well and help me to crack down on an agent that is not performing the way we would have them do so in our communities.

The CHAIRMAN. So you have the right to do that?

Ms. HOLLAND. I have the right to address an agent that is misbehaving.

Under the current circumstances, I am somewhat challenged in going back to the company and holding them accountable because the absence of appointment doesn't create that direct link. Hopefully, I am going to compel the insurer to step up anyway. But it creates a difficulty in us creating that contractual link between the agent and the company to hold the company responsible for the performance of their agents in the field.

The CHAIRMAN. OK.

Ms. Mowell, you talked movingly and very well about the misrepresentations and fraud that are going on in your State. Again, you do have the opportunity and the responsibility and the opportunity, again, to deal with them—each and every one of these individual misrepresentations—don't you?

Ms. MOWELL. We have the authority over the agents, yes, sir. But, there, again——

The CHAIRMAN. That is a considerable authority, isn't it?

Ms. MOWELL. It is a considerable authority. However, there are only six investigators for the entire State of Georgia for all types of insurance fraud. Right now, we cannot keep up with all the problems on this and our other duties.

The CHAIRMAN. That is fair enough.

It would also be very helpful, wouldn't it, if the companies themselves could be held severely accountable for their representatives out there, selling fraudulent packages?

Ms. MOWELL. Yes, it would make it much nicer for us to be able to go to the companies and say, "What are you doing about it?" because at this point in time, we do not have that authority to go to them and make them speak for their agents and bring their agents in, or to even look at the allegations.

The CHAIRMAN. Very good.

Mr. Sochor, what do we need to do to eliminate this problem?

Mr. SOCHOR. The problem is when agents never really appoint with many of these Medicare Advantage companies. These companies set up independent-marketing organizations that contracts the agent. The contract is between the agent and that marketing organization. That is why the States have no way of knowing who is

appointed with whom and have not been able to try to track down agent records.

These companies advance commissions to the agents. The marketing organizations are actually responsible for the payment. Then, later, the marketing organization get—reimbursed—by the Medicare Advantage companies. This is how the payment system works. I think allowing the agents to appoint with the MA companies and licensing the agents with the State insurance departments, has to be done. Then there is some kind of record where you can track of the agents and develop a database, because without that, there is no way to know what is going on.

The CHAIRMAN. Very good.

Senator Wyden.

Senator WYDEN. Thank you very much, Mr. Chairman. It has been an excellent panel. I commend all of you for it.

I am going to spend most of my time with you, Commissioner Dilweg and you, Commissioner Holland.

I was the principal author of the Medigap law in the early 1990's and, essentially, came to it after, really a 15-year history. I have been the director of the Oregon Gray Panthers for about 7 years. I ran a legal aid office for the elderly, and then I was on the Aging Committee in the House and spent a lot of time on it.

I have been struck by the number of parallels between the climate before Medigap was enacted and which you all are describing today. In fact, what is so helpful about the wonderful service you are performing, Ms. Holland and you, Mr. Dilweg, is we really got it going in the late 1980's because a handful of insurance commissioners like yourselves really spoke out and blew the whistle.

In fact, the language you are using today—the language of lawlessness—is exactly what a handful of insurance commissioners said back then. We talked about how the Medigap market was pretty much like Dodge City before the marshals showed up.

In fact, when you think about it, the situation between the Medicare Advantage abuses you are describing today and Medigap back then—other than the fact that in the Medigap market, you could sell these multiple policies and it was common for a senior back then to have a shoebox full of policies—you know, 15, 20 policies—and they would have these subrogation clauses, and, eventually, they wouldn't be worth the paper they were written on—there is pretty much a parallel here between the Medicare Advantage abuses and what went on in Medigap.

Now, my question to you—my first one—is back then, what we essentially did was bring in the National Association of Insurance, you know, Commissioners, led by a handful of commissioners like yourselves, and we used the National Association of Insurance Commissioners to develop a model so that the States would have aggressive tools to deal with the abuses and we would have these uniform, standardized kind of policies. Then, it would be backed up by Federal authority. In other words, if a State didn't go forward and there was a specific, you know, timeline, then the Federal Government could step in.

It strikes me that most of that model makes sense today. They are different products, obviously. Medicare Advantage is a different product than Medicare supplement. But most of what made sense

back then for Medigap looks like a pretty good model today for us under Chairman Kohl's leadership to proceed with. I would like to get your views on the record on that. Then I want to ask some other questions with respect to how it would go forward.

Commissioner Dilweg and then Commissioner Holland.

Mr. DILWEG. Thank you, Senator. Your reputation is quite well-known as it relates to Medigap. I appreciate that.

When I turned to my staff and said, "What could work here?" it was, really, that model. It is really—you know, with other Federal agencies in the State of Wisconsin—we have the EPA—delegates their authority to our natural resources department over the environment. This is really a very similar situation. How does CMS delegate their authority to the insurance commissioner's office, which is on the front lines of complaints?

It was that regulators—where NAIC worked with CMS and built those minimum standards. Then States were given, I believe, 12 months or 18 months to adopt the standards. Now, some States, they don't want to, and so the power remained with CMS. But I think it is a good model to look at. It may have to be tweaked.

Senator WYDEN. Eventually every State came around, I think.

Mr. DILWEG. Yes, I believe so.

Senator WYDEN. So you feel it is a pretty good model.

Commissioner Holland.

Ms. HOLLAND. I would concur, Senator Wyden.

I think that it demonstrates the kind of partnership that we are looking for between the States and the Federal Government. It creates a framework that gives the States the opportunity and authority to respond quickly to the needs of our consumers in our State and to hold the insurers accountable for the products and the activities that are being rendered.

I am the Vice Chair of the Healthcare and Managed Care Committee, of which your commissioner, Joel Ario, serves as Chair. We work very closely. I can tell you that the Healthcare Committee, which also supports the Seniors' Issues Task Force, of which Commissioner Dilweg is a Chair, would welcome the opportunity to work with you and to work with CMS is revising and re-looking at guidelines and regulations to more model Medigap.

Senator WYDEN. My understanding—and you correct me otherwise—is that Chairman Kohl, to his credit, has already begun some of these efforts with NAIC. I am going to support him in this because I don't think we have to reinvent the wheel.

I think the idea is to get with NAIC, give the States the opportunity to indicate what tools, specifically, they need, as it relates to this market. You have given us valuable information about the advertising abuses. I am going to ask about the companies in a second—and try to turn this around quickly.

I mean, it took us, literally, 12 years—I mean, in terms of actively working for the Medigap, you know, law—to get it done. I don't think seniors and their families can afford to wait for another decade in order to get the tools in your hands to protect them and their well-being.

Now, on this question of the companies and the sort of line of demarcation about how you all don't have the authority with respect to companies themselves, let me make sure that I understand this.

You can go after brokers and agents even under the limited authority that came out of the Medicare Advantage program. Is that correct?

Mr. DILWEG. Yes. They are licensed in our States.

Senator WYDEN. Are there any limits at all with respect to your ability to go after the agents and brokers?

Mr. DILWEG. No, I deal with enforcement action every day on agents and brokers, and——

Senator WYDEN. Yes, please.

Ms. HOLLAND. The only thing I would add to that is the issue with the appointment, Senator. That does create a limitation for us.

Senator WYDEN. So what you all would like, essentially, as it relates to the companies, is some ability along the lines of what was done with Medigap to make sure that the companies would have to come in advance and, essentially, show you their materials, show you their marketing kind of practices. From that point on, you would have authority—oversight authority and regulatory authority—over the companies. Is that essentially what you want?

You seemed to touch on that Commissioner Dilweg, on page five. You have got a variety or points with respect to tools that come out of the Medigap law that you would like to have in Medicare Advantage. But aren't those the key points?

Mr. DILWEG. Yes, page six of my written testimony shows a crosswalk——

Senator WYDEN. Oh, yes.

Mr. DILWEG [continuing]. Of what authority we have under Medigap.

This is not—you know, with private health insurers, we look at their marketing aspects, we look at their representations. We are then able, as complaints come in, to really perform market-conduct studies and look at—you know, if we see an outlier of 30 complaints coming in on an issue, we can then get in there with the companies and, "How are they treating their agents?" We audit that relationship with their agents and have full access to that.

So these types of tools are—like I said, we don't need to reinvent the tools that the States currently have. I believe we have them.

Senator WYDEN. OK.

Well, you all have been very helpful. Bouquets to you, Special Agent Mowell and Mr. Sochor, for you all speaking out as well. This is exactly the kind of thing that has to be done so we don't have to wait another decade to make sure that the government and regulators are on the side of seniors.

I really thank our two commissioners, because this doesn't happen unless people like yourselves who, under McCarran-Ferguson, essentially have the primary responsibility to kind of step in and advocate for people. We wouldn't even know about this for the most part, other than angry folks—you know, going to senior centers—unless you all had those toll-free lines and the capacity, at least, to find out about brokers.

So I am very much committed. I hadn't even seen page six. It has been a crazy day, here, Commissioner Dilweg. But I am especially committed to taking the Medigap model, which we know has

worked—it worked better than I could have dreamed of. I mean, it really drained the swamp.

It is very rare today that you get a complaint about a Medigap practice. I would be curious if your offices are picking up something else. But it happened almost overnight, because the fact that there was uniformity, the fact that there was standardization, the fact that you had authority over a company—essentially what we saw is the sleazy operators, essentially, couldn't go in that kind of environment; and people who could make a marketplace work, sell a private policy that was responsible and of good quality, did just fine under it.

So it worked for seniors. It worked for responsible people in the industry. I am glad Chairman Kohl is taking the lead with the National Association of Insurance Commissioners and the States, because we don't have to wait forever to get this done again.

Thank you, Mr. Chairman.

The CHAIRMAN. That was very good, Senator Wyden. I think you succinctly and clearly highlighted the problems as well as pointing out the things we can do to not only rectify, but, maybe, to eliminate most of these problems.

We thank you all for being here. Your testimony and your ability and willingness to respond to our questions have been very helpful and we will continue to be in touch with you.

Our first witness on the third panel will be Karen Ignagni of the American Health Insurance Plans. She serves as AHIP's president and CEO.

Second witness on this panel will be Heidi Margulis of Humana. Ms. Margulis is a senior vice president for that company.

Third, we will hear from Peter Clarkson, Senior Vice President of distribution operations for United Health Group.

Finally, we will hear from Gary Bailey of WellCare. Mr. Bailey is vice president for Medicare operational performance at WellCare.

Ms. Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman. Good morning. Good morning, Senator Wyden. It is a pleasure to be here. We thank you for the opportunity to testify.

You will hear shortly that our members are strongly committed to the long-term success of the Medicare Advantage and Part D programs. Today at AHIP—and we represent all of the companies at the table and, virtually, all of the members who are participating in both programs—we are announcing a new initiative that will be giving beneficiaries additional peace of mind by strengthening protections against improper conduct in marketing Medicare plans to beneficiaries.

I would like to tell you, Mr. Chairman, what we did and what we didn't do. First, we did not try to size the problem and get a sense of, "If this was a small problem, we would act in such a way; if it is a larger problem, we would act in such a way." In our view, this issue that is now occurring, that you have been talking about for the last several hours—any abuse is one too many. So we approached it through that prism. What I am going to tell you about

is what our members have committed to do. In this endeavor, we are going to be partnering not only with CMS, but with the State insurance commissioners. I will outline specifically where.

First, we are going to be requiring core competency training that meets standards that we are going to be urging CMS to establish. We think it is very important, as the insurance commissioners stated, that we have core standardized requirements for specific training. We are going to be requiring that threshold scores be achieved so that training not only is adequate, but the performance and efficiency and proficiency are there.

Second, we are going to be ensuring that continuing-education credits are available for the core competency training. We are going to be partnering with the broker organizations and with beneficiary groups to make sure that those objectives are achieved.

Fourth, we are going to be requiring achievement of threshold scores on specific plan training; not only on the program itself, but specific plan training.

Fifth, we are going to be requiring annual recertification through achievement of threshold scores.

Sixth, targeted re-training throughout the year on specific topics required by CMS for special attention.

Seventh, we are going to be requiring a new beneficiary attestation on enrollment applications to confirm that individuals understand the program that has been chosen.

Eighth, we are going to be conducting oversight to verify the beneficiary's intent to enroll. We are not going to stop with an attestation. We are committing, for all products, to do post-enrollment outbound calls to confirm the intent and to make sure that we are doing systematic monitoring of intent-to-enroll.

Next, we are going to be requiring that plans proactively track and analyze the performance of brokers, agents and plan-marketing staff in such areas as beneficiary satisfaction, rapid dis-enrollment and complaints.

We are going to be requiring that individual plans address verified complaints through an inbound call system to make sure that if there is any kind of a pattern that is being observed, that that is taken care of.

Finally, we are going to be working with CMS and the NAIC to urge the establishment of a uniform process and criteria for broker, agent and staff misconduct—reporting of that misconduct to State agencies. Right now, we have a very uneven system. It is not clear. It is not the same in every State. We have been working very closely with the insurance commissioners. We think they can play an important leadership role here.

We want to partner with them, partner with beneficiary groups and partner with CMS to make sure that the fabric of rules and oversight is there and it is consistent. We, then, will know what the rules are, how to report bad practice, practice that is sub-par, and we commit to doing that.

Mr. Chairman, you also heard today considerable discussion about the issue of lock-in. I would like to make a comment about this. This is a new program, but we have a number of plans at the table who have been in this program, serving seniors for a number of years.

In the old days, it was called the Medicare Plus Choice program. Now it is the Medicare Advantage program. At that time, the rules of the road were as follows: If an individual joined a plan and realized and found out that he or she was not happy in that plan, they were allowed to dis-enroll. We did not support the movement toward lock-in.

We would be very comfortable and would endorse and support the idea of taking a look at that to go back to the way it used to be. We had very low dis-enrollment. But it did provide a safety net for beneficiaries and for advocacy organizations, knowing that, sometimes, people make the wrong choices.

We are very comfortable with that. We are comfortable with what we put on the table. We intend to stand by it. We spent a great deal of time in 2006 working on a range of operational initiatives responding to pharmacy issues, physician issues.

I just want you to know our personal assurance—my personal assurance—that we are going to make this a major priority so that when you have your next hearing, as you indicated earlier that you intend to do, we can give you a very positive report about specifically what actions have been taken.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Ignagni follows:]

Testimony on

Medicare Advantage Marketing and Sales

by

Karen Ignagni
President and CEO
America's Health Insurance Plans

Before the
U.S. Senate Special Committee on Aging

May 16, 2007

I. Introduction

Mr. Chairman, Senator Smith, and members of the committee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members serve most beneficiaries in both the Medicare Advantage and Medicare Part D prescription drug programs. They also participate in other public programs and offer a broad range of products in the commercial marketplace.

We appreciate this opportunity to testify on the Medicare Advantage program and issues surrounding the marketing and sales of Medicare Advantage plans to beneficiaries. Our members are committed to the long-term success of the Medicare Part D and Medicare Advantage programs, and to providing clear and accurate information to beneficiaries about these important benefits in an effort to assist them in making the most informed decision possible about their medical and prescription drug coverage. We recognize that concerns have been raised about the practices of certain brokers and agents, and today we will be announcing a new initiative that we will be working side by side with the Centers for Medicare & Medicaid Services (CMS) to implement to give beneficiaries additional peace of mind.

As you know, the Medicare Advantage and Part D programs generally open up enrollment for a limited time each year, which also limits the time periods during which plans are allowed to actively market their benefit packages to beneficiaries. As a result, plans recognized the need to develop a new means of marketing these products to serve the Medicare population. Many plans have accomplished this goal by using a contracted sales force to supplement the activities of their directly employed sales force, and by implementing new approaches to ensure that their sales force interacts appropriately with those they seek to serve.

In February 2007, we met with our Beneficiary Issues Advisory work group, which includes beneficiary advocates, to discuss various priority issues, including marketing practices. We went to work designing specific steps to address areas of concern. We did not approach these concerns as isolated events. Rather, we sought to establish a series of systematic initiatives that could be broadly adopted. I will review the elements of that plan in my testimony today.

Our testimony will outline aggressive new measures AHIP member organizations are undertaking to ensure that brokers and agents and plan marketing staff meet specific qualifications and follow appropriate standards of conduct when providing information to Medicare beneficiaries. These measures differ from the existing policies and requirements in several important respects, including the following:

- Requiring core competency training that meets standards we are urging CMS to establish;
- Requiring achievement of threshold scores on the core competency training;
- Ensuring that continuing education credits are available for the core competency training;
- Requiring achievement of threshold scores on plan-specific training;
- Requiring annual recertification through achievement of threshold scores on tests;
- Requiring targeted retraining on topics requiring special sensitivity throughout the year;
- Requiring beneficiary attestation on the enrollment application and outbound post-enrollment calls to verify the beneficiary's intent to enroll and understanding of key plan benefits and structure;
- Requiring plans to systematically and proactively track and analyze broker, agent, and staff marketing performance in such areas as beneficiary satisfaction, rapid disenrollments, and complaints;
- Requiring inbound pre-enrollment verification calls if broker, agent, or staff complaints surface to ensure beneficiary intent to apply for a plan; and

- Establishing uniform processes and criteria for reporting broker, agent, and staff misconduct to state agencies.

In addition to discussing these important issues relating to marketing and sales of Medicare plans, our testimony also will review the success the Medicare Advantage program has achieved in providing high quality, comprehensive, affordable coverage options to beneficiaries and the rapid growth the program has experienced in recent years.

II. Improving and Monitoring Medicare Marketing Practices

AHIP's Board of Directors has issued a statement outlining seven principles for ensuring that safeguards are in place to provide appropriate information to beneficiaries, that they intended to enroll in Medicare Advantage or Part D plans, and that appropriate steps are put in place to ensure that contract agents and brokers and internal plan sales teams are appropriately trained and regularly recertified.

Ensuring Best Practices

In each of the following areas, AHIP members are working on an accelerated basis to promote marketing practices that assist beneficiaries in making informed decisions about their health care options.

Establishing Qualifications for Brokers and Agents and Plan Marketing Staff:

Plan sponsors will specify the qualifications that brokers and agents and plan marketing staff must meet to market Medicare Advantage and Part D plans, clearly communicate these qualifications, and consistently apply them. Plans will use multiple strategies for accomplishing this, including:

- Performing background checks, including verification of required state licensure;

- Checking applicable databases for documentation of prior serious misconduct;
- Obtaining documentation substantiating that threshold test scores have been achieved on core competency training and ensuring that continuing education credits are available for licensed brokers, agents, and plan marketing staff. We are urging CMS to establish standards for training that requires that specific topics must be addressed in detail including:
  - Medicare fee-for-service eligibility and benefits;
  - Medicare Advantage and Part D plan types and structure, including the key differences between HMOs, PPOs, PFFS plans, and SNPs; and
  - Permissible and prohibited marketing practices, including non-discrimination rules and the prohibitions against door-to-door marketing; and
- Requiring brokers and agents and plan marketing staff to obtain threshold test scores on plan-specific training that provides detailed information about the plan types and benefits offered by the plan sponsor.

Annual Recertification and Targeted Retraining:

Plan sponsors will establish requirements for brokers and agents and plan marketing staff to achieve threshold scores on annual recertification tests and repeat core competency training, as needed. Plan sponsors also will require targeted retraining addressing topics requiring special attention that may arise throughout the year and provide updated information through e-mails, websites, or other means on an ongoing basis.

By setting threshold scores for annual training, our objective is to ensure that brokers and agents and plan marketing staff regularly update their knowledge or expertise so that they can fully and clearly inform beneficiaries about the details of their coverage options. Moreover, the additional requirement for targeted retraining ensures that brokers and agents and plan marketing staff will promptly receive in-depth information on specific issues that arise during the year.

Enrollment Safeguards:

Plan sponsors will include steps in their marketing and enrollment processes to verify beneficiaries' intent to enroll and understanding of the plans they are electing. Strategies for verification include:

- adding to the plan's enrollment application attestations by the beneficiary or his/her legal representative or guardian and the broker, agent, or plan marketing staff that address the beneficiary's understanding of the plan structure and benefits; and
- conducting oversight such as post-enrollment outbound calls from the plan sponsor to the beneficiary or his/her legal representative for face-to-face enrollments or systematic monitoring of recorded telephonic enrollments.

We understand that beginning this fall CMS will require that private fee-for-service plans make calls to beneficiaries who have enrolled to verify their intent to enroll and to ensure that they understand the coverage they have chosen. We will be working with CMS to add a safeguard to all plans' enrollment applications: an attestation to be signed by the beneficiary and the broker/agent/plan marketing staff that addresses the beneficiary's understanding of the plan structure and benefits and how they compare to the beneficiary's previous Medicare coverage. We also support requiring post-enrollment outbound calls from the plan sponsor to beneficiaries selecting all products. These measures will help to avoid misunderstandings about whether beneficiaries actually intended to enroll in a plan and to reaffirm that beneficiaries understand the coverage offered by the plan they choose.

Monitoring Compliance:

Plan sponsors will establish processes for tracking and analyzing individual broker and agent and plan marketing staff performance in such areas as beneficiary satisfaction, rapid disenrollments, and complaints. This ongoing process of evaluation allows plan sponsors promptly to identify conduct that merits urgent investigation, such as provision of incorrect, misleading, or inaccurate

information; unauthorized contact or home visit; fraudulent enrollment submission; or intimidation.

Protecting Beneficiaries:

Plan sponsors will establish processes for rapidly investigating complaints and taking immediate and decisive action when complaints are verified, including requiring inbound calls by the broker, agent, or plan marketing staff and beneficiary before each application is completed, re-qualification, suspension, or termination. We strongly urge CMS to work with the National Association of Insurance Commissioners (NAIC) to develop a uniform process and criteria for plan sponsors to report serious misconduct by licensed brokers, agents, and plan marketing staff in a timely fashion to state agencies overseeing broker and agent licensure.

These processes will give plans the information they need to move quickly in taking corrective measures – including requiring pre-enrollment inbound calls by the broker and beneficiary before the application is completed or dismissal, if warranted – when brokers or agents engage in inappropriate conduct while marketing Medicare Advantage or Part D plans to beneficiaries.

Compensation:

Compensation arrangements must comply with CMS Medicare Marketing Guidelines, including withholding or withdrawing payment for rapid disenrollments.

We have strongly supported compensation requirements in the CMS Medicare marketing guidelines which are designed to reward brokers and agents when beneficiaries are satisfied with their choices and penalize brokers and agents who use marketing tactics that result in beneficiaries signing up for a product that they do not fully understand – and then disenrolling a short time later after learning more about the plan. We will take additional steps to ensure that beneficiaries understand the program they have joined and that brokers and agents have correctly answered their questions.

Provider Outreach:

Plan sponsors will make available to physicians, hospitals and other providers detailed information about plan structure, benefits, rules and payment terms of the plans they offer. Plan activities will include strategies to educate providers prior to market entry and ongoing efforts to build and maintain relationships to serve plan members. CMS should increase outreach to educate providers about the types of Medicare Advantage plans and expand availability of CMS materials for providers.

The seven principles outlined above reflect our members' commitment to zero tolerance for broker and agent misconduct in carrying out Medicare marketing and sales activities and a comprehensive approach to improving the performance of brokers and agents and plan marketing staff. At the same time, the initiatives represented by these principles will help beneficiaries receive the clear and accurate information they need to make informed choices that meet their particular needs.

III. The Success of the Medicare Advantage Program

The success of the Medicare Advantage program is highlighted by the findings of a recent survey[1], released by AHIP in March 2007, regarding the important role Medicare Advantage plans play in providing health security to Medicare beneficiaries. This survey found that 90 percent of beneficiaries enrolled in Medicare Advantage are satisfied with their coverage overall. Other findings show that a large majority of beneficiaries are satisfied with the quality of care they receive (93 percent), the number of doctors from which they can choose (92 percent), the benefits they receive (89 percent), the coverage they receive for preventive care (87 percent),

[1] Ayres, McHenry & Associates, Inc. and The Glover Park Group, *National Survey Of Seniors Regarding Medicare Advantage*, February 26 - March 2, 2007

their out-of-pocket costs (80 percent), and the coverage they receive for prescription drugs (76 percent).

Additionally, 35 percent of seniors – including 62 percent of low-income seniors – enrolled in Medicare Advantage say they would skip some of the health care treatments they currently receive if the option of choosing a Medicare Advantage plan was taken away. Another 42 percent say they would pay higher out-of-pocket costs if the option of choosing a Medicare Advantage plan was taken away.

The creation of the Medicare Advantage program has provided valuable opportunities for seniors and Americans with disabilities to benefit from the innovations developed and implemented by private health insurance plans. Approximately 8 million beneficiaries currently receive high quality coverage through the Medicare Advantage program, reflecting a more than 50 percent increase in Medicare health plan enrollment since 2003. As a result of this rapid growth, nearly 20 percent of all Medicare beneficiaries nationwide currently are enrolled in Medicare Advantage plans.

The participation of private health insurance plans in Medicare has enabled millions of seniors and persons with disabilities to benefit from chronic care initiatives and other innovations that are improving their health care and enhancing their overall quality of life. Recognizing that many Medicare beneficiaries suffer from multiple chronic conditions – such as diabetes, heart disease, cancer, asthma, and depression – Medicare Advantage plans meet a critical need by offering care coordination and management for diseases that commonly afflict the elderly.

Health insurance plans are playing a leadership role in developing strategies and programs to improve patient care for persons with chronic conditions. Our members are focused not only on ensuring that patients with chronic conditions live longer – but also helping them live healthier lives, with fewer symptoms, so they can fully participate in the activities they enjoy. This requires a strong emphasis on preventive care, personal responsibility for healthy lifestyles, and early intervention to promote care strategies that are effective in improving the patient's quality of life.

Health insurance plans have a strong track record of encouraging prevention and evidence-based care for individuals with chronic conditions. Our members also are working on an ongoing basis to continue to develop new tools and greater expertise to help physicians customize care strategies to meet the unique needs and circumstances of individual patients. Building upon the success of early innovations in disease management, they are taking personalized service to a new level through a new generation of chronic care initiatives. These efforts reflect four interconnected trends:

- Plans are offering health coaching to change patient behavior. Using nurses and other health professionals who are trained to serve as health coaches, health plans are helping enrollees make lifestyle changes to improve their health, understand and follow their doctors' treatment plans, and address other health and social service needs.

- Plans are using advances in information technology – including moving toward personal health records (PHRs) for health plan enrollees – to improve the delivery of care, enhance health care quality, and increase productivity. In November 2006, AHIP's Board of Directors endorsed a set of recommendations calling for the industry to implement steps to standardize health plan-based PHRs. These recommendations, developed in partnership with the BlueCross BlueShield Association, will facilitate both information-sharing between consumers and caregivers and portability when a consumer changes health plans.

- Plans are recognizing that patients are well-served by a comprehensive strategy that addresses the needs of each person as a whole, rather than a narrow approach that targets individual diseases. Accordingly, our members are using nurse case managers to identify barriers to effective treatment – including financial, transportation, or social support issues – and helping individuals overcome these barriers.

- Another trend is the increased focus health insurance plans are placing on the continuum of health care services that people need throughout their lives. By providing a full spectrum of services – ranging from wellness and prevention to acute, chronic, and end-of-life care – our

members are improving health outcomes and addressing the unique needs and circumstances of each individual patient.

In addition to improving patient care for chronic illnesses, the Medicare Advantage program also provides many additional benefits that are not included in the Medicare fee-for-service benefits package. According to CMS, Medicare Advantage plans are providing enrollees with, on average, savings of $1,032 annually – through improved benefits and lower out-of-pocket costs – compared to what they would pay in the Medicare fee-for-service program.[2] This translates into aggregate savings of approximately $8 billion annually. Examples of the additional benefits Medicare Advantage plans provide to beneficiaries include:

- **Protection against out-of-pocket costs:** Ninety-three percent of all beneficiaries nationwide have access to Medicare Advantage plans that provide protection against out-of-pocket costs for Medicare-covered (non-drug) benefits of $2,500 or less. This protection is not available in the fee-for-service program.

- **No cost sharing for preventive screening:** All Medicare beneficiaries have access to a Medicare Advantage plan that does not require cost sharing for screenings for breast cancer, cervical cancer, and prostate cancer.

- **Extra benefits not available in FFS:** Medicare Advantage plans are widely available that provide hearing, vision, and other benefits that the Medicare program does not offer. For example, all Medicare beneficiaries can choose from a Medicare Advantage plan that covers hearing benefits. Over 98 percent of beneficiaries can enroll in a Medicare Advantage plan offering preventive dental benefits.

- **Comprehensive prescription drug benefits:** Almost every Medicare beneficiary can choose from a Medicare Advantage plan that provides protection in the Part D coverage gap.

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[2] Keynote Address by CMS Administrator Mark McClellan before the AHIP Medicare Conference (September 11, 2006).

Almost 90 percent of beneficiaries can choose a Medicare Advantage plan that provides Part D benefits for no additional premium.

Research studies indicate that these additional benefits are particularly important to low-income and minority Medicare beneficiaries, especially those who fall just short of qualifying for Medicaid. In February 2007, AHIP published a new study[3] showing that financially vulnerable beneficiaries who do not have Medicaid or employer-based coverage are more likely to enroll in Medicare Advantage plans than other beneficiaries.

This AHIP study demonstrates that Medicare Advantage plans serve as an important source of support for beneficiaries who may not qualify for state Medicaid programs, but are still likely to need assistance paying for necessary health care services. This is why Medicare Advantage plans remain the most popular option for beneficiaries with incomes between $10,000 and $20,000 who are less likely to have access to Medicaid or employer-sponsored coverage. AHIP's study found that beneficiaries with incomes above this range are more likely to have employer-based coverage to supplement their Medicare benefits. However, beneficiaries in the lower income categories are less likely to have employer-based coverage. And those with incomes in the range of $10,000 to $20,000 generally are not eligible for Medicaid – meaning that Medicare Advantage is their only option for comprehensive, affordable coverage.

Other key findings of the AHIP study include:

- 49 percent of Medicare Advantage enrollees in 2004 had incomes below $20,000; and

- among minority (non-white) beneficiaries in Medicare Advantage, 68 percent had incomes below $20,000, while 70 percent of African-American and Hispanic Medicare Advantage enrollees had incomes below $20,000; and

[3] AHIP, *Low-Income and Minority Medicare Beneficiaries in Medicare Advantage Plans*, February 2007

- in areas where Medicare Advantage plans were offered, 40 percent of low-income Medicare beneficiaries not enrolled in Medicaid or employer-based coverage chose a Medicare Advantage plan.

These findings demonstrate that Medicare Advantage plans play an important role in providing health coverage to many minority beneficiaries and many low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program. For many beneficiaries who do not receive supplemental coverage through Medicaid or a prior employer, the Medicare Advantage program serves as a crucial health care safety net by providing comprehensive, affordable coverage that is not available under the Medicare fee-for-service program.

In discussing the value of Medicare Advantage, it also is important to recognize that the program includes incentives that generate high quality health benefits and savings for beneficiaries and the program. Under the program's competitive structure, Medicare Advantage plans return 25 percent of the savings to the federal government when they bid below the benchmark; the remaining 75 percent is used to provide beneficiaries improved cost savings and supplemental coverage. According to CMS, the 25 percent that plans return to the government total approximately $26 per beneficiary per month.[4] This translates into approximately $3 billion in aggregate savings for taxpayers in 2007 alone.

IV. Conclusion

Thank you for this opportunity to testify on these important issues. We look forward to continuing a dialogue with committee members regarding our members' ongoing activities to improve marketing practices and beneficiary information in the Medicare Advantage and Medicare Part D programs. We also stand ready to work with you to further strengthen these programs, building upon the competition, choice, and innovation that have played such a crucial role in delivering savings and value to our nation's Medicare beneficiaries.

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[4] Keynote Address by CMS Administrator Mark McClellan before the AHIP Medicare Conference (September 11, 2006).

The CHAIRMAN. Thank you, Ms. Ignagni.
Ms. Margulis.

STATEMENT OF HEIDI MARGULIS, SENIOR VICE PRESIDENT, HUMANA INC., LOUISVILLE, KY

Ms. MARGULIS. Thank you, Mr. Chairman, Senator Wyden. Thank you for the opportunity to testify.

I am Heidi Margulis, senior vice president, Government Relations for Humana. Humana has contracted, for over 20 years, with CMS to offer Medicare beneficiaries affordable, comprehensive health-plan coverage. We offer MA products in all 50 States and Puerto Rico.

We know you have valid consumer-protection concerns about the marketing of plans to Medicare beneficiaries. We share those concerns.

Humana knows that CMS placed trust in us to provide health-plan options for beneficiaries, many who are vulnerable with special needs. Our long-term success comes directly from satisfied beneficiaries who remain with us and trust us. Over 8 out of 10 renewed with us this past year.

We have zero tolerance for misconduct in sales practices. Last year, we terminated 78 agents. We are serious about wrongdoing and take action when found. We understand our responsibility to meet Federal and State requirements.

Today, I will describe our marketing, training and oversight program, what has worked, how we can improve, suggest ways in which CMS States and plans can strengthen the program.

All of our employed and contracted agents must comply with our marketing code of ethics. For years, we have had a verification process so beneficiaries understand the plan that they are enrolling in, that their plan is not a Medicare supplement plan, and that their providers accept Humana.

Humana employs 2,000 sales reps who are licensed, appointed and certified to sell our MA product, and about 600 tele-sales agents. These Humana employees accounted for about 82 percent of agent-assisted MA sales in 2007.

For these agents, we have a formalized process that includes extensive background checks, 12-part classroom and field training on everything from Medicare and ethics to plan suitability and communicating with seniors. We test, coach and recertify.

We field-monitor and investigate all specific complaints, taking appropriate corrective action ranging from coaching to termination and regulatory reporting. We now track dis-enrollment rates. Commissions are not paid to agents if a member dis-enrolls in 90 days.

Humana contracts with about 14,800 independent agents through agencies. These agents were responsible for about 18 percent of our MA sales last year. These agents are licensed, appointed and certified to sell our products. These agents are also trained, monitored and overseen.

As mentioned, we investigate every specific allegation we get, regardless of source. During 2006, we investigated about 1,612 allegations, considerably less than one percent of sales. Of those, 304 were founded and corrective action was taken, with 78 agents terminated.

In terms of oversight, in 2005, CMS identified an unapproved marketing piece and identified changes needed in our verification script and expressed concerns about sales complaints and marketing practices. Humana implemented and CMS accepted several corrective actions, including enhanced verification scripts, revised training, increased oversight and complaint-resolution staffing.

Since 2006, Humana has reported findings from sales investigations on a bi-weekly basis to CMS. Last year, the Oklahoma Department of Insurance conducted a modified market-conduct examination. They identified issues relating to licensure and appointment of agents.

Even though CMS authority preempts State laws on appointments, we maintain that all but six of our agents were appointed consistent with Humana policy. Sixty-eight of 950 agents failed to have non-resident licenses. Specific action was taken with these agents.

Also, the department has been concerned about sales practices in the use of delegated agents. We share this concern, have made changes and decreased the use of delegated agents. In addition, we had 30 specific beneficiary sales complaints in Oklahoma investigated and took action on each. Nonetheless, we can all improve the system.

Aside from more rigorous training and oversight efforts, some additional actions should be considered. First, there is Federal legal authority to implement changes. Federal laws do not need to change for all parties to improve efforts to eliminate sales-and-marketing violations.

Second, we strongly support AHIP's principles to protect beneficiaries. In part, they call for CMS and the States to work together for uniform consumer protections. We believe a watch list, early detection registry, should be established similar to that in the area of information sharing for healthcare fraud, containing information on both agents terminated for cause and those who demonstrable trend in complaints. Humana does not want to contract with an agent who has been terminated by another plan or vice-versa.

Humana continues to implement improvements. Plans for secret-shopper efforts and callbacks to new members to solicit their feedback on sales visits are in progress.

Violations have occurred. While Humana's founded allegations are small in comparison to the number of sales, there is clearly room for improvement. You have our unqualified commitment to that objective. Humana strives daily to earn the trust that consumers place in us when they select our health-plan coverage.

I thank you and look forward to your questions.

[The prepared statement of Ms. Margulis follows:]

Testimony by
Heidi Margulis, Senior Vice President
Government Relations
Humana Inc.

May 16, 2007

Senate Special Committee on Aging

Mr. Chairman, Senator Smith, Committee members, I appreciate the opportunity to testify about marketing and sales activities related to Medicare Advantage products. I am Heidi Margulis, Senior Vice President, Government Relations for Humana Inc. Humana, headquartered in Louisville, Kentucky, has contracted with the Centers for Medicare and Medicaid Services (CMS) for over twenty years to offer Medicare beneficiaries, affordable, comprehensive health plan coverage through a variety of products. We currently offer three stand-alone prescription drug plans in 50 states, the District of Columbia and Puerto Rico, private fee-for-service plans in 50 states, regional preferred provider plans in 23 states, local preferred provider plans in 17 states and HMOs in 8 states and Puerto Rico. We also offer a Medicare Supplement product in 36 states. In addition, Humana offers private health plan options through the Department of Defense's TRICARE program to military families and plans to government employees through the Federal Employees Health Benefits Program. We offer Medicaid plans in Florida and Chicago, and a reforma plan in Puerto Rico. Finally, we offer health insurance coverage and related services to employer groups, other government-sponsored plans and individuals. In total, we provide medical insurance to over 11 million members.

Before I address issues related to the marketing and sale of Humana's Medicare Advantage products, I want to make three points at the outset:

1. We have served Medicare beneficiaries for over twenty years and recognize the vulnerability and needs of this population. Our marketing, sales and administration practices affect how beneficiaries view our company and the success of our products. Satisfied customers build great businesses. Our high retention rates are testament to that.
2. Humana takes very seriously our responsibility to meet federal AND state regulatory requirements as well as our Medicare contract obligations.
3. We have zero tolerance when we find violations of our Marketing Code of Ethics by both Humana employees and contracted agents. The 75 sales agents we terminated last year indicate we're serious about wrongdoing.

Here are some of the key components of and lessons we learned in our Medicare marketing licensure, training and oversight program as they relate to issues you, state and federal regulators and the press have expressed. I will also share some recommendations.

EMPLOYED CAREER AGENT LICENSURE, TRAINING AND OVERSIGHT

Humana sells its MA and PDP products through employed sales representatives (career agents) and through contracted, independent brokers (delegated agents), most of who are affiliated with large managing general agencies. These agents market to individuals by appointment only, in a variety of settings depending on their choice—through seminars, at home or other approved settings.

Humana currently employs about 2,000 career field agents who are licensed, appointed[1] and certified to sell our MA product and about 600 telesales agents. Those employees account for approximately **82%** of Humana's agent-assisted MA sales in 2007 (approximately 76% in 2006). Humana conducts a background check on all its employees. For Medicare sales employees, we also require a credit check, criminal background check, and we check these employees against the National Insurance Producer Registry.

All Humana Medicare sales employees or career agents are required to take a three week training course approved by CMS that encompasses the following subjects:

- Humana orientation (Successful Beginnings)
- Humana history & background
- Ethical sales practices and compliance [Sales & Marketing Code of Ethics review/signature[2] *(Attachment #1)*, HIPAA policies, etc.]
- Original Medicare (utilizing "Medicare & You")
- Medicare Advantage products
- Medicare Part D
- Humana's enrollment process (proper completion of forms)

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[1] The Medicare Modernization Act of 2003 provided that federal law preempted all state laws and regulations with regard to Medicare products with the exception of licensure and solvency. CMS Marketing Guidelines also preempt Medicare plans from state requirements to appoint agents to sell their products. However, it is Humana's policy to appoint licensed agents with their respective Departments of Insurance to sell our products.

[2] The Humana Code of Ethics includes seventeen (17) policies to which the agent must attest including: how they are to comport themselves, no door-to-door solicitation, not identifying themselves as representing the government, using only CMS-approved materials, fairly and accurately presenting sales materials, not using false or misleading statements, not disparaging competitors, not forging a signature, ensuring to the best of their ability, the beneficiary is of sound mind and is capable of understanding the product, etc.

- Senior awareness and senior sensitivity training
- Humana sales system, sales materials, use of suitability and needs assessment
- Selling skills
- MA & PDP sales presentations [these presentations have been updated to address issues identified through trends in beneficiary complaints and regulator concerns—issues that cause beneficiary confusion, e.g. an MA product is not a Medicare Supplement policy; ensuring that the beneficiary's provider accepts the particular MA product]
- Seminar selling and small group sales presentation role-playing
- Computer training

At the end of the session, all career agents must successfully pass a "certification test" in order to be authorized to sell Humana's MA and/or PDP plans. Employees who fail to successfully pass the test in two attempts are terminated.

Annually, career agents must successfully pass a recertification test to demonstrate ongoing knowledge and competence related to the sale of MA and/or PDP plans. Career agents who fail to successfully pass the recertification test in two attempts are terminated.

Career agents are trained extensively on the use of our CMS-approved sales presentations. The sales presentations were created to help ensure that all beneficiaries received consistent information and that beneficiaries (and/or their designee) can make informed decisions. One week of the aforementioned training is devoted to proper delivery of the sales presentation.

Upon completion of classroom training, career agents return to their local market and are to be evaluated in the field on their sales presentation to ensure they are accurately presenting it. Local field sales management is to conduct at least three evaluations initially before the agent is released to sell unsupervised. These evaluations are followed by an additional two evaluations for a total of five in the first month of selling. Career agents are then to be evaluated once every six months thereafter. Sales management completes an evaluation form for each visit and provides feedback, coaching and counseling.

Local sales managers provide ongoing training as needed on various topics based on local market issues, trends, new policies, procedures or regulatory requirements. Training may take the form of conference calls, face-to-face meetings, etc.

Sales reports are issued monthly to sales management to apprise them of the source of sales in their markets. We have recently begun to distribute early voluntary disenrollment reports which are designed to identify trends in unsatisfactory rates that could be a sign of inappropriate selling practices. Humana's policy dictates that agents are not paid commission for members who disenroll within the first 90 days of membership. This process is called a "chargeback" and serves as an incentive to ensure proper selling techniques.

Field sales management tracks and identifies trends in agent complaints and investigation findings. All complaints related to alleged agent misconduct or misrepresentation are investigated by a special unit outside of the sales area and follow a specific policy and procedure related to prohibited marketing and sales activities. Investigations include:

- Beneficiary statement.
- Agent statement.
- All supporting information, such as the customer service records of member conversations, claims and if applicable, the verification recording review.

Determinations are reported to local sales management and based on the investigation determination, corrective action is taken. Corrective action ranges from coaching and counseling, to additional agent training to agent termination, including, if applicable, reporting to the relevant state Department of Insurance. Humana has taken such actions every year since this process began in 1991.

DELEGATED AGENT LICENSURE, TRAINING & OVERSIGHT

Humana contracts with approximately 11,000 delegated agents (through managing general agencies) who are licensed, appointed and certified to sell our MA products and approximately 3,800 State Farm and USAA agents who are licensed, appointed and certified to sell our MA and PDP products. In 2007, delegated agents accounted for approximately 18% of Humana's agent-assisted MA sales (approximately 24% in 2006). Further, Humana's contract with managing general agencies includes an Agency Compliance Agreement that specifies certain compliance requirements and activities to which the agency and its agents must adhere, including the attributes of individuals best suited to market MA products, required background checks, training requirements, certification and recertification testing, requirements for agency management oversight of agent sales activity, privacy policy requirements, etc. Failure to comply with this Agreement may result in agency termination. *(Attachment #2)*

Humana requires a background check for all delegated sales agents at the time of contracting, including a credit check, criminal check and check against the National Insurance Producer Registry. While not required, Humana appoints each delegated sales agent with the respective state Department of Insurance.

Delegated agents are required to take sixteen hours of training. Delegated agents complete four hours of pre-work and a test online prior to attending classroom training. The content of training includes:

- Ethical sales practices and compliance—Sales & Marketing Code of Ethics review and signature, HIPAA policies, etc.
- Original Medicare (using "Medicare and You").
- Medicare Advantage products.
- Medicare Part D.
- Humana's enrollment process—proper completion of required forms.
- Humana sales system and sales materials, including emphasis on suitability and needs assessment.
- MA & PDP sales presentations [these presentations have been updated to address issues identified through trends in beneficiary complaints and regulator concerns—issues that cause beneficiary confusion, e.g. an MA product is not a Medicare Supplement policy; ensuring that the beneficiary's provider accepts the MA plan].

Humana requires that delegated agents must successfully pass a certification test in order to be authorized to sell Humana's MA and PDP plans. Agents who fail to successfully pass the test in two attempts are not allowed to sell our MA plans.

Delegated agents must also pass a recertification test annually to demonstrate ongoing knowledge and competence related to the sale of MA and/or PDP plans. Agents who fail to successfully pass the recertification test in two attempts can no longer sell our MA plans. Recertification testing is administered online and takes place just prior to the next annual enrollment period.

Delegated sales agents are trained extensively on the use of our CMS-approved sales presentations that were created to help ensure all beneficiaries receive consistent information. Agents must commit to using only the standardized presentation for all selling opportunities to ensure that beneficiaries (and/or their designees) are able to make informed decisions.

Humana has provided and received signed acknowledgements from all contracted managing general agencies of their obligations with regard to compliance oversight of their contracted agents. That Agreement requires the agencies to conduct one field evaluation the first week after the agent's successful certification. A second field evaluation must be completed within ninety days of certification. A subsequent field evaluation must be conducted at a minimum of once every six months. Further, in some Humana markets, our sales management team has reached out to delegated agents to provide assistance, additional coaching and some have conducted evaluations and have secret-shopped sales presentations.

We have recently begun to distribute early voluntary disenrollment reports to agencies that are designed to provide identify trends in unsatisfactory rates that could be a sign of inappropriate selling practices.

All complaints related to alleged agent misconduct or misrepresentations are investigated by a special unit outside of the sales area. Investigations include:

- Beneficiary statement.
- Agent statement.
- All supporting information, e.g. customer service records of member conversations, claims, verification recording review, if applicable.

Determinations are reported to local sales management and based on the investigation determination, corrective action is taken. Corrective action ranges from coaching/counseling, to additional agent training to agent termination, including, if applicable, reporting to the relevant state Department of Insurance. Sales compliance staff tracks and trends agent complaints and investigation findings and confers with field management on necessary actions.

Finally, field sales managers provide ongoing training as needed on various topics based on local market issues, trends, new policies, procedures or regulatory requirements. Training may take the form of conference calls, face-to-face meetings and other activities.

ENROLLMENT VERIFICATION SYSTEM

With over 20 years of serving Medicare beneficiaries, Humana understands the special needs and vulnerability of this population, including adversity to change and cognitive disparities. Since 1991, Humana has had an enrollment verification system in place. This verification system was established as a final check to ensure that the beneficiary (or his/her authorized representative) understood (s)he was enrolling in a

Medicare Advantage plan and understood the basic rules of the plan. The system has been enhanced on a regular basis since then to include the lessons learned from customer service calls, regulator input, beneficiary advocate input and our experience over time with this process. The last major improvements were made just prior to the 2007 annual enrollment period.

Verification is conducted outside the sales area by a trained customer care representative or by an interactive voice response (IVR) system, the choice of which resides with the beneficiary. For employed career agents, prior to the beneficiary's executing the application, the agent phones our toll-free verification line. The plan representative/IVR asks the beneficiary a set of questions designed to ensure the beneficiary (or his/her authorized representative) has made an informed decision. The script is approved by CMS. Questions range from ensuring that the beneficiary understands that (s)he in enrolling in a plan with medical and prescription drug benefits and is not a stand-alone PDP to ensuring beneficiaries understand that the plan is not a Medicare Supplement plan. Beneficiaries are told to confirm that their providers will accept the plan. Beneficiaries are also asked whether their agent compared their current coverage to the new coverage to ensure suitability to their coverage needs.

If the beneficiary chooses the IVR option and hesitates to reply, fails to reply or answers negatively, the beneficiary is transferred to a live customer care representative. Any hesitation or negative response halts the verification process and the agent is advised to further review the sales presentation with the beneficiary. When the beneficiary fully understands the plan and desires to enroll, the agent is instructed to call back. If for whatever reason, an enrollment is not verified upfront, an outbound call is made

following our enrollment center's processing of the application.[3] If we are unable to reach the beneficiary, a letter is sent. Less than 1% of enrollments are stopped as a result of verification. Verification recordings are used in investigations of sales practice allegations.

For delegated agents who use Humana's telephonic enrollment/signature technology, virtually 100% of their enrollments are verified as part of the enrollment process and the beneficiary is automatically connected to a verification option. All telephonic signature calls are digitally recorded. Delegated agents who use laptop technology to enroll beneficiaries where the beneficiary digitally signs the application and those agents who use paper enrollment call the toll-free verification line to begin the process as described above. Regardless of verification form, Humana seeks to ensure that beneficiaries understand and intend to enroll in an MA plan.

SALES ALLEGATIONS

As mentioned previously, Humana takes seriously any and all specific sales allegations brought to our attention. Our company's reputation and brand promise is inextricably tied to best sales practices and agents the public can trust. We have an established unit, process and procedure outside the sales area to individually investigate each issue. This program has been in place since 1991 and has been enhanced on a regular basis to address trends and current issues. During 2006, we received and investigated approximately 1,612 allegations. That represented .0008% of our total MA sales in 2006. Of those allegations, approximately 304 were "founded" and corrective

[3] Under current CMS rules, we must process an executed application. We cannot stop an application after it has been signed.

action was taken. We terminated 75agents and reported the relevant agents to state Departments of Insurance according to their laws. We have a zero tolerance policy for violations of our Sales Code of Ethics. We can only investigate those complaints where we have specific information such as identifiable beneficiary information. When we receive a complaint, whether from a beneficiary, CMS, the Department of Insurance, the State Health Insurance Assistance Program (SHIP), consumer advocate or whomever, we will investigate that complaint and report the findings to the appropriate parties. If there is a marketing violation, we will take immediate action up to and including termination and will report terminations for cause as outlined in state law to the relevant Department of Insurance.

REGULATORY OVERSIGHT

The MA program is subject to regulation and oversight by CMS and, as previously discussed, MA plans are subject to state regulatory oversight for issues related to licensure and solvency. As required by law, Humana has undergone regular and special reviews by both federal and state regulators. When issues are identified that were not already identified by Humana and corrected, Humana has taken necessary corrective action. These actions have improved program operations.

In 2005, CMS identified issues related our verification script, filing of marketing materials and increased complaints related to sales and marketing practices. Humana implemented (prior to the report of findings) and CMS accepted, several corrective actions including: revised sales training materials, revised verification script, revised sales presentation, increased management oversight, increased delegated agent training

and oversight, increased staffing for complaint resolution, revised marketing review and approval processes. Humana began biweekly reporting of sales complaint investigations and analysis of complaint trends as well as biweekly calls with CMS central and regional office staff. That reporting process continues today.

The Oklahoma Department of Insurance conducted a modified Market Conduct Examination covering the 2006 open enrollment period and found issues related to agent licensure and appointment. Even though it is preempted by federal law, it is Humana's policy to appoint each agent who sells our product in a state. While we maintain that all of our agents were appointed pursuant to Humana policy and not subject to the Oklahoma appointment law, we did have issues related to non-resident licensing for 68 of 950 agents (7%) reviewed. We have taken corrective action as follows:

- For those Humana employed telesales agents whose job is to complete enrollment forms, we are seeking licensure in all jurisdictions. We are also enhancing our call management system to alert staff as to licensure status needed in order to accept a routed call. (Our call system misrouted certain calls and call queues caused 26 telesales agents to enroll beneficiaries in states in which they were not licensed.)
- For 2 employed career agents without a non-resident license in Oklahoma, they were both counseled and applications for non-resident licenses are underway. The commissions have been charged back to Humana.
- For 40 delegated agents, no commission was ever paid to them for these sales as our commission management system checks for delegated agent licenses for each sale. Those agents who remain with us have been counseled and

applications for non-resident licenses are underway. One agent has been terminated.

The Oklahoma Department has been concerned about sales allegations of misconduct and the use of delegated agents. We share their concern and, as previously discussed, have increased training and oversight. We have decreased the use of delegated agents. In addition to the 68 cases discussed above, with regard to sales allegations, during 2006, we received and investigated 30 specific beneficiary complaints in Oklahoma. Of those 30 complaints, 1 was founded, 19 unfounded and 10 were inconclusive. All resulted in remedial action and findings are contained in the agent's file. No trends were identified. Sales in Oklahoma in 2006 totaled over 31,200. Humana seeks to investigate each and every specific complaint or concern a beneficiary or his/her surrogate has. Founded complaints are one way we can identify weaknesses in our systems and ferret out bad apples. Regrettably, we cannot fully investigate issues and take focused action where we do not have specific beneficiary information.

LESSONS LEARNED

Outreach & Education: The Part D Medicare Prescription Drug benefit and the new products offered under Part C, Medicare Advantage (MA) represented the most fundamental change in Medicare since its inception. The new benefits brought new choices and coverage options for beneficiaries, their families and caregivers as well as for providers. Humana recognized the need to educate these individuals on the new benefits and options and on enrollment and post-enrollment processes. For both the 2006 and 2007 open enrollment periods, we conducted national education campaigns in places

where beneficiaries frequented, and we reached out to provider organizations, pharmacy associations, state health insurance counseling groups and regulatory agencies. One of the lessons learned from the first enrollment season was that our outreach failed to adequately reach state insurance departments, SHIPs and other beneficiary advocacy groups. For the 2007 open enrollment season, we reached out to **all** state insurance departments and SHIPs as well as beneficiary advocacy groups to orient them prior to November 15 about our products, how we sell—including copies of our sales presentations--and provided them with contact names and a special toll-free number to call with constituent issues. We have also been active members with our trade group, America's Health Insurance Plans, in a Beneficiary Advocates Working Group, to respond to concerns of consumer advocates and make improvements in our processes.

Agent Licensure: As a result of regulatory findings in a market conduct exam, we have strengthened our processes for ensuring non-resident licensure status. We implemented a new policy on confirmation of state licensure of agents to ensure that agents selling outside their primary state hold the relevant non-resident license. We also amended agreements and enhanced our training programs. Any willful violation will result in termination. We note that during the state's regulatory examination period, any delegated agent who sold a beneficiary in a state where (s)he did not hold a non-resident license, was not paid commission. Our system will not pay a commission without a license in the system. Further, we strengthened our in-house, non-resident licensing process for those employed telesales agents who enroll beneficiaries telephonically, but do not externally solicit sales. Previously, calls were system-routed to telesales agents with a license in the state of the caller. Due to misrouting of calls and call queue issues,

some enrollments were completed by agents not licensed in the relevant state. We have counseled management and have applied for licenses for all states for all these employees. Further, we are enhancing our systems to bring up additional flags to indicate the state of the caller and to screen agents' licensure status.

Investigation of Sales Allegations: In late 2006, we established a new unit (outside of our Medicare Sales operation) to investigate sales allegations to expedite our resolution of these cases. (The investigation of sales allegations has always been conducted outside our Sales operation. Previously, our Market Compliance Directors handled these cases.) Our field sales management keeps the findings of these investigations in the agents' files and continues to monitor for trends. Failure to comply with Humana's sales practice rules results in various corrective actions--from coaching/counseling and retraining to termination.

Verification Process: We reengineered our verification system based on issues related to system inadequacy during the 2006 open enrollment season. We were unable to verify some sales due to "hold" times for live representatives and length of calls or sales made outside the verification unit's hours of operation. Based on beneficiary, regulator and agent feedback, we revised all product scripts and made available both live and IVR options. The script was also modified as previously indicated.

Training/Certification Program: Mid-summer 2006, we implemented improvements to our comprehensive training program as a result of trends identified through beneficiary and regulator complaints/concerns and observations by training staff. We redesigned our delegated agent training program to bring it closer to our career agent training program. We doubled the length of training, added self-directed study prior to

classroom work, self-study competency testing and strengthened the process to ensure certification is completed. We gave increased emphasis to ethics and compliance, election periods, sales presentation skills, proper enrollments, needs analysis and suitability assessments and added follow-up phone calls to answer agent questions after they started selling. We know our program is extensive from comments made by delegated agents who chose not to sell for us based on our training and oversight programs and from those who chose to sell for us because they value and appreciate the focus we place on these issues.

Further, we moved to an online method for delivering training and testing for recertification. Instructor-led training manuals and guides were created as an alternative to online learning/testing. The focus for recertification included changes to Medicare, CMS rule changes, election periods (what changed and what was new), ethics issues, compliance standards and expectations, and suitability assessments. We changed test questions to be more scenario-based rather than a recitation of facts.

Sales Presentations: We added a component to the sales presentation that requires the use of a CMS-approved Suitability Worksheet *(Attachment #3)* that is given to the beneficiary during the presentation. This Worksheet is left with the beneficiary (as it contains personal information and includes questions the agent is not permitted to ask). The Worksheet, designed in consultation with a former NAIC Health Insurance/Senior Issues Task Force staff director, compares the beneficiary's current coverage to the coverage being considered by the beneficiary. It also compares medical needs, providers and costs of coverage. It was designed to assist the beneficiary in determining whether or

not an MA plan is a good fit for their particular needs. This Worksheet augments the needs assessment the agent discusses during the presentation.

Management Oversight Reports: For the 2007 year, we designed early voluntary disenrollment reports to allow field sales management to track and trend any outliers among agents for beneficiaries who voluntarily disenrolled in the first 90 days of enrollment. Early voluntary disenrollment could be an indicator of a violation of sales practice policies.

CONCLUSION/RECOMMENDATIONS

Humana recognizes the trust that CMS has placed in us to provide affordable, comprehensive health care coverage options for Medicare beneficiaries. We understand the vulnerability of this population and their special needs. Our success over the past 20 years has come from the retention of beneficiaries who place their trust in us. None of us is advantaged when one of us is not.

Today, our trade association, America's Health Insurance Plans, has put forth Medicare sales and marketing practice principles that all its members will ascribe to, thus creating a national standard for plans. We wholeheartedly endorse those principles. Within those principles are provisions for CMS and state regulatory agencies to work together to ensure the best consumer protections for beneficiaries are in place and that those protections are uniform across the regulatory landscape. For example, state and federal regulators should work together to determine an appropriate reporting mechanism for agents who are not only terminated for cause (reportable under state law), but also for those who exhibit a demonstrable trend in complaints that result in inconclusive findings—a "watch list" registry. We believe that the current information-sharing model

for detecting health care fraud could serve as a model for such a registry. Under the auspices of a national fraud association, state, federal and company fraud investigators share information related to suspected fraudulent activities. This information-sharing model allows for early detection of potential violations. Further, we believe licensure and appointment rules should be uniform across the state and federal regulatory landscape. We encourage the states to work together with CMS to explore whether it is feasible to have a uniform definition of "for cause" reporting that addresses all parties' concerns. We encourage CMS to require plans to distribute CMS new product information to beneficiaries as part of the pre-enrollment process to ensure beneficiaries have additional information. There are others. Through public, private and partnership efforts, we all should work together to ensure as much uniformity in agent training and agent oversight requirements as possible.

Within our own organization, we continue to look for ways to improve our operational processes. At the top of that list are the formalization of secret shopping initiatives and call-backs to new members to solicit feedback on sales visits.

Finally, we recognize that consumer protection is among your most important concerns and that you have valid concerns about the marketing and sales of insurance products to Medicare beneficiaries. We share those concerns. We want you to know that Humana and our employees are working to earn the trust that consumers place in us when they select our coverage. If we do not work with the beneficiary to provide a product that best meets their needs, they will make a different choice. In doing so, we continue to work to ensure that we comply with all regulatory and contractual requirements.

Thank you for allowing me to present this testimony and I am happy to answer any questions.

The CHAIRMAN. Thank you, Ms. Margulis.
Mr. Clarkson.

STATEMENT OF PETER J. CLARKSON, SENIOR VICE PRESIDENT, DISTRIBUTIONS OPERATIONS, UNITEDHEALTH GROUP, MINNETONKA, MN

Mr. CLARKSON. Thank you, Mr. Chairman. Thank you, Mr. Chairman, for the opportunity to testify today.

I am Pete Clarkson. I am the senior vice president of distribution operations for Secure Horizons, which is part of UnitedHealth Group.

I was raised in rural America, and I have spent the past 20 years working in healthcare. I am personally committed and UnitedHealth Group is personally committed to making sure seniors have access to quality coverage and that they have the information they need to make informed decisions.

Today's hearing focuses on concerns about the sale and marketing of healthcare plans to people with Medicare. For UnitedHealth Group, the overwhelming majority of the issues that arose last year involved private fee-for-service plans, and these plans account for less than one percent of our overall Medicare business.

In late 2005, UnitedHealth Group acquired PacifiCare Health Systems, which was ramping up its private fee-for-service business. At the time, no one could have predicted how fast this market was about to grow. The entire industry had about 200,000 private fee-for-service beneficiaries then, but PacifiCare alone enrolled 178,000 new members for 2006, nearly as many as the entire industry had before.

In early 2006, it became apparent that the systems and procedures that were put in place by PacifiCare were not keeping pace with the rapid growth. We added staff to our customer service and other support operations and we moved the administrative support for the plan in-house, to our shared-services group.

PacifiCare relied heavily on external brokers to sell private fee-for-service plans. There were reports of misconduct in 2006 and we took aggressive action. Between January and July of 2006, we terminated more than 80 individual brokers, including two entire agencies.

After these events, the Centers for Medicare and Medicaid Services sent PacifiCare a letter on August 16th describing shortcomings in the sales and operation of private fee-for-service plans. The letter directed PacifiCare to address each area of weakness and to demonstrate rapid improvement.

We inherited these issues and we accept full responsibility for them. We have been working closely with CMS to address them. Among other things, we created a post-sale verification process in which we call new members to make sure they understand private fee-for-service and agree to be enrolled in the plan. Now, CMS plans to require all plans to make similar calls in the next annual enrollment period.

In February, CMS provisionally accepted our corrective-action plan and they continue to closely monitor our performance. Meanwhile, we continue to make improvements.

Early this year, we launched a national quality-assurance team, which works full-time with brokers and sales agents to make sure members get the information that they need. If we find that a broker may not be explaining the plan well enough, depending on the situation, the quality team can do everything from providing additional training to making site visits and going out with the broker on sales calls. If the broker's performance doesn't improve, we impose sanctions up to and including termination.

UnitedHealth Group is working with AHIP and others in the industry to develop best practices, but Congress and CMS could do two things to improve the overall structure of the private fee-for-service marketplace. The first involves the process known as deeming, which means accepting the terms and conditions of the plan.

Unlike an HMO, private fee-for-service generally has no network. A member is free to seek treatment from any Medicare-eligible provider, but the physician has to agree to the terms of the plan. A physician can decide not to provide services on any given office visit, even if the physician previously agreed to treat that same patient.

We need a deeming structure that is good for both physicians and members to increase satisfaction and improve continuity of care.

For our part, we will work with physicians and CMS to address the physicians concerns and help them become more willing to accept private fee-for-service plans.

The second suggestion relates to the fact that whenever one company terminates a broker, that same person often starts selling for another competitor. The Federal Government could help by creating a national registry of sanctioned brokers, along with an appeal process to protect honest brokers.

At UnitedHealth Group, we want only well-trained and highly ethical brokers selling our plans. We are committed to working with Congress, State and Federal regulators, health advocates in the industry, to enforce that standard.

Thank you.

[The prepared statement of Mr. Clarkson follows:]

Testimony of
Mr. Peter J. Clarkson
Senior Vice President
Distribution Operations
SecureHorizons
A UnitedHealth Group Company

For the

Special Committee on Aging
United States Senate

Wednesday, May 16, 2007

Thank you Chairman Kohl, Representative Smith, and other distinguished members of the Committee for the opportunity to testify today. I am Peter J. Clarkson, Senior Vice President for Distribution Operations at SecureHorizons, which is a business unit of Ovations, the division of UnitedHealth Group that serves Medicare beneficiaries.

Today's hearing focuses on concerns related to the sales and marketing of health care plans to seniors and others with Medicare. We are committed to continuing to work with Congress, state and federal regulators and others to ensure that Medicare beneficiaries can make informed choices and gain access to appropriate coverage.

In our experience, the overwhelming majority of issues that arose last year involved Private Fee For Service (PFFS) plans – which represent less than 1% of our overall Medicare business. But because the PFFS segment has been the subject of regulatory scrutiny, we welcome this opportunity to discuss our efforts regarding the PFFS Medicare offering.

In late 2005, UnitedHealth Group acquired PacifiCare Health Systems, a large insurer that was ramping up its PFFS efforts. At the time, the entire industry had just over 200,000 PFFS beneficiaries – but the market was about to expand rapidly. PacifiCare had modest enrollment projections for the PFFS business, but unexpectedly enrolled 178,000 new members for 2006 – nearly as many as the entire industry had before.

PacifiCare was using an external vendor to provide customer service, enrollment and claims processing for PFFS, and in the rapid growth environment, it was our view that the vendor was unable to provide the level of service to which members and health care providers are entitled.

Most PFFS plans are sold during an intensive six-week Annual Election Period, from November 15 through December 31 each year, during which members purchase coverage for the following calendar year. There is also an opportunity to switch to a different plan from January 1 through March 31. The plans are sold through a combination of internal sales agents (employees of the insurance company) and external brokers. External brokers are either independent career agents or members of Field Marketing Organizations (FMOs), and typically have contracts to sell products from multiple insurance companies.

After we acquired PacifiCare, we learned of instances of misconduct by a small number of external brokers who were selling these plans. We have zero tolerance for misconduct. We investigate every documented complaint, and require additional training or impose sanctions as appropriate, up to and including termination.

We acquired PacifiCare, and we accept full responsibility for these inherited PFFS issues. We took aggressive action throughout 2006 to improve broker oversight, operational performance, and member and provider services. In May 2006 we began transitioning PFFS administrative support from the vendor to our in-house Shared Services group, which has extensive experience in claims processing, customer service and enrollment. In responding to complaints from members and state Departments of Insurance about broker conduct, we terminated more than 80 external brokers from January to July 2006.

We also began longer-term, member-focused initiatives to improve our policies and procedures. We began to ramp up recruiting for business development infrastructure, and created the position of Senior Vice President for Distribution Operations, with broad responsibility for the operations, training and support of the distribution channel, both internal and external. We created a Broker Support Unit outside of the customer support system to focus on answering broker inquiries and providing information about our plans. We created an FMO Advisory Council to begin to work directly with the FMOs to address areas of concern. All these steps were taken with the goal of improving service to our members and providers.

Subsequently, on August 16, 2006, CMS sent PacifiCare Life and Health Insurance Company (PLHIC) a letter detailing a variety of shortcomings in PFFS sales and operations.

The letter directed PacifiCare to create a detailed Corrective Action Plan (CAP) to address each area of weakness, and to show satisfactory progress in correcting these deficiencies in time for the beginning of the next Annual Enrollment Period. As the successor to PacifiCare, we have been taking aggressive action, working in close cooperation with CMS to ensure that issues were resolved in a timely way. In February 2007 CMS provisionally accepted the remainder of the CAP, and the agency continues to vigorously monitor our performance against it. We welcome this oversight as an external validation of the effectiveness of our policies and procedures and of the added protections we are providing to Medicare beneficiaries.

Early on, we resolved to look at the CAP not just as a mandate to address the issues raised, but also as an opportunity to study the PacifiCare PFFS business closely, and to remake and improve it.

We implemented long-term solutions intended to prevent issues from recurring and to significantly improve sales and marketing functions; agent training and oversight; and claims processing systems.

Distribution/sales – In addition to having zero tolerance for broker misconduct or misrepresentation of our plans, there is also a need to guard against accidental misunderstanding of how PFFS plans work. To prevent these problems, we have:

- Proposed and implemented a new post-sale verification process, consisting of an outbound call to new enrollees to ensure they understand the PFFS product and agree to be enrolled in it. CMS now intends to require all plans to make similar calls in the next Annual Election Period, which we welcome.

- Tightened quality control procedures to enable us to more effectively identify and retrain or sanction the historically small number of brokers who are responsible for the vast majority of enrollee complaints.
- Developed and implemented a National Quality Assurance team dedicated to our distribution channel. These employees work full-time to ensure our policies, procedures and training are accurate and updated; monitor performance of brokers and FMOs; and make certain generally that the Company delivers what it promises to beneficiaries.
    - Their activities are tightly coordinated with the results of the post-sale verification calls. When post-sale calls raise concerns about an individual broker, a member of the Quality Assurance team will conduct site visits and ride along with the broker to look for appropriate disclosures and conduct.

  We believe this is the first Quality Assurance effort of this type in the industry.
- Established a Distribution Oversight Committee to review the performance results of brokers on a monthly basis, reporting to an Executive Distribution Oversight Committee that meets at least quarterly and has authority to take action at an executive level.
- Refined and expanded training programs for brokers, to reiterate and underscore proper communications with beneficiaries and appropriate handling of enrollment. Before being certified to sell SecureHorizons products, brokers must successfully complete a training course specific to that product. Brokers must then recertify on an annual basis. We monitor the performance of both brokers and FMOs, and work with the FMO leadership to address any issues that arise.

  Our training for external brokers has evolved beyond a primarily on-line process to include distribution of printed material and a greater emphasis on face-to-face training, proctored examinations and refresher training where necessary.

Operations – While more progress needs to be made, we have enhanced our information technology systems to improve enrollment, eligibility, record-keeping and claims processing. In addition to bringing administrative support in-house as previously described, we have:

- More than doubled our PFFS Customer Service Unit staff to more than 200 people.
- Created a dedicated operations management Command Center to ensure that urgent inquiries, outstanding claims and complaints are resolved.
- Hired a nationally known expert in call center operations to begin re-engineering our processes from end to end.

Provider programs – We have taken a host of steps to improve the experience for providers and educate them about the benefits of PFFS plans – for both their patients and for them. These include:

- Significantly increasing staff dedicated to handling providers' questions, claims resolution and complaints, as well as enhancing staff training.
- Revising and enhancing our provider education materials and education process, including routine outreach to hospitals, provider groups and medical associations by market managers at the local level.

- And, in conjunction with our systems transitions and upgrades, expediting payment of claims, escalating complaints and improving claims processing.

In addition to these specific actions, we have been working closely with America's Health Insurance Plans (AHIP) and its members on a series of proposals to strengthen processes and policies across the industry. We support AHIP's efforts, and I'm pleased to be here while AHIP outlines its plan to this Committee today.

There are two other specific areas where we believe legislative or regulatory changes could help improve the PFFS program.

1. "Deeming"

From a member's point of view, the greatest weakness of PFFS plans lies in the rules governing "deemed" providers. The concept is confusing, and leaves beneficiaries uncertain about whether their ongoing care will be covered.

In a PFFS plan, members can use any Medicare-eligible provider who agrees to accept the payment rates, terms and conditions of the plan. Such a provider is known as a "deemed" provider. Because no advance contractual relationship is required between the provider and the insurer, a member does not need to choose a provider from a network – so the model becomes practical in rural areas and other places with relatively few providers.

Providers can decide unilaterally whether to be deemed – and they can exercise that choice with every patient visit, regardless of whether they have previously agreed to be deemed with that very same patient. This flexibility may make providers more willing to agree to be deemed on any given day, because they are not locked in to a year-long contract. However, that same flexibility means that a member has less certainty about whether a particular visit or service will be covered.

Deeming is necessary for PFFS plans to be able to operate without a provider network. But a mechanism for requiring or encouraging providers to "stick with the program" would increase beneficiary satisfaction, ensure better access and continuity of care, and reduce complaints. We understand that change in this area could be complex, but we feel that it is important to begin discussing these issues and to look for appropriate solutions.

2. National Registry of Brokers

Some people have questioned why plans need to use external brokers. There are a few reasons PacifiCare structured the business that way. Independent brokers can help match each beneficiary with the most suitable available plan, regardless of which company offers it.

Furthermore, the short annual selling season creates a need for additional distribution capacity for a short period of time. This additional capacity is particularly important in rural areas, which PFFS plans were largely designed to serve, but where it would be difficult to sustain full-time employees.

However, we believe there would be merit in a national registry of sanctioned brokers (coupled with an appeal process to guard against unfair accusations), to stop brokers who are terminated for misconduct at one plan from going on to sell for another. We want only well-trained and highly ethical brokers selling our plans. We believe federal regulation with high standards, better information-sharing and better communication with the states would help achieve this goal.

In conclusion, we are fully committed to safeguarding the rights of people with Medicare. We will continue to work closely with Congress, CMS and other state and federal regulators, health advocates, as well as others in the industry, to identify and implement best practices in the PFFS marketplace.

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The CHAIRMAN. Thank you, Mr. Clarkson.
Mr. Bailey.

STATEMENT OF GARY BAILEY, VICE PRESIDENT, MEDICARE OPERATIONAL PERFORMANCE, WELLCARE, TAMPA, FL

Mr. BAILEY. Mr. Chairman, Senator Smith and other members of the Committee, I appreciate the opportunity to testify about the marketing of Medicare Advantage programs.

I am Gary Bailey, vice president, Medicare Operational Performance for WellCare Health Plans. At WellCare, I am responsible for monitoring and improving our Medicare Advantage and prescription-drug plans. Previously, I spent over 30 years at CMS, working to improve the operations of the Medicare program and the services delivered to Medicare beneficiaries.

Today, I am proud to be working at WellCare, a company committed to providing top-notch services to Medicare beneficiaries. WellCare has a strong corporate compliance program and prides itself on continuous improvement, and I have seen this firsthand in our approach the Medicare Advantage sales and oversight.

Today, I will speak about WellCare's efforts to go above and beyond the law to protect Medicare beneficiaries in the marketing of Medicare Advantage plans. WellCare has developed a corporate-wide compliance program known as the Trust Program. This has a zero-tolerance policy for the unethical marketing of our products, including Medicare Advantage.

But first, let me tell you about WellCare. WellCare is a leading provider of managed-care services, with a longstanding commitment to Medicare and Medicaid. Founded in 1985, our team of over 3,000 associates currently serves more than 2.2 million Medicare and Medicaid members nationwide.

We offer Medicare Advantage plans in 39 States and DC Because of this national scope, WellCare contracts with over 8,000 State-licensed agents. These sales agents are carefully screened by WellCare before they interact with beneficiaries.

Prior to contracting, agent must prove they are State-licensed. Agents must pass a criminal-background check. Agents must be trained on product benefits, marketing guidelines and other important issues. Agents must pass a test with a 100 percent score. Agents are monitored in the field. Agents are retrained and retested on plan terms and marketing guidelines. Agents must follow all Federal and State laws and must follow our own code of conduct. Agents are immediately investigated and subject to rapid resolution of any identified compliance issues.

Also, in today's Washington Post: A situation involving unethical behavior of an agent was raised in the State of North Carolina. The Department of Insurance notified us on March 20, 2007, that an agent was conducting inappropriate marketing in a low-income senior-housing complex. We terminated that agent the next day. We worked with the State to eliminate the bad apple. We paid no commissions to that agent that was terminated. Our new inbound real-time enrollment-verification process will prevent these situations.

Finally, creation of a national database will assure us and others that agents like this will not work with other health plans. This

is but one of several instances where our communication between State insurance officials and the plan worked.

The Trust Program's compliance process works. Over the past 6 months, WellCare has terminated 16 sales agents for marketing-conduct violations. Our program exposes and punishes unethical behavior. For example, in monitoring Medicare Advantage enrollment applications, we discovered an agent in Georgia submitted applications for deceased individuals. Working with the Georgia Department of Insurance and others, aggressive action was taken against the agent. This agent and his accomplice have been arrested.

WellCare is continuing to improve and strengthen its compliance program. First, WellCare is developing an inbound real-time enrollment and verification process. This will allow prospective enrollees an opportunity to verify their understanding of plan benefits. It will also allow Medicare beneficiaries to tell us what information they received—that they needed to make an informed health care decision. This new and improved enrollment and verification process will confirm that the sales agent treated the beneficiary appropriately.

The next improvement is a secret-shopper program. WellCare will use an independent organization to monitor the compliance of Medicare Advantage sales agents. This program is being launched in five States and will be rolled out nationwide. All results of WellCare's secret-shopper program will be reported directly by this independent organization to WellCare's corporate compliance department.

We support even more improvements. We strongly support our trade association's draft principles to enhance oversight of sales-and-marketing efforts. We believe all private Medicare Advantage plans should adhere to these issues. We believe there should be a national training program for agents who sell Medicare Advantage products.

We also support greater coordination and communication between the Centers for Medicare and Medicaid Services, the State departments of insurance, private Medicare Advantage plans and licensed agents. There should be no barrier to communication.

We support the creation of a national database to share information about those agents and brokers who have been sanctioned by a State or terminated by a health plan. We do not want to be associated with an agent or broker who has been terminated by another plan because of their noncompliance with State or Federal rules. This should be done immediately. It will help our current efforts.

So thank you again for this opportunity to testify. WellCare is committed to the long-term success of the Medicare Advantage program. No one should accept behavior that results in a Medicare beneficiary being inappropriately treated or enrolled in a product that is not suitable to their needs.

We appreciate the support the Committee has demonstrated for Medicare Advantage, and I look forward to answering your questions.

[The prepared statement of Mr. Bailey follows:]

Statement

of

Gary Bailey

Vice President, Medicare Operational Performance

WellCare Health Plans, Inc.

Before the

United States Senate

Special Committee on Aging

Hearing on

Medicare Advantage Marketing and Sales

May 16, 2007

Good afternoon, Chairman Kohl, Ranking Member Smith and members of the Committee. I am Gary Bailey, Vice President, Medicare Operational Performance for WellCare Health Plans. In that role, I am responsible for monitoring and improving WellCare's operations and performance in its Medicare health plans, including both its Medicare Advantage ("MA") plans and Medicare Prescription Drug Benefit plans ("PDP"). Previously, I was Deputy Director for Plan Policy and Operations, in the Center for Beneficiary Choices at the Centers for Medicare & Medicaid Services ("CMS") in Baltimore, Maryland. During my tenure at CMS, the Center for Beneficiary Choices was responsible for the administration of the Medicare Advantage plans and the Medicare Prescription Drug Benefit. I appreciate this opportunity to testify about sales and marketing oversight in the Medicare Advantage program.

In my testimony today, I will provide information on: (I) WellCare's government-sponsored health care plans, specifically its Medicare Advantage plans; (II) WellCare's zero-tolerance approach to the marketing of Medicare Advantage plans; (III) CMS's audit of WellCare; and, (IV) recommendations to improve the marketing of Medicare Advantage plans.

First, I would like to offer some thoughts on WellCare's role in delivering government-sponsored health care plans. In my 32 years of Federal government service in Medicare, I helped improve the operations of the Medicare program to serve the needs of Medicare beneficiaries. During my tenure at WellCare, I have been extremely impressed with the company's commitment to serving the needs of Medicare beneficiaries, its responsiveness to rapidly changing Medicare program dynamics, and above all else, its commitment to strong corporate compliance. WellCare is a company

that prides itself on continuous improvement, and I have seen this improvement first hand in our approach to Medicare Advantage sales and oversight. This approach is not only good business, but it is the right thing to do.

WellCare understands the challenges and the rules governing the marketing practices in the Medicare Advantage program. We have a zero tolerance policy for non-compliance with our marketing guidelines and will promptly terminate any contracts of non-compliant sales agents or sales management personnel. It is our company's ethic to do more than merely "follow-the-rules" – we have NO tolerance for any ethical or inappropriate actions.

I. About WellCare Health Plans

WellCare is a leading provider of managed care services dedicated exclusively to government sponsored healthcare programs, such as Medicare and Medicaid. WellCare operates a variety of Medicaid and Medicare plans, including health plans for families, children, and the aged, blind, and disabled as well as prescription drug plans. Founded in 1985, our team of over 3,000 associates serves more than 2.2 million members nationwide. We currently operate networked managed care programs in eight states, including both Medicare and Medicaid programs, and we are currently the fifth largest vendor to CMS for the nationwide PDP program.

In order to better serve the Medicare population, WellCare continues to expand its range of Medicare products. In 2006, WellCare laid the foundation for the January 2007 nationwide launch of its Medicare Advantage plans that feature an open provider network and other additional benefits for members. As of March 31, 2007, WellCare has enrolled over 32,000 members in its Medicare Advantage private fee-for-service plans and

contracts with over 8,000 licensed, independent sales agents across 39 states. We operate our open-network MA plans through three life and health insurance subsidiaries under the WellCare name. We currently offer these MA plans in 793 counties in 39 states and Washington, D.C.

WellCare's objective is to be the leading provider of managed care services for government-sponsored healthcare programs. To accomplish this mission, we work with members, providers, governments, and the communities we serve. If a product or service is not good for a beneficiary, then it is not good for WellCare.

II. WellCare's Approach to the Marketing of Medicare Advantage Plans

WellCare vigorously enforces a zero-tolerance policy for the violation of all laws, rules, and policies. I will address both the federal and WellCare controls in turn.

A. Federal Controls on the Marketing of Medicare Advantage Plans

As a rule, WellCare employees are responsible for compliance with all federal, state, and local laws and regulations. All employees and representatives of WellCare must become and remain knowledgeable on the legal and regulatory requirements applicable to their respective positions, duties, and contractual requirements. Additionally, WellCare has created an environment enabling all people who work and are under contract with WellCare to exercise this individual responsibility.

The marketing of Medicare Advantage plans is controlled by federal regulations and CMS guidance. Federal regulations prohibit the distribution of any marketing materials or election forms or making such materials or forms available to prospective beneficiaries unless approved by CMS. In conducting marketing activities, MA organizations may not: (i) provide cash or other monetary rebates as an inducement for

enrollment; (ii) engage in any discriminatory activity, including targeted marketing to Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas; (iii) solicit Medicare beneficiaries door-to-door; or, (iv) engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the MA organization. Importantly, federal rules also require a MA organization to establish and maintain a system for confirming that enrolled beneficiaries have in fact enrolled in the MA plan and that beneficiaries understand the rules applicable under the plan. 42 C.F.R. § 422.80.

In addition to regulations, CMS has implemented marketing guidelines that reflect CMS's current interpretation of the marketing requirements and related provisions of the Medicare Advantage and Medicare Prescription Drug Plan rules. These guidelines were developed after careful evaluation by CMS of current industry marketing practices, recent advancements in communication technology, and how best to protect the interests of Medicare beneficiaries.

B. WellCare Health Plans Compliance Programs for Medicare Advantage Plans

While we believe the federal regulations and guidance on marketing are robust, WellCare Health Plans has implemented even stronger internal policies. These are based upon our corporate ethics and compliance program, known as the Trust Program, that was adopted in 2002. All people associated with WellCare must accept the individual responsibility and duty to conduct WellCare's business in an ethical and compliant manner by consistently adhering to the standards of conduct embodied in the Trust Program.

1. The Trust Program

The Trust Program is the foundation and guide of WellCare's operations. Due to the increasingly complex legal and ethical questions facing all participants in the health care industry, WellCare has unified its long-standing corporate ethics and compliance policies by implementing this comprehensive program. The goal of the Trust Program is to establish a culture of integrity and trust within WellCare. The Trust Program promotes prevention, detection, and the resolution of conduct that does not conform to applicable federal or state laws or our high standards of business ethics. The Trust Program applies to WellCare, its Board of Directors, employees, and its business partners. The Trust Program provides guidance and oversight to ensure that work is performed in an ethical and legal manner.

The Trust Program, however, cannot substitute for an individual's personal sense of honesty, integrity and fairness. We strongly encourage our people within the WellCare community to rely on their common sense in recognizing right from wrong and to use the Trust Program to ensure that we adhere to high ethical standards.

2. Additional Compliance Measures

To augment the Trust Program, we recently announced additional compliance measures designed to protect the rights of Medicare beneficiaries. These new enhancements will increase the oversight of independent sales agents who market the company's MA products. Our recent improvements include two new components for oversight of MA independent sales agents. Because independent sales agents market more than health plans, WellCare firmly believes these improvements are necessary to ensure that WellCare's compliance program remains the best in class.

The first improvement is an inbound telephone enrollment and verification process. This system will allow prospective enrollees an additional opportunity to verify their understanding of plan benefits, acknowledge that they received all the information needed to make an informed decision before joining a Medicare Advantage program, and confirm that they were treated appropriately by the sales agent. The phone call verification will be digitally voice recorded at the point of enrollment for all Medicare Advantage beneficiaries. With this new enrollment process, WellCare will eliminate most paper applications for private fee-for-service enrollments in favor of a real-time verification and quality assurance process. The inbound verification program will be in addition to the 100 percent outbound callback program already in place for new members.

The second new component is the launch of a "secret shopper" program. Here, WellCare will use an independent organization to anonymously monitor the compliance of Medicare Advantage independent sales agents. This program is being rolled out nationally, but in its initial phase will cover five states with high enrollment in WellCare's private fee-for-service plans. All results of WellCare's secret shopper program will be reported directly by the independent organization to WellCare's Corporate Compliance department, generally on a same-day basis.

In addition, more protections are in the pipeline. Right now, WellCare is working with America's Health Insurance Plans ("AHIP") on new principles to further protect Medicare beneficiaries. In short, these new measures will tolerate nothing less than strict adherence to a code of conduct that appropriately educates and protects our members.

We are confident that with these new enhancements, our overall compliance strategy will continue to be best-in-class.

The focus of our oversight is to ensure that each Medicare beneficiary receives high quality, professional interaction in their service experience. Medicare beneficiaries must fully understand their health plan benefits, coverage limitations, and policies to make an informed choice about their health care coverage. Ensuring a positive sales experience is in everyone's best interest. Other enhancements to WellCare's compliance program will build upon the extensive activities already in place to oversee independent sales agents for Medicare Advantage private fee-for-service products. Among others, these include:

- Confirmation of state licensure;
- Extensive criminal background screening;
- Mandatory training and testing on product benefits and marketing guidelines;
- Mandatory contract terms, incorporating a sales agent code of conduct;
- On-site monitoring of agents by field sales management;
- Mandatory re-training and re-testing to refresh knowledge of plan terms and marketing guidelines;
- Rapid resolution of any identified compliance issues; and,
- Zero tolerance for verified infractions.

3. Sales Agent Code of Conduct

As a leading provider of Medicare products, WellCare has established a reputation for providing quality health plans at affordable rates for beneficiaries. In an

effort to ensure all independent producers and sales agents contracted with WellCare are representing our plans with the highest degree of integrity, we also require every sales agent to abide by the "WellCare Sales Agent Code of Conduct." This code of conduct requires the following:

a. **Respect the beneficiary**: Agents must provide guidance with the beneficiary's best interest in mind at all times. It is important to be respectful of the beneficiaries' wishes and to understand their unique health care needs. Sales agents should be available for any questions or concerns before and after the sale.

b. **Provide full disclosure**: Agents must present all plan options completely with full disclosure of any plan limitations. Agents must always compare WellCare plans to the beneficiary's current coverage to ensure they understand differences in features, benefits, costs, and access to providers.

c. **Follow proper marketing guidelines**: Agents must follow approved marketing methods for setting appointments and conducting sales sessions as outlined by CMS regulations. Agents cannot solicit individuals via door-to-door sales, phone calls or unsolicited email. Also, agents cannot solicit or enroll members where health care services are dispensed.

d. **Use approved materials**: Agents must use only WellCare and CMS approved materials and agents must not alter the materials in any way. WellCare has developed all the sales and marketing material needed to present plan information to the beneficiary. WellCare also makes these materials available in multiple languages.

e. **Proper use of sales tactics**: Agents must never use high pressure sales tactics to influence a beneficiary's decision to enroll. Agents must allow the beneficiary time to review and understand the information and offer them independent sources of information such as the CMS web site: www.cms.hhs.gov

f. **Representation**: Agents must always represent themselves and WellCare appropriately. Agents must ensure that beneficiaries understand they represent WellCare but are not an employee of WellCare, Medicare, Social Security, or any other government entity.

g. **Use enrollment forms correctly**: Agents must not back-date, falsify, or alter any enrollment document or form. Applications must be submitted so that information on the original copy matches exactly with the copy that was left with the prospective member. Completed enrollment forms must be mailed or faxed to WellCare within 24 hours of the date the beneficiary signed the form.

h. **Do not discriminate**: To ensure fairness, agents must not discriminate against potential enrollees on the basis of health status, ethnicity, or any other improper criteria. If an agent believes a beneficiary lacks understanding of the program or is of questionable competence, he or she must observe proper procedure by having the member's authorized representative present at the time of enrollment and approve the member's decision.

i. **Comply with oversight standards**: WellCare has rigorous compliance standards for all independent sales agents. Agents must know and understand these standards.

To ensure compliance with all marketing guidelines and the Code of Conduct, all Sales Agents understand that WellCare undertakes the following initiatives:

- Deployment of a secret shopper service to pose as potential beneficiaries to experience the sales process/presentation;
- Completion of mandatory training and testing for all sales agents;
- Revocation of selling privileges for sales agents who do not complete the training and score 100% on the required testing;
- Follow-up calls to all beneficiaries enrolled by any terminated sales agent to confirm the beneficiary's enrollment decision or to facilitate disenrollment;
- Monitor sales data for potential issues and to educate or even terminate agents based on the findings, with emphasis on proactive resolution of issues; and
- Monitor a confidential compliance Hot Line where members, associates and government regulators can report concerns about potential marketing misconduct.

C. Recent Examples of WellCare's Zero Tolerance Policy

Through WellCare's compliance programs, 16 independent sales agents have been terminated for marketing conduct violations across the country. As WellCare employs over 8,000 sales agents, we do have a high degree of confidence that federal

laws and our internal controls are working. However, as WellCare has a zero-tolerance for agent misconduct, we are not satisfied with our past performance. As we continue to improve our internal compliance measures, I would like to share some recent experiences.

In January 2007, WellCare learned of improper marketing efforts by a California licensed, independent sales agent who was not an employee. This agent translated approved marketing materials into Chinese and aggressively distributed them to a group of Medicare beneficiaries who did not speak English. WellCare immediately analyzed the selling history of this agent to reveal that the agent used inappropriate sales tactics and that the materials he was using were not approved. As a result, WellCare immediately terminated its contract with the sales agent.

Because WellCare takes its responsibilities under the Medicare program seriously, we moved quickly and aggressively. First, WellCare staff commenced mandatory retraining for the insurance agency that contracted with the terminated agent to reinforce the agency's understanding of the Medicare marketing guidelines and WellCare's expectations. Second, WellCare initiated mandatory retraining and testing on a national basis for all licensed independent sales agents under contract with WellCare for its Medicare Advantage products. If sales agents do not complete this follow-on training and score 100% on the required retesting, their selling privileges with WellCare will be revoked. Third, WellCare initiated mandatory new member call-backs to 100% of new Medicare Advantage enrollees to confirm that their sales experience was positive and that they understand their benefits. WellCare also placed follow-up calls to the beneficiaries

enrolled by the terminated agent to confirm their enrollment decision or facilitate disenrollment.

Another recent action occurred with a sales agent in Georgia. In early December 2006, through our monitoring of enrollment applications, we learned that an agent submitted several Medicare Advantage applications for deceased persons. That day, an investigation was initiated. Within two days, the agent in question was terminated. We conducted an analysis of and contacted all of the fired agent's enrollees. Through the investigation, we learned that the terminated agent participated in several prohibited marketing activities in violation of federal regulations, CMS guidelines, and WellCare policies. Accordingly, WellCare informed the Georgia Department of Insurance and federal authorities of the agent's actions, and we cooperated with them on their investigation. In the spring, the fired agent was escorted at sunrise from his home in handcuffs by Georgia law enforcement authorities. He and his accomplice are now behind bars.

III. CMS Audit of WellCare

As you may know, there was a recent report in the New York Times about a CMS audit conducted on WellCare's private fee-for-service operations. The review consisted of documentation review, interviews with WellCare staff, and sampling of various records. Preliminary findings were issued during the exit conference in mid-March and formal findings were subsequently delivered to WellCare.

As a result of the CMS audit, WellCare has improved several marketing processes of Medicare Advantage plans. Two of these in particular, the secret shopper program and the telephonic enrollment system, will go a long way towards addressing the concerns put

forth by CMS. In addition to those improvements, WellCare is implementing mandatory broker re-training and re-testing, translation of additional materials into multiple languages, and additional outreach and coordination with advocacy groups and state agencies.

WellCare appreciated the opportunity to have CMS come on-site within the first 10 weeks of its launch of the Medicare Advantage private-fee-for-service program to provide early identification of concerns and improvement opportunities. We welcome input and communication from others on issues and concerns. We will investigate and take swift action when we find any abusive practices.

IV. Recommendations to Improve Medicare Advantage Marketing Practices

WellCare is extremely proud of its Medicare Advantage offerings. The plans offer beneficiaries new choices to broaden the ways in which they can receive high quality health care. We are confident that existing federal regulations combined with our robust internal compliance efforts will help ensure that beneficiaries are treated with the highest standards of integrity. Nonetheless, through the operation of our zero-tolerance policy as well as our recent dialogue with CMS, we do believe there is room for improvement in the marketing of Medicare Advantage products.

We believe the most effective action to undertake on behalf of Medicare beneficiaries is to improve communication channels and provide effective confirmation of allegations of abuses. Thus, we believe it is critically important to foster cooperation at the federal, state, health plan, and agent or agency levels in communicating and resolving complaints and taking swift action against those who defraud Medicare beneficiaries. We strongly support AHIPs draft principles on the actions Medicare

Advantage plans should undertake to enhance oversight of sales and marketing efforts. We believe all private MA plans should adhere to these principles. At WellCare, we are going above and beyond these principles.

In addition to these recommendations, WellCare strongly supports the creation of a federal database where information can be shared about those agents and brokers who have been sanctioned by a state or terminated by a health plan. We do not want to be associated with an agent or broker who has been terminated by another plan because of their non-compliance with state or federal rules. This is an action that can be undertaken immediately and will improve our current efforts.

CONCLUSION

Thank you again for this opportunity to testify about our perspectives on these important issues. Please be assured that WellCare remains deeply committed to the long-term success of the Medicare Advantage program. We will not accept behavior that results in a Medicare beneficiary being inappropriately coerced or enrolled in a product that they did not want or need. We are continuing to work with our colleagues at AHIP to support the new principles on what all Medicare Advantage plans should do regarding marketing. While all MA sponsors should implement a vigorous internal compliance program like WellCare's, we believe all plans should adhere to these principles -- at a minimum. We appreciate the support the Committee has demonstrated for this valuable program and look forward to continuing to work with you to meet future challenges in Medicare and throughout the U.S. health care system.

The CHAIRMAN. Mr. Bailey, as recently as April 19, CMS cited your company in a corrective-action plan for inadequate oversight of your Medicare Advantage sales-and-marketing operations—your company's response and your public rebuke from CMS Acting Administrator, Leslie Norwalk, on the front page of the New York Times, May 7, as you know.

She indicated that your response to CMS's review was inadequate; caused concern. Does Ms. Norwalk know what she is talking about?

Mr. BAILEY. Well, actually, we were pleased to have CMS visit our corporate operations. On March 12, they spent almost a week with us—the CMS staff from the Atlanta regional office and from the central office staff. They conducted an extensive documentation review. They talked to the WellCare staff. They talked to WellCare senior officials. They pulled a number of multiple—and varied samples.

As a result of their work, they gave us preliminary findings in areas relating to marketing, in terms of managing our brokers and making sure that our beneficiaries totally understand the product for which we are responsible for selling.

The formal report did come to us on April 19. Those particular findings relating to marketing were in the report we received later. We are now in the process of developing a corrective-action plan that is due to CMS by June 3. I am confident that they will accept the recommendations that we have in there.

Much of the work we had already done in implementing our proactive compliance program, our zero-tolerance program, was already underway before this CMS review.

The CHAIRMAN. Well, when you say the report covered the areas of proper training of the people who represent you out there and it also covered the need to be sure that people who enroll in your program know what they are enrolling in, I mean, isn't that the ABCs of your business?

Mr. BAILEY. It is.

The CHAIRMAN. Well, wait, wait, wait. If those are the ABCs of your business, aren't you responsible to be sure and scrupulous—totally scrupulous—to be sure that these things are not happening? Isn't that your job?

Mr. BAILEY. That is our responsibility.

The CHAIRMAN. Well, then——

Mr. BAILEY [continuing]. Quite seriously.

The CHAIRMAN [continuing]. Why do you—I mean, how is it you come here today and talk about, "Well, we are doing this, we are doing that," and, "Absolutely, we would like to have a national registry," when, in fact—yes, it would be helpful and I think it is a good idea and I think we are going to see if we can't do that—but it is your job to be sure that the people you are hiring have been background-checked——

Mr. BAILEY. That is right.

The CHAIRMAN [continuing]. In a complete manner so that if they do have things in their past that should deny them employment in your company, it is your job to do that. Isn't it?

Mr. BAILEY. Yes. There are a number of action we take. In fact, we do a very extensive screening process before we contract with

a broker. We check the excluded lists of the OIG and the GSA. We do a rigorous examination for appropriate State licensure. We have to make sure they are licensed by a State. We do Federal criminal background checks, as well as in the county of residence.

We also train, train and retrain our agents. We also do field management. There has been——

The CHAIRMAN. But if you do all of these things and do them carefully, properly and well, then infractions would be very, very rare. Wouldn't they be?

Mr. BAILEY. Yes, they would. I think the infractions are very rare. There are a few infractions. There are some bad apples that we have been dealing with.

We have established systems along the lines of what I was describing, as well as new ones, in my oral testimony that will provide for a very strong compliance program. We are proud of this compliance program.

But in those instances where something happens and someone becomes a "bad apple", we also have processes in place to immediately identify that agent and terminate that agent, such as the one I had mentioned in the North Carolina case, and in the Georgia case. Both of those situations had been brought to our attention by the DOIs and we acted swiftly to terminate the brokers and work with those particular States.

The CHAIRMAN. Mr. Clarkson, last August CMS wrote to your company that your firm's sales of Medicare Advantage plans had drawn hundreds of complaints. The CMS letter was a pretty firm indictment of your sales-marketing and outreach activities.

In the same way that I asked Mr. Bailey, I ask you: How do these things—recognizing nobody is perfect, you know; and I understand that. I have been in business all of my life and I understand imperfections. But I have always, in my own businesses, taken personal responsibility for anything that had gone wrong, and felt it was my job to be sure that those people who represented us were as thoroughly checked out and trained, you know, as was humanly possible and that any infraction was a severe indictment of my companies, as well as my management.

It was just not acceptable for people to act unscrupulously or fraudulently or intentionally misrepresenting a product. I mean, that was beyond the pale.

Now, if that is the position in your company, why aren't we almost perfect, recognizing that we can't be perfect? But why aren't we almost perfect?

Mr. CLARKSON. Senator, I can appreciate your question and your comments.

We have made progress as an organization, but we are not perfect. There were several factors that contributed to the corrective-action plan: Our relative newness to using brokers in a marketplace—we moved to a condensed selling cycle, so there were shorter periods of open enrollment; the relative newness of the private fee-for-service plan—it was introduced in 2003, but really didn't begin to get or gain momentum until the fourth quarter of 2005. The market response was immense.

As we described, we went from relatively no enrollment to 178,000 members in 2006. That is explosive growth for any type of

product. We had challenges with our integration with PacifiCare and we had infrastructure issues. We made modest projections of enrollment that we, quite frankly, Senator, blew right past, and did not have some of the infrastructure in place to manage the business.

The CHAIRMAN. Ms. Margulis, in your testimony, you outlined a very impressive regimen of training and education program for your sales representatives and broker agents at Humana. That being the case, how did you get into such difficulty with CMS, winding up in a corrective-action plan and also have serious problems with the State of Oklahoma, as was outlined by the commissioner who testified before you?

Ms. MARGULIS. Mr. Chairman, first, any violation is an issue. As I mentioned in my testimony, Humana has been in the Medicare business for 20 years. Likewise, we are not perfect and we seek continuous quality improvement.

The CMS audit of us occurred in 2005. We did make extensive changes to our program. As the last witness mentioned, we, too—while we have a very large employed sales force, we also contract with independent agents primarily through agencies.

As a result of increased complaints, we took corrective actions. We are responsible for both our employed agents and also our contracted agents. They are all appointed. We set up a compliance contract with agencies after that CMS audit and after we received significant numbers of complaints. We established a compliance agreement with our delegated agencies that specified what was required of us and them. We even terminated one agency in the process.

Furthermore, we worked with a former NAIC staffer for the Senior Issues Committee to develop a suitability assessment, since many of the complaints stemmed from the fact that people did not know they were buying a Medicare Advantage product and not a Medicare-supplement product.

We have had a verification process in place since 1991. That verification process has been modified over time. Based on complaints that we receive, we modify our processes.

We also, based on both what happened with the Oklahoma Department of Insurance as well as CMS, have implemented within our internal audit department at Humana a complete internal audit of all of the areas.

We seek to improve each day. Ways in which we are are in my testimony.

Again, the sales allegations and those that are founded are a very small percentage; considerably less than one percent of all sales. Even so, that is more than we want. We give you our commitment, as we have the States, to work to find a way that it is even less than what it is today.

The CHAIRMAN. All right. Before I turn it over to Senator Wyden, I just want to make the point that this Committee, just like you, wants to do its job well. You know our job is consumer protection.

Without trying to be unfair, our job is consumer protection, and I think you understand that and you accept that. You would expect and accept for us to be very scrupulous in doing our job. The only way we can do our job is if you do your job.

So, you know, we need to work in a cooperative way, obviously; not necessarily adversarial, but, certainly, cooperative. To the extent that we disagree, we have to find ways in which to move forward that will provide maximum consumer protection. You know, that is our job and that is your job, too.

You can, I hope, look forward to the kind of an involvement from this Committee that will result in the only thing that we want, which is almost zero mistreatments of people who sign up to do business with your companies. That is your goal. Our job is to oversee you, which, I am sure, you understand and accept.

You know, personally, I am looking forward to working with you to be sure that in the months and years ahead, we do not have problems with people who sign up with your companies to do business—you know, the very least that they expect—right?—is that it is honest, straightforward; that there is nothing there that is misrepresented.

I mean, that is the very least that people who do businesses with your companies have a right to expect. Isn't that true? I mean, any disagreement with that?

Mr. Bailey.

Mr. BAILEY. No disagreement with that.

The CHAIRMAN. Mr. Clarkson.

Mr. CLARKSON. No disagreement, Senator.

The CHAIRMAN. Ms. Margulis.

Ms. MARGULIS. No, sir—zero tolerance.

The CHAIRMAN. Ms. Ignagni.

Ms. IGNAGNI. Absolutely no disagreement, sir. I think you are absolutely right. We are going to take the responsibility of addressing these issues affirmatively, very specifically, and in an accountable fashion.

The CHAIRMAN. That is great. I appreciate that.

Ms. IGNAGNI. Thank you.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. I just want to comment you, first of all, for all your leadership. This has been an excellent hearing. You have really shone a hot light on this problem, where seniors are getting ripped off. It is clearly not an isolated case. There is a pattern.

I am very appreciative that you are going to stay at it and get to the bottom of it. You will have my full support in that effort, Mr. Chairman. I commend you for it.

Ms. Margulis, you made a statement in the course of your testimony that disturbs me very much. I want to make sure I understand it and give you a chance to amplify so the record is clear. You said that the Federal law doesn't have to change here. You said that there are already adequate tools to deal with it.

Do you continue to assert that position?

Ms. MARGULIS. We believe that the Federal Government, working together with the States, can, indeed, ensure consumer protection.

Senator WYDEN. Well, that, then—in fact, let's make sure I can get the views of everybody else on the record on that as well.

Mr. Clarkson, do you agree with that—that Federal law does not need to change here?

Mr. CLARKSON. I think we have to look at what is going to be most beneficial to the beneficiary.

Senator WYDEN. Just a yes or no. Do you think Federal law needs to change? Do you believe, as Ms. Margulis said, that there are already adequate tools in Federal law to deal with it? Just a yes or no.

Mr. CLARKSON. No, Senator.

Senator WYDEN. You think Federal law may have to change?

Mr. CLARKSON. No, I do not think Federal law needs to change.

Senator WYDEN. Very good.

Then, Mr. Bailey, yes or no—do you think Federal law needs to change?

Mr. BAILEY. I think the tools have been provided to us, but we need much more communication between all of the parties involved.

Senator WYDEN. OK.

What you three have now stated on the record is contrary to what the insurance commissioners have told us earlier. What the insurance commissioners—Mr. Dilweg and Ms. Holland—have said—and it is at page five and six of Mr. Dilweg's testimony—is that under the Medicare Advantage statute, they have got authority as it relates to brokers and as it relates to those individuals, but very limited authority over the actual insurance companies.

They would like to have actual authority over insurance companies, actual legal authority. That is why I asked them about the applicability of the Medigap law.

So what you have stated here, on the record, is contrary to what the insurance commissioners have stated earlier—they say they need. Now, that is not very different than what happened the 10 years that I was battling to get those Medigap changes.

I want to assure you—I want to assure each of your companies—I am not going to wait 10 years to have this corrected. It is not going to happen again. I don't think Chairman Kohl is going to allow it and I don't think Republicans of the U.S. Senate are going to allow it.

We are going to drain this swamp because this is not an isolated set of instances. There has been a pattern here. By the way, it is given a bad name to the many good people who are offering private health insurance. I have got many of them in my State. We have the largest incidence in our State in the country—in Portland—of managed care. We have had a long history of private roles.

So you are having older people ripped off and also giving a bad name to the many people in private insurance who do a good job. I and others are not going to accept it.

Now, what are we going to do to get you on the same wavelength as the insurance commissioners who described a very different position than you all have stated?

Let's start with you, Ms. Margulis.

Ms. MARGULIS. Senator, first, with regard to appointment in the States, Humana has a policy to appoint our agencies. So the State, indeed, does know who represents Humana.

As I mentioned to you, we take full responsibility for delegated agents or contracted agents, as we do with our employed agents. So my suggestion would be that CMS and the States work together

so that appointment is required of companies. That will give the insurance commissioners information to work directly with the insurers.

I might add that it is, from where I sit, our responsibility to work with both State and Federal regulators.

Senator WYDEN. You are still reflecting a position that is contrary to what these insurance commissioners are saying they need in terms of tools. I would urge you—and we will keep the record open, you know, for you on this—read what Commissioner Dilweg says at page five and six. He is talking about how he has the tools for Medicare Advantage as it relates to State regulation of the agents and brokers.

He is saying he doesn't have the tools with respect to the companies. He needs those tools. Ms. Holland said that as well.

I just think it is unfortunate—we are interested, as the Chairman has said, in working with all of you. I am not one who thinks that private insurance ought to be put out of business. I mean, I have written a universal-coverage health bill—the Healthy Americans Act—that has that role for private health insurance. But this has got to change.

So I will hold the record open for you on this. If either of you two other individuals, Mr. Clarkson or Mr. Bailey, would like to add anything—but I don't think this is the right way to end a hearing, when the private companies, after a pattern of abuse—it is revealed that private companies are then taking a position which is contrary to what the insurance commissioners say they need. That is something that we are going to revisit.

Ms. Ignagni, do you want to add anything?

Ms. IGNAGNI. Yes, sir. Would you consider a suggestion?

Senator WYDEN. Sure, of course.

Ms. IGNAGNI. What we have laid out as a community are some very specific, measurable standards that go beyond what we are being required to do today.

We are going to be now initiating dialog with CMS, working collaboratively with CMS. We found out about these issues in listening to the insurance commissioners and advocacy groups around the country.

We are very comfortable with CMS proceeding to accept these recommendations and being in dialog about continuing to add to the standards we are required to meet. That is point No. 1.

Point No. 2, which I think is something that the insurance commissioners talked about and could be done today, is for the NAIC and every insurance commissioner to agree on a single standard that would be established at the State insurance-commissioner level to require us very specifically to set up terms and conditions under which we report bad practices, whether they be agent or broker or our own employees. We think that absolutely needs to be done—not simply dismissals for cause, but at sub-par practice.

I think these two issues could be taken together. What you have out there is inconsistent approaches to brokers. Now that we understand that, we have made some specific recommendations. We are fully comfortable with CMS proceeding along these lines. We would like to be in dialog with you and add to those recommendations.

We think the State appointment process also, as Ms. Margulis has said, does offer us an opportunity. So, I think, taken together, you are looking at a fabric of accountability mechanisms that don't exist today. So we hope we have started something positive here.

We want to be very transparent about it. We are going to be working with all parties, including advocacy organizations, because we think they have a lot of important learnings to add to this important issue.

Senator WYDEN. I appreciate that. There is no question at all that steps are being taken by your organization, by all of the three companies.

What I find troubling, however, is when the insurance commissioners—the lead commissioners like Commissioner Holland, Commissioner Dilweg—come in, state for the record in their testimony that they need additional tools because the Federal Government has limited their authority, and then, we have the companies saying, "No, we can do all this with the current tools." That still leaves me very troubled.

We are going to continue to follow this up. We will leave this for the record. There is no doubt that steps can be taken by the agency called CMS, the private companies. Steps ought to be taken immediately. You have made it clear that that is going to be the case.

But there still is a significant gap between what the insurance commissioners have told us today they need and what the three companies have said that they are willing to support. So we will continue to revisit this and continue to have a discussion about it.

One last question, then, if I might, for the three companies—starting with you, Ms. Margulis. Just go down the row. How did this problem get out of hand? It seems to me you all have described various programs, verification programs. Ms. Margulis talked about the training programs and the like. But it was clear this was going to be a big market.

I have got a Wall Street Journal article here, recently, talking about Humana making 66 percent of its net income from Medicare Advantage this year. I mean, it was clear it was going to be a big market. I think it would be valuable to have, on the record, from each of you, your perspective as to how this problem got out of hand.

Ms. Margulis.

Ms. MARGULIS. We, as I mentioned, Senator, do have and always have had a zero-tolerance policy. When allegations come to our attention, we seek to investigate and to take corrective action.

The allegations that we have, no matter how many they are, are troubling, but in terms of the number of members whom we have, are small.

Senator WYDEN. But that is——

Ms. MARGULIS. However——

Senator WYDEN. That is not, ma'am, what the Oklahoma Insurance Department said.

The Oklahoma Insurance Department said that there were many problems. My question is, given that the regulators are saying that there are many problems, I would like to hear your thoughts about how it got out of hand. Because if a company has a zero-tolerance policy and then an insurance regulator documents that there are

many problems, that would suggest to me that the zero-tolerance policy wasn't working particularly well.

I am just interested in getting your sense of how things got out of hand.

Let me say that, in the past, in terms of our experience, we have had employed sales representatives and a strong program; although, there have been sales complaints in that process, as well, which we have addressed.

As one of the witnesses mentioned, there are short enrollment periods during which we marketed throughout the country, which caused us to contract with a number of independent agents. We needed to strengthen the program for the contracted sales force. That is what we put into place going forward. We have, as we have gone forward, worked to reduce the number of contracted agents who sell our products.

As I mentioned, last year, for the 2007 season, we had about 82 percent of our sales coming from employed agents. So there was strengthening of the training programs.

There were complaints that people were not receiving full and fair disclosure with regard to the kind of products that they were buying, which caused us to re-look at our verification processes that had been in place for years, but, obviously, did not address the new products that were in the market that needed additional clarification.

So we made some mistakes, Senator. We put into place mechanisms to address those. We are not perfect today. Let me mention two more mechanisms.

We need to be making callbacks to people who have purchased our product to make sure that the sales experience was what it should have been and fully disclose to people what they were buying. Secondarily, we, as I mentioned, are working very hard to see—and we will work with States and CMS to see if we can't have some sort of national registry for reporting infractions; not just those that are caused by people who violate our marketing code of ethics, but where there are demonstrable trends and complaints.

Senator WYDEN. Mr. Clarkson, how did problems get out of hand?

Mr. CLARKSON. Thank you, Senator.

I, first of all, would say that we understand our accountability to this and accept that responsibility for these issues. During the open-enrollment period, we made changes in terms of the selling cycle and the length of time that is open for enrollment.

We introduced a private fee-for-service plan, which was designed to serve traditionally underserved markets, specifically the rural market, where older Americans have not had an opportunity for traditional insurance products to be offered in those areas because of network issues, because of coverage issues and because of staff issues in terms of being able to place people in those remote areas.

In addition to that, Senator, we underestimated the popularity of this plan and we had, and experienced, explosive growth without having an infrastructure in place to support that as effectively as what our members and our providers are entitled to.

Senator WYDEN. What does that mean, that, "There wasn't an infrastructure in place"? There wasn't training? I mean, you know,

are marketing abuses infrastructure? I mean, what does that mean?

Mr. CLARKSON. I am referring to training mechanisms, broker oversight mechanisms; the ability for the IT infrastructure to handle enrollment, claim processing; our customer service areas; of which we have, over the course of 2006 and into 2007, have made much progress and advances in all of those areas that we would love to be able to share with you. But we have work to do.

Senator WYDEN. Mr. Bailey, how did problems get out of hand?

Mr. BAILEY. WellCare's experience with the new private fee-for-service product, which has proved to be extremely popular with the Medicare beneficiaries is less than 20 weeks old. It is somewhat of a hybrid between fee-for-service and managed care plan.

I think the challenges we faced were in educating ourselves, all of our partners, and the beneficiaries—we have developed new compliance initiatives. I think the secret shopper program is going to help us in gauging beneficiary satisfaction with marketing and making sure that they are not given inappropriate information.

We are very excited about the inbound enrollment-verification process calls. We are going to be talking to Medicare beneficiaries at the point of enrollment, with another WellCare representative on the phone, other than the broker, to make sure the beneficiary, clearly understands the implications of joining a private fee-for-service plan. Heretofore, we were not doing that. We are going to be doing that now.

Coupled with the back-end post-enrollment calls we have been doing, we hope to minimize instances of inappropriate marketing even more. So when we do come here in the future, there will be even less problems to discuss.

I do want to say I believe these inappropriate marketing by agents are the exception and not the rule. It doesn't mean they are acceptable. It doesn't mean we don't have a zero-tolerance policy. But we are doing everything we can. We are open to ideas from the Committee. We support the AHIP principles and will work with our colleagues here to make sure that we are doing all that we can do.

Senator WYDEN. Mr. Chairman, I think your hearing has covered it. I am glad that you are going to keep the hot light of the congressional-hearing process and your gavel on this.

I will tell you, based on everything that I have heard, I think there is a lot of heavy lifting left to do because it is clear that the insurance commissioners feel they need additional tools to deal with the problem. We have had three companies go on the record as indicating that the existing tools are sufficient.

So I look forward to following this up with you. Given how many complaints there have been from our constituents, I think moving quickly now, while people see that your Committee is going to stay at it, is particularly helpful.

I look back at the history of Medigap. Again and again, interest would flag and people would move on to another subject. With you and your capable staff, we are going to stay at this now and get it done and get it done quickly.

I look forward to working with you, Senator Smith. Of course, my colleague and friend from Oregon will be working as well on a bipartisan way. I thank you.

The CHAIRMAN. Thank you very much, Senator Wyden. Your experience with Medigap has really been beneficial here today. I think it points the way in terms of the directions in which we need to travel.

We do appreciate your presence here today, folks. I have no doubt you want to be as perfect as human beings can be, understanding that 100 percent is hard to get to. But I believe you want to get as close to 100 percent as we can get.

I think that there is a lot of opportunity for us to work together to get there in a way that would cast positive light on all of us and, particularly, you, because these are your companies. We know you want to be regarded as A-plus players in the industry. We have no doubt about that.

So we will work together. We will get a lot done. Again, we appreciate you being here today and we are looking forward to working with you. Thank you so much.

This hearing is closed.

[Whereupon, at 1:58 p.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY, JR.

I want to thank you Chairman Kohl for holding this hearing on such a critical issue to our older citizens. I am grateful to have the opportunity to hear from the impressive panels of witnesses you have brought together on the issue of the marketing and sale of Medicare Advantage Plus.

The Medicare Modernization Act of 2003 made some significant changes regarding benefit options available to Medicare beneficiaries. Part D, the Medicare prescription drug benefit, was initiated with the MMA. Another significant change was an increase in payments by the government to private insurance plans, also known as Medicare Advantage (MA) plans, that offer Medicare benefits. The original intent of this provision was to encourage participation, competition and enrollment. Payments to Medicare Advantage plans average anywhere from 12% to 18% higher than payments to traditional Medicare fee-for-service providers.

I am deeply concerned about troubling reports I have heard from my state about the marketing tactics of Medicare Advantage Plans. These reports have come from the Department of Aging and concern citizens who are enrolled in the Pennsylvania Pharmaceutical Assistance Contract for the Elderly, also known as the PACE Program. With the advent of Medicare Part D, seniors had the option of enrolling in PACE Plus Medicare, thus supplementing prescription drug coverage under PACE with the federal Medicare Part D program. The PACE program currently serves about 15% of the 65-plus population in Pennsylvania.

The PA Department of Aging, which administers the PACE Program, has informed my office that literally hundreds of Medicare beneficiaries have reported being misled and in some cases even deceived into enrolling in Medicare Advantage plans by the independent agents who sell these private plans, a practice known as "slamming." Specifically the beneficiaries have complained of being subjected to high pressure sales pitches about benefits and coverage offered. I understand that seniors who are concerned about the high cost of healthcare and prescription drugs are often told they will pay less on a private plan, only to find out that just the opposite is true. It is particularly troubling because MA plans receive financial incentives from the government for removing beneficiaries from Medicare and enrolling them in a private plan.

According to reports and some of the testimony we will hear this morning, this is also happening I states all over the country. Older citizens may end up enrolling in plans that are not appropriate for their needs. They may not find out until they go to a regular doctor's visit that their doctor is no longer covered under the Medicare Advantage program in which they are now enrolled. Another troubling aspect is the question of jurisdiction over these disputes. The Center for Medicare and Medicaid Service (CMS) oversees MA plans and claims sole authority to regulate the corporate providers that sell these plans. Yet states clearly have a compelling interest in protecting their citizens against fraud. This is an egregious situation that must be resolved quickly and comprehensively. I will be working with the Aging Committee and Pennsylvania state officials to get to the bottom of this problem and ensure that our senior citizens are well protected from such deceptive and misleading practices.

RESPONSES TO SENATOR KOHL'S QUESTIONS FROM ABBY BLOCK

Question. How many complaints has CMS received regarding the marketing and selling of Medicare Advantage plans? How have these complaints been resolved?

Answer. Between December 2006 and April 2007, CMS received approximately 2,731 complaints related to Medicare Advantage marketing issues. Most of these complaints are received via 1–800–MEDICARE, phone, fax, and through CMS Regional Offices. Of the 2,731, 1,925 have been closed and 806 are still open.

Question. Do you analyze complaint data to identify trends, poor business practices, and other large thematic concerns in specific geographic areas?

Answer. Yes. Complaints received through 1–800–MEDICARE are logged into a Complaint Tracking Module (CTM), which was designed to allow CMS to better identify sponsor-specific, plan type-specific, and area or region-specific trends. The CTM captures and tracks Medicare Part C and D complaints to facilitate immediate and longitudinal oversight for the Medicare Advantage and Medicare Drug Benefit Programs.

Question. What is CMS doing proactively to anticipate and prevent problems with sales and marketing of Medicare Advantage plans?

Answer. With the significant expansion of MA enrollment we remind organizations that they are responsible for the actions of sales agents/brokers whether they are employed or contracted. Organizations must ensure agents/brokers are properly trained in both Medicare requirements and the details of the products being offered. Employees of an organization or independent agents or brokers acting on behalf of an organization may not solicit Medicare beneficiaries door-to-door for health-related or non-health-related services or benefits. Medicare Advantage organizations must provide strong oversight and training for all marketing activities. This is especially critical for the marketing of private fee-for-service (PFFS) plans, which are unfamiliar to many beneficiaries and providers.

CMS has established policies for MA plans to follow in order to protect beneficiaries from inappropriate sales tactics. For example, CMS requires that plans use only State-licensed marketing representatives; monitor marketing representative activities to ensure compliance with applicable laws and policies; ensure that the identity and other information of a marketing representative is reported to a State when required; and ensure that terminations for cause are reported to the appropriate State agency, if a State has such a requirement.

Because organizations are required to use only a State-licensed, registered, or certified individual to market a plan, if a State has such a requirement, CMS expects an organization to comply with a reasonable request from a State insurance department, or other State department that licenses individuals for the purpose of marketing insurance plans, which is investigating a person that is marketing on behalf of a organization, if the investigation is based on a complaint filed with the State insurance or other department. CMS also encourages an organization to report a person that markets on the plan's behalf to the appropriate State entity if an organization believes that the person is violating a State's licensing, registration, certification, insurance or other law.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM ABBY BLOCK

Question. What are the findings from the Secret Shopper program, and what actions will CMS be making in response to any concerns raised by the secret shoppers?

Answer. Because CMS has received an increasing number of complaints from Medicare beneficiaries resulting from PFFS marketing activities, we investigated the practices of sales agents in the field to evaluate which marketing requirements and guidelines may have been violated. These complaints range from minor to egregious. To help CMS assess the proliferation of non-compliant PFFS marketing tactics, auditors from our contractor observed 42 sales events in varying geographic locals nationwide under a "Secret Shopper" initiative. The auditors observed many areas of violation and identified specific compliance concerns. Medicare program violations were documented in the following general categories: (i) incentives, (ii) preferential targeting of healthier beneficiaries ("cherry picking"); (iii) misrepresentation of potential charges/fees, and (iv) misrepresentation of plan rules/services. The top four violations were:

1. Failure to clearly communicate the deeming process.
2. Failure to clearly communicate provider or network restrictions with the PFFS plan.
3. Failure to communicate that if a beneficiary obtains a service not covered under PFFS that the beneficiary is responsible for the cost.
4. Failure to clearly explain the charges for which the prospective member will be liable.

CMS takes any violation of our marketing policies very seriously. We will be closely monitoring plan marketing activities, and will take appropriate corrective action where necessary to protect Medicare beneficiaries from being misled or harmed.

Question. What recourse does a beneficiary have who has been misled into enrolling in a MA plan, and can you please explain the process for disenrollment?

Answer. CMS has the legal authority to establish a Special Election Period (SEP) for exceptional circumstances. In the case where a beneficiary has been misled into enrolling in an MA plan, we believe an SEP is appropriate. This SEP would allow the beneficiary to disenroll from one plan and enroll in another or return to Original Medicare. The beneficiary may request disenrollment from their plan either in writing or electronically (if the plan offers that option), or by calling 1–800–MEDICARE.

Follow Up Questions:

Question a. How does CMS publicize the disenrollment process to beneficiaries, plans, SHIPS, and advocacy groups?

Answer. Retroactive disenrollment actions are performed on a complaint/request basis. The SHIPs, 1–800 Medicare customer service representatives and caseworkers, and beneficiary advocate partners are aware of the availability of such actions when appropriate.

Question b. Is there a way for CMS to simplify and better publicize the disenrollment process?

Beneficiaries can call 1–800–Medicare to disenroll, which we believe is a very simple and well-understood option. The availability of customer service representatives at 1–800–Medicare to meet a variety of beneficiary needs and handle complaints is well publicized.

Question c. For the period January 2005 through May 2007, how many retroactive disenrollments from MA plans have been applied for? Of the foregoing, please specify the type of MA plan (HMO, PFFS, etc.) to which the request relates.

Question d. For the period January 2005 through May 2007, how many retroactive Disenrollments from MA have been granted, and on what basis? Of the foregoing, please specify the type of MA plan (HMO, PFFS, etc.) to which the request relates.

Answer for c and d. In Calendar Year 2006, there were 303,732 disenrollments from PFFS MA/MA–PD plans and 1,374,212 disenrollments from non-PFFS MA/MA–PD plans. Of the total disenrollments in 2006, 74,922 were retroactive.

From January 2007 to April 2007, there were 136,359 disenrollments from PPFS MA/MA–PD plans and 387,953 disenrollments from non-PPFS MA/MA–PD plans. Of the January to April 2007 disenrollments, 8,693 were retroactive.

These disenrollment figures include routine enrollment changes made during open enrollment periods. Disenrollments due to death are not included. Some beneficiaries may have had multiple disenrollments during these timeframes.

Comparable data on disenrollments between January 2005 and December 2005 is currently unavailable due to the transition in database systems from 2005 to 2006.

Question. Many stakeholders have suggested implementing a national registry of agents and brokers as one mechanism to create greater accountability and enhance oversight of sales agents. What is CMS' perspective regarding the utility of this registry?

Answer. CMS will be gathering agent/broker information and will make that information available to States. While this is does not constitute a national registry, it would serve the purpose of informing State regulators of which agents and brokers are selling specific Medicare managed care products for specific organizations. CMS also is exploring the feasibility of making this information available to the general public.

Question. In light of the state law preemption provisions of the Medicare Modernization Act (MMA), can state laws on appointment of agents be lawfully implemented by states, or instead, would the MMA need to be amended to restore state appointment laws?

Answer. Organizations have State appointment of agent laws with which they can voluntarily comply, and often do. At the same time, as noted above, CMS will be gathering agent/broker information and make that information available to States that have signed the MOU with CMS.

Follow Up Questions:

Question a. Commissioner Delwig has suggested that Congress look to Medigap. As a jurisdictional model for oversight of the MA program. Is that a sound approach, and why or why not?

Answer. We question that approach. Medicare Advantage plans differ from Medigap plans in some significant ways. For example, Medigap plans are paid for entirely by the purchaser (i.e., either a beneficiary or an employer/former employer) and they supplement Medicare. Medicare Advantage plans, in contrast, provide all original Medicare benefits and in some cases additional benefits. The Medicare Advantage program is run and heavily subsidized by the Federal government and for that reason we believe that oversight of this program must remain at the Federal level.

Question b. It is my understanding that in relation to the Memorandum of Understanding with the states, CMS will be implementing a secure website for states to access regarding complaints received by CMS. Can you provide more information about this website, e.g., what types of information will it contain, what entities will have access, when it will be operational, etc.?

Answer. The purpose of the website is to create a place where MOU States can easily access documentation pertaining to compliance and enforcement actions that CMS has undertaken in the Medicare Advantage and prescription drug programs. The types of information that will be available on this website, which is targeted to be operational by the end of the summer, include:

- Summaries of CMS program audits
- Civil monetary penalty letters
- Intermediate sanction letters (e.g., freezing marketing and enrollment activity)
- Letters announcing the Agency's intent to terminate a Medicare managed care or prescription drug organization contract
- Letter announcing the Agency's intent to non-renew a Medicare managed care or prescription drug organizations contract
- Individual complaints received by CMS where individual marketing agents or persons are named.

Question. For the period January 2005 to May 2007, how many complaints has CMS received related to sales and marketing of Medicare Advantage (MA) plans? In your response, please indicate: Please see the attached spreadsheets for answers to the following questions.

- 1. for each month during the period January 2005 to May 2007, a monthly numerical summary of the type of plan to which the complaint relates (HMO, PFFS, etc.);
- 2. for each month during the period January 2005 to May 2007, a summary of the type of complaint received (e.g., alleged inappropriate enrollments, questions about broker tactics, etc), and the number of each type of complaint;
- 3. for each month during the period January 2005 to May 2007, of the complaints received each month, how many complaints presently are closed, and how many remain open;
- 4. a yearly summary indicating the originating source of the complaint, e.g., beneficiary, SHIP, state department of insurance, etc.;
- 5. a yearly summary of complaints received, complaints closed, and complaints remaining open;
- 6. a yearly summary setting forth the average resolution time for closing complaints; and,
- 7. for each month during the period January 2005 to May 2007, the number of complaints received by CMS relating to MA plans offered by each of the following entities—Humana, WellCare, and United Health Care.

Question. For the period January 2005 to May 2007, for Humana, WellCare and United Health Care MA plans, how many complaints has CMS received with respect to slow payments to providers?

Answer. Between December 2006 and May 2007, CMS has received 24 complaints related to slow payments to providers. Nine concern Humana, one concerns WellCare, and 14 concern United Health Care. Prior to December 2006 and the establishment of the Complaint Tracking Module (CTM), CMS did not have one central method for collecting and classifying complaints and therefore cannot provide data for January 2005 to November 2006.

Question. For the period January 2005 to May 2007, how many disciplinary actions has CMS taken against plans in relation to sales and marketing of Medicare Advantage (MA) plans? In your response, please indicate for each month during the period January 2005 to May 2007, the number and type of disciplinary action(s) undertaken (e.g., warning letter, corrective action plan, civil monetary penalties, contract termination, etc.) and the name of the plan against which the action was taken.

Answer. This question is answered in combination with the follow-up question, below.

Question. For the period November 2005 to May 2007, how many disciplinary actions has CMS taken against plans in relation to sales and marketing of Medicare Part D plans? In your response, please indicate: for each month during the period November 2005 to May 2007, the number and type of disciplinary action(s) undertaken (e.g., warning letter, corrective action plan, civil monetary penalties, contract termination, etc.) and the name of the plan against which the action was taken.

Answer: The following table summarizes CMS enforcement actions taken against Medicare Advantage (MA) organizations and Prescription Drug Plans sponsors (PDPs) since January 2005. The Contract Numbers beginning with "H" denote MA organizations and those beginning with "S" denote PDP sponsors.

RO	Organization Name	Contract Number	Date Received	Basis for Action	Action Taken	Duration	Status
CO	AHC	H1034	May-07	Multiple Contract Violations	Proposed Non-renewal of PDP		CMS has issued a non-renewal letter
CO	Torchmark-First United American	S5580	Mar-07	Failure to Issue ANOCs in a timely manner	$15,000 CMP	N/A	$15,000 CMP will be offset in May 1 payment.
4	Florida Health	H1035	Mar-07	Failure to Issue ANOCs in a Timely Manner	$10,000 CMP	N/A	Penalty was offset in June 1 payment
4	Freedom Health	H5427	Mar-07	Failure to Issue ANOCs in a Timely Manner	$5,000 CMP	N/A	Penalty was offset in June 1 payment
4	Vista Health	H1076 H5850	Mar-07	Failure to Issue ANOCs in a Timely Manner	$11,050 CMP	N/A	Penalty was offset in June 1 payment
4	HealthNet	H0755	Mar-07	Failure to Issue ANOCs in a Timely Manner	$15,000 CMP	N/A	Penalty was offset in June 1 payment
4	HealthNet	S5678	Mar-07	Failure to Issue ANOCs in a Timely Manner	$10,000 CMP	N/A	Penalty was offset in June 1 payment
4	SunCoast	H5942	Mar-07	Failure to Issue ANOCs in a Timely Manner	$2,100 CMP	N/A	Penalty was offset in June 1 payment
4	Wellpoint	S5596 S5726	Mar-07	Failure to Issue ANOCs in a Timely Manner	$20,000 CMP	N/A	The CMP will be offset in the Plans April 1 2007 payment

4	Universal	H5820	Mar-07	Financial Solvency Concerns	Suspension of Marketing and Enrollment	Indefinite	Additional action including termination is possible
5	United HealthCare	49 H#s	Mar-07	Failure to Issue ANOCs in a Timely Manner	$130,000 CMP	N/A	Penalty was offset in June 1 payment
CO	United Health Care	S5805 S5820 S5921	Mar 07	Failure to Issue ANOCs in a Timely Manner	$75,000 CMP	N/A	Penalty was offset in June 1 payment
7	Humana	8 H#s	Mar-07	Failure to Issue ANOCs in a Timely Manner	$120,000 CMP	N/A	Full Payment of $120,000 made by check dated 03/21/2007
3	Elder Health	H2108 H3949 H4528	Mar-07	Failure to Issue ANOCs in a Timely Manner	$15,000 CMP	N/A	Penalty was offset in June 1 payment
CO	Elder Health	S1566 S5822	Mar-07	Failure to Issue ANOCs in a Timely Manner	$4,000 CMP	N/A	Awaiting Payment
4	Doctor Care, Inc.	H5411	Dec-06	Financial Solvency Concerns	Termination	Permanent	Closed
4	Doctor Care, Inc.	H5411	Oct-06	Financial Solvency Concerns	Suspension of enrollment and marketing	3 months	Additional Sanctions Imposed
4	America's Health Choice	H1034	Jul-05	Numerous Compliance Issues	Suspension of enrollment and marketing	Indefinite	

RESPONSES TO SENATOR BLANCHE L. LINCOLN QUESTIONS FROM ABBY BLOCK

Question 1. My state office in Little Rock has received many calls from constituents who have been the victims of misleading sales and marketing pitches for Medicare Advantage plans. Here are just two examples:

In one case, insurance agents went into low-income housing buildings for seniors (housing projects) and set up shop in common rooms. They offered free food or $15 Wal-Mart gift cards to residents, and signed up the seniors for MA plans. The company listed all the doctors who were supposedly on their plan, but many of these doctors were not in the plan, and one of the listed doctors was actually dead.

Another example is misleading marketing strategies related to the MA plans logos. One company in Arkansas used a logo that implied that it is selling Medicare with extra perks (MedicareExtra is in big letters and the company name in small letters). Many people switched to this plan because they believed it was a better version of Medicare.

Also, the agents call themselves "Medicare Specialists" when they are selling their plans. This made the seniors believe that they are just improving their Medicare coverage rather than switching to a new system.

Companies and agents like this are clearly misleading seniors. Are there any plans to tighten the marketing guidelines to prevent these types of practices in future? Has CMS heard of other cases like this and what type of action is the agency taking to remedy marketing violations such as this?

Answer. The Centers for Medicare & Medicaid Services' (CMS') priority is to ensure that Medicare beneficiaries have accurate and meaningful information necessary to help them make informed decisions about their Medicare health care and prescription drug coverage options. CMS shares your concerns and therefore, has been working diligently to implement stronger oversight requirements to ensure better accountability of marketing activities conducted by MA organizations.

In general, CMS is taking actions aimed at strengthening our oversight of the overall Medicare marketplace, and taking specific actions against any organization that we suspect are violating Medicare program requirements. MA organizations that directly employ or contract with a person to market an MA plan must ensure that a plan representative or agent complies with the applicable MA and Medicare Part D laws, Federal health care laws and CMS policies, which include CMS' Marketing Guidelines. In order to ensure that the marketing activities and outreach of these plans is accurate and complies with all program requirements, CMS has taken a proactive approach in developing additional MA oversight features.

Question 2. I am concerned that seniors seemed to be getting blamed when they receive misleading information and sign up for the wrong plan.

For example, if a person disenrolls before the plan takes effect (in the same month of enrollment), he or she can disenroll and enroll in another plan. If the senior enrolls for the first time in a managed care plan, he or she can disenroll. It appears most of these cases are handled on a case-by-case basis. But the senior has to allege misinformation or fraud and be specific. Some of these people are just stuck until next year.

When my staff has contacted the Regional Dallas CMS office about this, they have been told: "Don't these people check to see if their doctors are on the provider lists?"

I don't think they are taking into account that salespeople are knocking on doors and pressuring the seniors into enrolling in their plans. In Arkansas, there are a high percentage of uneducated seniors, not to mention those with cognitive problems, who may have difficulty understanding the different Medicare plans.

Do you think that it is fair that senior who have been misled by sales agents have to prove that they received faulty information? How is this being addressed and do you have any recommendations for how we can better serve seniors when this occurs?

Answer. CMS takes these concerns very seriously, and we are taking steps to ensure that beneficiaries are protected, and that there is better understanding of Private Fee-For-Service plans on the part of beneficiaries as well as providers. We are particularly concerned about reports of marketing schemes designed to confuse, mislead or defraud beneficiaries, and are taking vigorous action to address violations. Possible CMS enforcement responses to marketing violations range from issuing a corrective action plan, to suspension of enrollment, civil monetary penalties, or even termination of the plan from the program.

CMS has the legal authority to establish a Special Election Period (SEP) for exceptional circumstances. In the case where a beneficiary has been misled into enrolling in an MA plan, we believe an SEP is appropriate. This SEP would allow the beneficiary to disenroll from one plan and enroll in another (or return to Original

Medicare). The beneficiary may request disenrollment from their plan either in writing or electronically (if the plan offers that option), or by calling 1–800–MEDICARE.

Question 3. I have several questions related to MA disenrollment. When individuals sign up for an MA plan, they may find out only afterward when they have received bills that they have been rejected both by the carrier for Original Medicare and their new Medicare Advantage plan.

Individuals in this situation have the right to retroactively disenroll from the MA plan re-enroll in Original Medicare and have their provider resubmit claims to the Medicare carrier for payment. Few individuals are aware that they have these rights, however, and, even with the help of an advocate, it can be a difficult process.

How are Medicare beneficiaries made aware that they have this right? Are the customer service operators at 1–800–Medicare aware of the right to a retroactive MA disenrollment?

Answer. Retroactive disenrollment actions are performed on a complaint/request basis. The SHIPs, 1-800 Medicare Customer Service Representatives (CSR) and caseworkers, and beneficiary advocate partners are aware of the availability of such actions when appropriate.

Question. Are they able to initiate and complete the process for a beneficiary in this situation?

Answer. No, 1–800–MEDICARE CSRs are only able to process prospective disenrollments. Retroactive disenrollments are processed and sent to either the plan or a CMS Regional Office.

Question. How long does it take to complete a retroactive disenrollment?

Answer. A retroactive disenrollment from an MA plan entered into the CMS system online on a Monday, for example, would be processed and completed Monday night. The completed transaction would be available in the system by Tuesday morning. Once the disenrollment is complete, CMS notifies the plan of the change with a once weekly report.

Question. Is the MA plan given any discretion on whether it will allow disenrollment in these situations?

Answer. No. MA plans do not have discretion over disenrollment in these situations.

Question. How many requests for retroactive enrollments has CMS received?

Answer. In Calendar Year 2006, there were 303,732 disenrollments from PFFS MA/MA–PD plans and 1,374,212 disenrollments from non-PFFS MA/MA–PD plans. Of the total disenrollments in 2006, 74,922 were retroactive.

From January 2007 to April 2007, there were 136,359 disenrollments from PPFS MA/MA–PD plans and 387,953 disenrollments from non-PPFS MA/MA–PD plans. Of the January to April 2007 disenrollments, 8,693 were retroactive.

These disenrollment figures include routine enrollment changes made during open enrollment periods and disenrollments due to death. Beneficiaries may have had multiple disenrollments during these timeframes.

Question 1 - Complaint Data: For each month, a monthly numerical summary of the type of plan to

Dec-06	
Count of ORGANIZATION_TYPE	
ORGANIZATION_TYPE	Total
Local CCP	9
PDP	1
PFFS	10
Grand Total	20

Jan-07	
Count of ORGANIZATION_TYPE	
ORGANIZATION_TYPE	Total
Local CCP	12
MSA	1
PFFS	34
Regional CCP	1
Grand Total	48

Mar-07	
Count of ORGANIZATION_TYPE	
ORGANIZATION_TYPE	Total
Local CCP	11
MSA	2
PFFS	57
Grand Total	70

Apr-07	
Count of ORGANIZATION_TYPE	
ORGANIZATION_TYPE	Total
Local CCP	17
PFFS	52
Regional CCP	2
Grand Total	71

which the complaint relates

Feb-07

Count of ORGANIZATION_TYPE	
ORGANIZATION_TYPE	Total
1876 Cost	1
Demo	1
HCPP - 1833 Cost	1
Local CCP	27
MSA	3
PFFS	79
Regional CCP	6
Grand Total	118

May-07	
Count of ORGANIZATION_TYPE	
ORGANIZATION_TYPE	Total
Local CCP	9
PFFS	56
Regional CCP	3
Grand Total	68

Question 2 - Complaint Data: For each month, a monthly numerical sur

Dec-06

Count of SUBCATEGORY_DESCRIPTION	
SUBCATEGORY_DESCRIPTION	Total
EE (ENROLLMENT EXCEPTIONS)	1
Enrollment inappropriate	5
Illegal marketing practices	2
MA-RD (MA RETRO DISENROLLMENTS)	2
Other Enrollment/Disenrollment issue	3
Other Marketing issues	6
Payment denied	1
Grand Total	20

Mar-07	
Count of SUBCATEGORY_DESCRIPTION	
SUBCATEGORY_DESCRIPTION	Total
Dental	1
Disenrollment delayed	9
Disenrollment inappropriate	1
EE (ENROLLMENT EXCEPTIONS)	1
Enrollment delayed	8
Enrollment inappropriate	12
False advertising	3
Illegal marketing practices	1
MA-RD (MA RETRO DISENROLLMENTS)	20
Other Alleged Fraud/Abuse issue	2
Other Customer Service issue	1
Other Enrollment/Disenrollment issue	6
Other Enrollment/Disenrollment issue, please describe	1
Other Marketing issues	5
Grand Total	71

nmary of the type of complaint received

Jan-07

Count of SUBCATEGORY_DESCRIPTION	
SUBCATEGORY_DESCRIPTION	Total
Disenrollment delayed	3
Disenrollment inappropriate	1
Enrollment delayed	5
Enrollment inappropriate	6
False advertising	5
Illegal marketing practices	4
MA-RD (MA RETRO DISENROLLMENTS)	7
Other Alleged Fraud/Abuse issue	5
Other Customer Service issue	1
Other Enrollment/Disenrollment issue	5
Other Marketing issues	5
Plan customer service representative rude, couldn¬ t answer question, or gave incorrect info	1
Grand Total	48

Apr-07	
Count of SUBCATEGORY_DESCRIPTION	
SUBCATEGORY_DESCRIPTION	Total
Disenrollment delayed	9
EE (ENROLLMENT EXCEPTIONS)	2
Enrollment delayed	3
Enrollment inappropriate	18
Illegal marketing practices	1
MA-RD (MA RETRO DISENROLLMENTS)	12
Other Alleged Fraud/Abuse issue	3
Other Enrollment/Disenrollment issue	13
Other Marketing issues	9
Plan encouraged beneficiary to disenroll	1
Plan hasn¬ t responded in a timely manner to complaint or appeal	1
Plan materials or provider directory incorrect	1
Plan would not cover a service even though it was advertised as covered	1
Specialist physician	1
Grand Total	75

Feb-07	
Count of SUBCATEGORY_DESCRIPTION	
SUBCATEGORY_DESCRIPTION	Total
Delay receiving plan materials	1
Disenrollment delayed	7
Disenrollment inappropriate	14
EE (ENROLLMENT EXCEPTIONS)	3
Enrollment delayed	6
Enrollment inappropriate	27
False advertising	6
Illegal marketing practices	6
MA-RD (MA RETRO DISENROLLMENTS)	29
Other Access and Availability	1
Other Alleged Fraud/Abuse issue	2
Other Enrollment/Disenrollment issue	19
Other Marketing issues	5
Grand Total	126

May-07	
Count of SUBCATEGORY_DESCRIPTION	
SUBCATEGORY_DESCRIPTION	Total
Disenrollment delayed	3
Disenrollment inappropriate	2
Enrollment delayed	3
Enrollment inappropriate	19
False advertising	7
Illegal marketing practices	4
MA-RD (MA RETRO DISENROLLMENTS)	13
Other Access and Availability	1
Other Alleged Fraud/Abuse issue	2
Other Customer Service issue	1
Other Enrollment/Disenrollment issue	5
Other Marketing issues	5
Plan materials or provider directory incorrect	1
Plan would not cover a service even though it was advertised as covered	1
Primary care physician	1
Grand Total	68

Question 3 - Complaint Data: For each month, of the complaints received each month, how many complaints presently are closed, and how many remain open

Dec-06

Count of COMPLAINT_STATUS	
COMPLAINT_STATUS	Total
C	19
O	1
Grand Total	20

Jan-07

Count of COMPLAINT_STATUS	
COMPLAINT_STATUS	Total
C	44
O	9
Grand Total	53

Feb-07

Count of COMPLAINT_STATUS	
COMPLAINT_STATUS	Total
C	111
O	15
Grand Total	126

Mar-07

Count of COMPLAINT_STATUS	
COMPLAINT_STATUS	Total
C	60
O	11
Grand Total	71

Apr-07

Count of COMPLAINT_STATUS	
COMPLAINT_STATUS	Total
C	48
O	28
Grand Total	76

May-07

Count of COMPLAINT_STATUS	
COMPLAINT_STATUS	Total
C	22
O	47
Grand Total	69

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM COMMISSIONER DILWEG

Question 1—Preemption of State Laws

Question. Why is a Memorandum of Understanding is necessary to facilitate what it seems should be occurring anyway, that is, the sharing of information between states and CMS?

Answer. CMS maintains the MOU is necessary for the exchange of confidential agent and company information between CMS and state insurance regulators. Absent an MOU, CMS is unwilling to provide information on agent activity.

Follow Up Questions:

Question a. Can you tell the Committee what you hope to gain from the agreement, and is more needed?

Answer. I am hopeful the MOU will lead to greater communications between states and CMS regarding MA complaints. While increasing shared information is a positive step, I do not believe it is the final answer to ensuring greater consumer protection from agent and company abuses.

Question b. Many states would like to see a rollback of federal preemption provisions contained in the MMA, but plans maintain that it would be too onerous to comply with varying laws in 50 different states. Is there a middle ground that can be reached, for example, would it be a useful first step to restore state appointment laws?

Answer. A rollback of federal preemption provisions would give me authority over insurance companies selling MA plans. As I mentioned in my testimony, I have all the regulatory tools I need. Federal pre-emption, however, prohibits me from using them to protect consumers purchasing MA plans. Without the ability to regulate the plans themselves, I am not able to provide input as to whether a marketing strategy, plan or advertisement is appropriate. Authority over the insurance companies would increase my ability to prevent abuses. It would allow me to hold companies responsible for inappropriate agent action.

I put forth the Medigap regulatory model as a means to restore state commissioners' authority over companies while also addressing industry concerns related to compliance with varying state laws. Under the Medigap model, there would not be 50 different laws regulating Medicare Advantage. Rather, states would enact one set of laws, developed by NAIC and CMS, to regulate MA. States electing not to enact the laws would remain pre-empted as they are now under the current federal regulatory structure for MA.

It would be useful to restore state appointment laws given agent appointment by an insurance company creates a trackable link for states in determining which agents write MA coverage for which plans. However, there is some question as to whether CMS has the statutory authority to pre-empt state appointment laws. I would argue CMS does not have that authority.

Question c. What is the most critical complication arising from the current bifurcated regulatory system in which states are enforcing licensing laws over agents, and CMS is exercising purview over the plans.

Answer. Having regulatory authority over agents allows me to only address half the problem. Agents are not operating in a vacuum. They are responsible to a company that should be held accountable for the action of their agents, especially in those cases where company marketing and sales tactics are driving agent action. In cases where agents are initiating the problems, company accountability allows state regulators to turn to and require the insurers to fix the problems created by their sales force. Reaching the company with these complaints prevents further agent abuses.

Under the current regulatory scheme state regulators are limited in what we can do to prevent abuses and are instead acting on a high number of complaints that result from 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 enforcement staff.

MA complaints would be handled more efficiently and effectively if I could use my toolbox to investigate agents and companies collectively. This would allow for a much more proactive regulatory approach than states currently face.

Question d. You advocate that Congress look to Medigap as a jurisdictional model for oversight of the Medicare Advantage program. In response, CMS has indicated that it is critical that the federal government maintain supervision and oversight of Medicare Advantage plans because in contrast to Medigap, which is purchased by beneficiaries with their own money, Medicare Advantage is federal program, MA plans are heavily federally funded, and the plans are CMS contractors. In light of the foregoing, is Medigap really the best jurisdictional model for overseeing the MA

program? Can you point to other federal programs in which states are imbued with oversight of federal contractors?

Answer. Under the Medigap regulatory model, CMS would retain ultimate regulatory authority over MA plans. CMS would merely be allowing those states that have enacted the federal regulatory program for MA (developed by NAIC and CMS) to enforce the laws.

Beneficiaries are paying for MA with their own money. In addition to the part B premium, some pay a premium to the MA plans for additional coverage, including for prescription drugs.

It is important to note that companies sponsoring MA plans are insurance companies required by federal law to be licensed in the states in which they provide MA coverage. It does not make sense to bifurcate the regulatory responsibilities for this coverage.

As I mentioned earlier, CMS would have a significant role in developing the new regulatory provisions and would assure that the regulations CMS promulgates are properly enforced.

Question 2—Complaints referred to CMS

Question. For the period January 2006 through May 2007, how many MA marketing/sales complaints has your office referred to CMS, and of these complaints, how many remain unresolved?

Answer. To date, we have not referred any formal complaints to CMS regarding marketing/sales issues. We contact the insurers and/or agents and attempt to resolve marketing/sales complaints. As part of the MOU we recently signed, we will share information about enforcement actions. The states and CMS are still finalizing the procedures for sharing this information. We do refer MA beneficiaries who call our office with MA plan problems to CMS for handling.

Follow Up Question:

Question a. How many agents/brokers have you identified that have been selling MA plans in you state, but have not been licensed in your state?

Answer. We informed the insurers marketing MA products that we expected them to use only licensed agents. We have not identified any situations where unlicensed agents sold MA plans in Wisconsin.

Question 3—National Registry for Agents/Brokers

Question. Please elaborate on the concept of a national registry of agents, and explain your thoughts on what entity is best suited maintain the registry, what types of data the registry would contain, what types of complaints and/or disciplinary actions would result in an agent being placed on the registry, what parties would have access to the registry, and what the cost might be of implementing and maintaining such a measure?

Answer. I was a bit surprised to read in the AHIP response that it was looking forward to working with CMS and NAIC on a national producer registry for insurance agents who sell MA. There is already a national registry of insurance agents, the National Insurance Producer Registry. Insurers can access information in the public portion of this database, the Producer Data Base (PDB). The PDB is an electronic database consisting of information relating to insurance agents and brokers (producers). The PDB links participating state regulatory licensing systems into one common repository of producer information. The PDB also includes data from the Regulatory Information Retrieval System (RIRS) to provide a more comprehensive producer profile. Through PDB, industry is able to access all public information related to a producer provided by the participating state insurance departments. The product is designed to assist insurers in exercising due diligence in the monitoring of agents and brokers to reduce the incidence of fraud. Currently, PDB contains information on over 3.8 million producers. Information available includes:

- Demographics—name, date of birth, addresses
- License Summary—state of license, license number, issue date, expiration date, license type/class, residency, lines of authority, status, status reason, status/reason effective date.
- Company appointment information such as company, effective date, termination date and termination reason.
- Regulatory Actions—State of action, entity role, origin of action, reasons for action, enter date penalty/fine/forfeiture, effective date, file reference, time/length of dates.

All of the above information is supplied by the states to PDB. The information is updated on a regular basis, usually daily or as submitted by states.

Access to the PDB is sold on a subscription basis. There is a $75 annual fee per password and a $1.34 charge per "look up" of an entity in PDB. A "look up" includes

all the available license information being supplied by participating states for an individual producer, business entity, or company.

Question 4—CMS' Marketing Guidelines

Question. Do CMS' marketing guidelines provide sufficient protections for beneficiaries? In your response, please indicate your opinion regarding whether the marketing guidelines allow any unacceptable practices.

Answer. I believe CMS marketing guidelines unintentionally promote possible sales and marketing abuses in some areas. For example, the guidelines promote cross-selling of other products during the sale of Medicare products under the theory of financial planning for the Medicare-eligible. Agents sell seniors unrelated and sometimes unsuitable insurance products—including Medicare Advantage plans, annuities, life insurance policies, funeral policies, and other types of products. These other products are much more lucrative to the agents than Medicare Part D plans. Medicare Advantage plans are being reimbursed at an amount that is significantly higher than the cost of original Medicare; on average between 111% and 119% higher. As a side note, financial incentives tied to the MA plans are very likely driving the abuses we are seeing today.

CMS marketing guidelines allow MA plans to change the cost-share provisions and premiums annually. This is a very significant problem. All stability in coverage for the beneficiary is lost. MA plans do not provide the stability and consistency people are accustomed to having in their health plans from year to year. In contrast, the Medigap model would provide that needed stability. Medigap plans are guaranteed renewable, meaning plans cannot unilaterally change coverage from year-to-year except to adjust to original Medicare's changes of its deductibles and co-payments.

The CMS guidelines seem to be written first for promoting the products and second for protecting the beneficiary.

I feel that developing marketing and sales guidelines through a collaborative process, using the NAIC Medigap regulatory model, with CMS, state insurance regulators, the insurance industry, and consumer groups that the guidelines will accomplish protecting the consumer and the market place from abusive practices thereby promoting these products as valuable alternatives to the buying public.

RESPONSES TO SENATOR LINCOLN'S QUESTIONS FROM COMMISSIONER DILWEG

Question. Commissioner, you mentioned in your testimony the unscrupulous practice of agents signing up people with dementia into an inappropriate plan. How widespread do you think this is? What kind of protective measures are there for these persons?

Answer. My agency has received complaints regarding MA policies sold to people who have legal guardians appointed to make decisions on their behalf. The plans were sold without the guardians' consent. I do not have documentation of dementia specific cases but certainly have seen cases where developmentally disabled individuals purchased plans without being fully aware of what they were committing to. While I cannot quantify how widespread this is, the fact that it has happened at all sends a red flag and indicates to me that it is happening in the market place.

Individuals who feel an agent selling MA plans has acted inappropriately can file a complaint with my office. As I mentioned in my testimony, I can use my regulatory enforcement tools against bad agents but I can't get at the insurers employing the agents. The ability to do so would hold companies employing agents accountable for their misconduct and would certainly help in preventing agent abuses.

Question. You mentioned in your written testimony that Medicare Advantage plans can scale back benefits from year to year and seniors may not understand the changes and expect to get what they signed up for and at particular prices. How frequently are plans changing benefits and prices? Are seniors notified about these changes and how?

Answer. Insurers offering MA products are allowed by CMS to change benefits and prices every year. OCI is not notified or involved in the process and therefore I do not have information regarding the number of plans that have made changes. I can tell you that most plans changed either benefits, prices or both in 2007. My point in mentioning these changes in my testimony was to demonstrate the burden these constant changes place on seniors—it means they have to re-evaluate their plan decision every year and try to make comparisons between plans that are all very different.

CMS sets the standards for the notification of changes and the format for the notices which have to be filed with CMS. I believe they have to provide notice of plan changes by November 1 for changes effective the following January 1.

RESPONSE TO SENATOR KOHL'S QUESTION FROM COMMISSIONER HOLLAND

Question. Your office took marketing enforcement action against a Medicare Advantage plan sponsor, Humana, despite what we were told is a pre-emption of your authority to do that. In fact, Humana, in its written testimony, cites that pre-emption. Why did you take those actions?

Answer. Due to the high volume of consumer complaints Oklahoma received, we initiated a targeted market conduct examination. The examination was targeted at the agents' conduct, over which we retain oversight. Humana's claims practices that would have been violations of Oklahoma law, if not for federal preemption, were uncovered during the examination and was not the basis for the authority to conduct the examination.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM COMMISSIONER HOLLAND

Question 1—Preemption of State Laws

Question. Why is a Memorandum of Understanding necessary to facilitate what it seems should be occurring anyway, that is, the sharing of information between states and CMS?

Answer. Federal and state privacy laws, in particular, hinder the ability of state Departments of Insurance and CMS to share critical information about consumer complaints regarding carriers or agents and brokers. The MOU establishes that the information shared will remain confidential and not be misused by the regulator. The MOU allows for the free and open sharing of information between the state and CMS.

Follow Up Questions:

Question a. Can you tell the Committee what you hope to gain from the agreement, and is more needed?

Answer. As the insurance commissioner for the State of Oklahoma, I hope to receive complaints involving agents and brokers from CMS and send complaints involving carriers to CMS.

More importantly, I hope to receive information from CMS on how and when complaints are resolved and what complaints are being received in other states against companies selling insurance in my state. My understanding is that CMS is currently working on a database that could be accessed by states that have signed the MOU and provide them with this much-needed information. However, we are still awaiting this information.

Question b. Many states would like to see a rollback of federal preemption provisions contained in the MMA, but plans maintain that it would be too onerous to comply with varying laws in 50 different states. Is there a middle ground that can be reached, for example, would it be a useful first step to restore state appointment laws?

Answer. First, I would like to point out that MA plans operated very successfully before MMA rolled back state regulation of the plans—and without all of the consumer problems that have since arisen.

Second, I do think a middle ground exists. As suggested by Commissioner Dilweg of Wisconsin at the hearing, a single set of marketing rules could be developed and adopted by the states, which would then regulate the marketing practices of the plans. This model has worked with Medicare supplemental plans (Medigap) and would work in this instance, as well.

Question c. What is the most critical complication arising from the current bifurcated regulatory system in which states are enforcing licensing laws over agents, and CMS is exercising purview over the plans.

Answer. The inability of states to establish the marketing guidelines to be used by agents and brokers and hold plans responsible for the appointment, training and oversight of agents and brokers severely limits the ability of state regulators to do their job.

Question d. You advocate that Congress look to Medigap as a jurisdictional model for oversight of the Medicare Advantage program. In response, CMS has indicated that it is critical that the federal government maintain supervision and oversight of Medicare Advantage plans because in contrast to Medigap, which is purchased by beneficiaries with their own money, Medicare Advantage is federal program, MA plans are heavily federally funded, and the plans are CMS contractors. In light of the foregoing, is Medigap really the best jurisdictional model for overseeing the MA program? Can you point to other federal programs in which states are imbued with oversight of federal contractors?

Answer. While MA plans receive some federal funding, they are far from federal contractors. When a consumer purchases an MA plan, they enter into a contract

with that plan to provide payment for certain health services. As with other health insurance carriers, the state's responsibility is to ensure this contract was not entered into fraudulently or via unethical or misleading sales practices.

It must also be noted that the consumer does contribute quite a bit to the cost of this coverage. First, the Part A portion of the premium was contributed by the consumer while he or she was employed. Second, the consumer must pay a portion of the Part B premium. Third, the consumer is, in most cases, required to pay an additional premium for the additional coverage provided by the MA plan (similar to Medigap coverage).

Question 2—Complaints referred to CMS

Question. For the period January 2006 through May 2007, how many MA marketing/sales complaints has your office referred to CMS, and of these complaints, how many remain unresolved?

Answer. Due to the system established by CMS for complaints, the complaints are not referred by our office to CMS; rather the beneficiary must call 1–800–MEDICARE to make the complaint. However, in an attempt to serve our consumers, we do call CMS. When we call 1–800–MEDICARE on behalf of a beneficiary, we have trouble getting through, and when we do we speak to someone, it's difficult to get any response. We have referred 138 complaints to CMS. Again, due to the structure established by CMS, they do not report to us if or when the complaints have been resolved.

Follow Up Questions:

Question a. How many agents/brokers have you identified that have been selling MA plans in you state, but have not been licensed in your state?

Answer. The appointment process compels the insurer to verify the licensure of an agent because they cannot appoint an agent without a valid license. The only way to determine to what extent which insurers are utilizing unlicensed agents is to conduct targeted market conduct examination.

With that being said, the targeted market conduct exam we conducted on Humana was inclusive of both Medicare Part C and D sales. We found 68 agents to be unlicensed as a result of that examination.

Question 3—National Registry for Agents/Brokers

Question. Please elaborate on the concept of a national registry of agents, and explain your thoughts on what entity is best suited to maintain the registry, what types of data the registry would contain, what types of complaints and/or disciplinary actions would result in an agent being placed on the registry, what parties would have access to the registry, and what the cost might be of implementing and maintaining such a measure?

Answer. Such a national registry of agents and brokers has been in place since 1996. The National Insurance Producer Registry (NIPR) is a non-profit affiliate of the National Association of Insurance Commissioners and provides a national database of producers and allows state regulators to communicate and coordinate oversight.

Question 4—CMS' Marketing Guidelines

Question. Do CMS' marketing guidelines provide sufficient protections for beneficiaries? In your response, please indicate your opinion regarding whether the marketing guidelines allow any unacceptable practices.

Answer. The current marketing guidelines developed by CMS are not adequate to protect consumers. By allowing practices such as cross-selling, the guidelines encourage much of the unethical behaviors we are seeing in the market today. Further, it is obvious by the number of problems that currently exist in the market that CMS has inadequate resources which are necessary for enforcement deployed in the states. Thus, we maintain our assertion that CMS should work with the state regulators who already have the necessary resources and experience to protect their consumers.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM SHERRY MOWELL

Question 1—National Registry for Agents/Brokers

Question. Please elaborate on the concept of a national registry of agents, and explain your thoughts on what entity is best suited maintain the registry, what types of data the registry would contain, what types of complaints and/or disciplinary actions would result in an agent being placed on the registry, what parties would have access to the registry, and what the cost might be of implementing and maintaining such a measure?

Answer. In my opinion, a national registry would need to be maintained at the federal level. Each consumer complaint would need to be investigated and, if found

legitimate, the federal regulator would take appropriate action to restrict or prohibit an individual from selling any Medicare product. (I would suggest a sliding scale of punishment, with the most severe punishment being to completely and permanently bar an agent from selling any Medicare product.) The registry should be set up so that the public could check to see if an individual is under investigation (without full disclosure to the public of the details of the investigation); states should have full access for state licensing issues. Depending on the severity of the punishment, the states could use that information to take appropriate action against the individual agent license. (Congress should also consider modifying the federal law to enable states to take actions against licensed companies for company wrongdoing.)

Any company engaging in Medicare business should have an obligation to notify the registry of suspected agent wrongdoing. Also, I would recommend that, prior to being approved to sell Medicare, an agent be required to acknowledge that the agent is aware of the ramifications of potential wrongful acts.

I anticipate that the cost to implement such a registry and to employ adequate staff to conduct investigations would be substantial—you would need investigators in all 50 states to investigate each complaint. Investigators would need to be able to go into the field and meet with the complainant (the Medicare recipient). This would also require administrative attorneys to enforce the regulations and follow through with administrative orders.

If Medicare gave the states the jurisdiction that we have suggested during the Senate hearing, this system is already set up on a state-by-state basis. Each state already investigates insurance fraud at different levels. Through the NAIC, the states report actions taken against individuals and companies. Thus, when an agent's license is revoked in one state, it is unlikely that he or she will be given a license in another state.

Question 2—CMS' Marketing Guidelines

Question. Do CMS' marketing guidelines provide sufficient protections for beneficiaries? In your response, please indicate your opinion regarding whether the marketing guidelines allow any unacceptable practices.

Answer. No. The guidelines set out violations but do not provide for punishment. In our experience, if a company dismisses an agent for his or her practice, the agent just moves to the next company. The states do not even know a problem exists unless the consumer contacts us directly. However, in the State of Georgia, if a company dismisses an agent, the company must notify the state of the dismissal and of the reason for the dismissal. If wrongdoing occurs the company is obligated to notify the state.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM ALBERT SOCHOR

Question 1—National Registry for Agents/Brokers

Question. Please elaborate on the concept of a national registry of agents, and explain your thoughts on what entity is best suited maintain the registry, what types of data the registry would contain, what types of complaints and/or disciplinary actions would result in an agent being placed on the registry, what parties would have access to the registry, and what the cost might be of implementing and maintaining such a measure?

Answer: There is already a national registry process in place. It's called National Insurance Producer Registry (NIPR). Insurance companies, insurance agents and state insurance departments all use and have access to this registry. It has the capability of handling all that you have asked. Cost is set up on an as used basis. This would give CMS and the states a gathering sight for complaints, compliance and data. All insurance companies are required by the state insurance departments to use NIPR to appoint agents. (See attachment for more information) Web Site: http://www.licenseregistry.com/

Question 2—CMS' Marketing Guidelines

Question. Do CMS' marketing guidelines provide sufficient protections for beneficiaries? In your response, please indicate your opinion regarding whether the marketing guidelines allow any unacceptable practices.

Answer: No, if it had been doing so we wouldn't be experiencing the difficulties we have. The marketing guidelines do not allow any unacceptable practices; the problems are enforcement and accountability. You cant dictate compliance. Humana was the only company that had agents actually appoint with them and not contract through a third party, they also had the most comprehensive training (two days in school) and testing. Yet they had the most complaints. I have yet to read where Humana, their agencies or their agents have been fined for their infractions. What

would help beneficiaries is when they call 1–800–Medicare they should get help and guidance as to what to do when the beneficiary has made a mistake or has been taken advantage of. As I stated in my testimony, I and many other agents and beneficiaries have spoken with CMS and MA Company's service reps and have been given the wrong information. Beneficiaries and being told they are "Locked In" until the end of the year and are not being advised about the "Trial Period." All the CMS reps would have to do is asked the beneficiary a few questions when they call; such as, "Is this your first time on an MA plan? Did you drop a Medicare Supplement policy to join this MA plan?" "Have you called the company? What was their response?" CMS needs to be the advocate for these beneficiaries. They claim it's their program and the companies are their contractors. CMS needs to be handling the problems and doing it right, not SHICP or other entities. Senator Wyden was right when he said "We need to drain this swamp." As I stated in my testimony, all MA, MAPD and PDP plans need to be standardized to stop the confusion. Commissions need to be lowered and levelized to stop the churning and the incentive to cheat. You must get rid of the "Lock In" to give beneficiaries the freedom of choice. This will give them confidence that if they make a mistake or if something in the plan changes and it is not what they want, they can get out. I also believe that you need to have an equitable reimbursement rate to relieve the burden that it puts on the current Medicare system. The Federal and the State systems already had programs in place to protect the poor before MA plans came along; it was called Medicaid and the QMB and SLMB programs. These worked for years to help the poor with their medical costs.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM KAREN IGNAGNI

Question 1—National Registry for Agents/Brokers

Question. Please elaborate on the concept of a national registry of agents, and explain your thoughts on what entity is best suited maintain the registry, what types of data the registry would contain, what types of complaints and/or disciplinary actions would result in an agent being placed on the registry, what parties would have access to the registry, and what the cost might be of implementing and maintaining such a measure?

Answer. We are calling for strengthening of the processes and criteria for reporting broker and agent misconduct to state agencies, not creating a national registry. Uniform processes and criteria would enhance the ability of states regulators, plan sponsors, and the Centers for Medicare & Medicaid Services (CMS) to strengthen safeguards against broker misconduct.

At the same time, we are aware that the National Association of Insurance Commissioners (NAIC) has an existing database, the National Insurance Producer Registry (NIPR). AHIP is committed to working collaboratively on an expedited basis with the NAIC, CMS, and other interested parties to confirm whether NIPR or another mechanism could provide a workable vehicle for timely access to expanded information about misconduct. We believe that NIPR has the potential to serve as a platform that would enable this initiative to move forward more quickly, and we are in discussions with the NAIC about the functionality and data submission processes for this database, as well as NAIC's evaluation of the potential for an expanded role for NIPR. We understand that NIPR already contains information for brokers and agents whose licenses have been terminated, along with termination date and reason.

We also are prepared to work with NAIC, CMS and others on such operational issues as reporting criteria, data submission mechanisms, and data use and access. We believe that in these areas, as well, existing processes could provide a sound basis for moving forward. For example, State licensure laws include a variety of categories of broker and agent misconduct, processes for reporting such misconduct, and a range of disciplinary action when misconduct is verified through prescribed processes. We believe that a joint effort to review the critical elements of these laws, establish standard criteria that could be used across the country to enhance the breadth and timeliness of information reported, and make the resulting data available through a centralized database, such as NIPR could improve the ability of States and plans to take more effective preventive and corrective action regarding misconduct.

We have not yet developed a cost estimate for this project because it will be the product of the joint effort described above.

Question 2—CMS' Marketing Guidelines

Question. Do CMS' marketing guidelines provide sufficient protections for beneficiaries? In your response, please indicate your opinion regarding whether the marketing guidelines allow any unacceptable practices.

Answer. CMS' marketing guidelines require plan sponsors to follow a wide range of requirements that are designed to protect beneficiaries including requirements for the content and scope of marketing materials, the conduct of marketing activities and the qualifications and role of contracted brokers and agents. We believe these guidelines establish an effective foundation for holding plan sponsors accountable and for achieving CMS and plan oversight of broker/agent conduct but—in light of the concerns about marketing conduct that have been identified—we support efforts to clarify and strengthen this guidance. Specifically, we support the issuance of more detailed guidance, based on the principles outlined in the AHIP Board of Directors statement we submitted with our testimony to address the serious concerns discussed at the May 16 hearing.

Question 3—SHIP Hotline Numbers

Question. Please provide a list of your members' SHIP hotline numbers. To address privacy concerns, please provide two documents as follows:

- One document should be labeled "Document A." Document A should list your member plans and corresponding SHIP hotline numbers. Document A will not be published in the hearing transcript. Please mark Document A as "Not for Publication."
- One document should be labeled "Document B." Document B should provide a list of your member plans, and a yes/no acknowledgment next to each members' name as to whether the phone number has been provided on Document A. Document B will be entered into the hearing transcript.

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

July 31, 2007

Attachment B

AHIP Organizations Submitting Customer Service Number for SHIPS

Attachment B includes a list of member organizations that have established special processes and telephone numbers for State Health Insurance Assistance Partnership (SHIP) staff and volunteers to use in resolving sensitive Medicare beneficiary casework. The organizations included in the list serve the vast majority of enrollees in Medicare Advantage and Part D prescription drug plans.

To place these processes in context, we note that our members are employing a variety of strategies to address the need for expeditious handling of beneficiary cases referred by SHIPs. These approaches reflect their organizational structure, casework experiences, SHIP relationships and local dynamics, as well as other factors. They include:

- Designating SHIP-specific toll-free numbers;
- Triaging SHIP calls to customer service lines to SHIP-designated customer service representatives;
- Providing a designated special handling unit telephone number with customer service representatives who address SHIP inquiries along with other sensitive and urgent cases;
- Training all customer service representatives to flag and handle SHIP requests expeditiously; and
- Engaging in focused, ongoing evaluation of the handling of sensitive beneficiary casework through customer service lines so that additional measures such as designated lines can be instituted if warranted.

In addition, CMS has provided all plan customer service numbers for each state in the *Medicare & You* handbooks located at http://www.cms.hhs.gov/Partnerships/MY2007/list.asp#TopOfPage. If a SHIP office has difficulty reaching plan customer service representatives for resolving casework, we have made the SHIPs aware that they can contact us to facilitate access.

AHIP Member Organization	Submitted Telephone Number
Aetna	Yes
Blue Cross Blue Shield of Minnesota	Yes
Blue Cross Blue Shield of Tennessee	Yes
Blue Plus of Minnesota	Yes
California Physicians' Service dba Blue Shield of California	Yes
Cigna	Yes

AHIP Member Organization	Submitted Telephone Number
CIGNA HealthCare of Arizona, Inc.	Yes
Coventry	Yes
Fallon Community Health Plan	Yes
Group Health Cooperative	Yes
HealthNet	Yes
HealthPartners, Inc.	Yes
HIP Health Plan of New York	Yes
Horizon Blue Cross Blue Shield of New Jersey, Inc.	Yes
Humana Inc.	Yes
Independence Blue Cross	Yes
Independent Health	Yes
Kaiser Foundation Health Plan, Inc.	Yes
Memberhealth, Inc.	Yes
Northern Plains Alliance	Yes
The Regence Group - Regence Blue Shield of Idaho - Regence Blue Cross Blue Shield of Oregon - Regence Blue Cross Blue Shield of Utah - Regence Blue Shield of Washington	Yes
Sierra Health and Life Insurance Company, Inc.	Yes
Sterling Life Insurance Co.	Yes
Tufts Health Plan	Yes
United	Yes
Universal American Financial Corporation - Pyramid Life Ins.Co - American Progressive - Pennsylvania Life	Yes
WellCare Health Plans	Yes
Wellpoint - Anthem Blue Cross & Blue Shield - Blue Cross Blue Shield of Georgia - Blue Cross Blue Shield of Missouri - Blue Shield of California - Empire Blue Cross Blue Shield - Unicare	Yes

Senate Special Committee on Aging Hearing
"Medicare Advantage Marketing & Sales: Who Has The Advantage?"
May 16, 2007

Questions for the Hearing Record
Gordon H. Smith, Ranking Member

Panel 2 and Panel 3—Questions to all witnesses on Panels 2 and 3:
Question 1 – National Registry for Agents/Brokers

QUESTION:

Please elaborate on the concept of a national registry of agents, and explain your thoughts on what entity is best suited maintain the registry, what types of data the registry would contain, what types of complaints and/or disciplinary actions would result in an agent being placed on the registry, what parties would have access to the registry, and what the cost might be of implementing and maintaining such a measure?

The concept of the national registry or "watch list" involves the reporting of sales agents who meet certain criteria as established by regulatory entities. Criteria could include terminations for cause as well as trended serious complaints. CMS and the National Association of Insurance Commissioners (NAIC) should determine the best mechanism, the data requirements and the access provisions. They should seek input from relevant health plan and broker trade associations.

CMS and the NAIC should also explore the possibility of developing and implementing a standardized test and testing process such that any agent wishing to sell a Medicare Advantage or PDP plan would be required to obtain national certification.

Question 2 – CMS' Marketing Guidelines

QUESTION:

Do CMS' marketing guidelines provide sufficient protections for beneficiaries? In your response, please indicate your opinion regarding whether the marketing guidelines allow any unacceptable practices.

Yes, in that they are continually updated to meet marketplace concerns. For example, CMS has recently strengthened guidance providing for outbound verification of sales and strengthened beneficiary and provider materials required to be discussed and disseminated by plans. They are also conducting secret shopper surveys. Humana is also going to be contracting with an outside vendor to do the same as well as to further survey member experience with sales presentations post-enrollment.

We believe that sales agents should be appointed by plans. While most states require appointment (9 do not), CMS exempts plans from the appointment process. Our trade association has proposed that CMS share a list of agents by plan to states.

Question 3 – Marketing, Training and Complaints

QUESTION:

Do you provide your agents/brokers with beneficiary contact information (e.g., lead lists) from Part D or other programs, to use in generating leads for MA enrollments?

Humana provides pre-set appointments generated by licensed telemarketing agents to our career agents and select independent agents. Our career agents make appointments themselves as well from referrals they may have obtained after checking them against a Do Not Call list. We note that both career and contracted (delegated) agents keep client lists. Humana does not provide beneficiary contact information or lead lists for external independent agents who are contracted with us to represent our plans.

Humana does mail CMS-approved information on our Medicare Advantage program to Part D members. From these mailings, members call us to inquire for more information or for an appointment and for those who do not call, Humana employed telesales agents call those members to inquire as to interest (using a CMS-approved script) and set appointments if applicable.

Follow up:

a. Should agents/brokers be allowed to engage in cross-selling of MA plans with other products?

   Yes, but Humana agents are instructed to set a separate appointment. (Note: This instruction excludes Medicare Supplement policies as those may meet the beneficiary's need better than an MA product.)

b. I understand that most plans use computer or class room training, and have various certification requirements for their agents. While training and certification is critical, this does not provide the direct oversight necessary to observe abuses and misrepresentations that occur during agents' sales pitches. What steps does your company take to ensure that each and every agent/broker selling your products is observed a minimum number of times per year directly in the environments in which the agent/broker is selling to beneficiaries, such as in homes, at seminars or in retail establishments?

   Humana currently requires field evaluations be completed on its career agents where we observe the agent doing a sales presentation. Given the requirements of

annual enrollment and lock-in periods, for career agents, we initially conduct 5 field evaluations, followed by a field evaluation every six months after. We have outlined the requirement for field evaluations of our Managing General Agency (MGA) partners in the Agency Compliance document. The current requirement is for one field evaluation after training and one every 6 months. We have discussed increasing Humana's field management ranks to ensure we do not rely on the MGA to conduct field evaluations.

c. What protocols do you use to ensure that beneficiaries are getting enrolled in the plan that best suits their needs, even if that plan is not accompanied by high commissions, or is not one offered by your company?

- Agents are trained to conduct suitability assessments to determine whether a Humana plan is the best plan for the beneficiary. Further, in concert with a former NAIC health committee staff director, Humana developed a suitability worksheet that is left with the beneficiary. It is not in Humana's or the agent's best interest to enroll someone in a plan they do not want or is inappropriate for their needs or budget. (Humana's policy dictates that agents will not receive commission for members who disenroll within the first 90 days of enrollment—chargeback policy.)
- The sales presentation includes slides that specifically address selecting a plan that is most suitable to the beneficiary's needs
- Verification questions specifically ask the enrollee whether the agent conducted a proper suitability assessment.

d. One frequent complaint concerns the aggressive marketing of private-fee-for-service (PFFS) plans to dual-eligibles. How many duals have been enrolled in your PFFS plans, and is there any component in your agent/broker training that focuses on recruiting duals?

The number of duals in our PFFS plans is 76,985 as of 12/06. There are no provisions in our training that focus on recruiting duals.

e. For your PFFS plans, what steps do your require your agents/brokers to take, prior to enrolling a beneficiary, to ensure that a beneficiary's physicians will accept the plan's payment terms?

We have an extensive provider education and outreach program. Agents are instructed to clearly disclose to beneficiaries that their providers must accept Humana. Agents may call to verify acceptance with our provider relations staff or may suggest that the beneficiary contact his/her provider to verify. Beneficiaries may also call our customer service center. In some cases, beneficiaries have given us "leads" for new providers and our provider relations' staff has supplied information to those providers who then accept Humana.

f. Do you utilize either inbound or outbound verification calls for MA or Part D enrollments, and if so, with what results?

First, we note that CMS now requires outbound verification. For many years prior, Humana has utilized an inbound verification process for MA plans. Only if we were unable to reach a beneficiary, would we make an outbound call. Our experience showed that outbound calls resulted in fewer beneficiaries being reached. Further, in less than 1% of the cases is the verification stopped on inbound verifications. We note that verifications are completed by customer care representatives outside the sales operations area. We make three attempts to reach a beneficiary and then send a CMS-approved letter. For stand-alone Part D plans, we mail a letter.

g. Please provide a copy of any scripts used by call center customer service representatives during inbound and/or outbound enrollment verification and/or confirmation calls.

Please see attached **(#1-CMS-approved verification scripts)**

h. For the period January 2006 through May 2007, broken down by month, how many sales-related and enrollment complaints have you received from CMS, beneficiaries, SHIPs and/or other advocacy groups. Of the foregoing complaints, how many resulted in a beneficiary request to disenroll from the MA plan? Of the foregoing disenrollment requests, how many disenrollments were successfully completed?

Please see **Attachment #2 Complaints/Disenrollments.**

i. By dollar amount, please list the average sales commission paid to individual sales agents/brokers for beneficiary enrollment in each of the following types of plans: PFFS, HMO, PPO, Regional PPO, Special Needs Plans, Part D, and MA-PD. Please also set forth your policy for recapturing commissions from agents.

The dollar amount commission paid upon enrollment to the selling agent is the same for all Humana's MA products. These products include comprehensive medical coverage and enhanced Part D coverage. The dollar amount represents less than 3% of premium:

Employed agents: $180
Independent agents: $300

We have a commission chargeback policy that states that an agent is not paid commission for any member who voluntarily disenrolls within the first 90 days of enrollment.

The dollar amount commission paid upon enrollment to the selling agent for a stand-alone Part D plan (no medical coverage) is less than 5% of premium:

Employed agents: $30
Independent agents: $50

j. What is the percentage and dollar amount of your company's portfolio revenue that is comprised by MA products? By Part D products?

MA revenue as of 12/31/06: 39.7%; $8,499,064,000
Part D revenue as of 12/31/06: 14.2%; $3,050,304,000

k. How many in-house sales agents (also referred to at times as "captured agents" or "employed agents") do you employ?

We currently employ 1,555 agents. We also have approximately 570 licensed telesales specialists, of which approximately 450 only set appointments.

l. Set forth by state for each state in which you offer a MA plan, how many independent sales agents/brokers comprise your sales force?

Please see **Attachment #2-Independent agents/brokers by state**. Please note that many agents are licensed in multiple states and will be counted in each of the states in which they are licensed, thus, the numbers will reflect that fact. Also, not all agents actively sell MA products for us.

m. Do your training requirements differ as between independent agents/brokers and in-house employed/captured agents? If so, please explain.

The training content is consistent between independent agents and career agent training, however, the method of delivery is different. Career agents attend a three (3) week training course, which includes material specific to their employment status with Humana. Independent agents complete a defined pre-work course and then must successfully pass a test on that content prior to attending a classroom training session followed by conference calls. Our independent agent training program is undergoing significant revisions at this time. The revisions include frontloading more content into the pre-work course and testing process so that classroom training can focus more on learning and practicing the actual sales presentations. This would allow agents to have a better understanding of how to conduct a suitability assessment and how to explain key concepts of all plans, most especially PFFS.

As previously stated, we recommend that a national, standardized training program/course and national testing/certification be established.

n. For the period January 2006 to May 2007, please provide both monthly and yearly totals of the number of in-house employed agents and independent agents/brokers that have been sanctioned, and for each instance, what the disciplinary measures have entailed, e.g., suspension, termination, warnings, commission revocation, etc.? Please set forth your answer by state, for each state in which you offer a MA plan.

Please see **Attachment # 3 for a listing of #'s of sanctioned agents, disciplinary measures, type of action and source**. This listing covers information sought in item #n and #o below.

o. For the agent disciplinary actions accounted for in paragraph "n" above, please indicate the nature of the conduct that resulted in disciplinary actions, including but not limited to door-to-door sales, misrepresentations, using unapproved marketing materials, forging signatures, and/or selling without a valid license. In your response, please specify how the agent/broker misconduct was brought to your company's attention, e.g., by CMS, by state department of insurance, direct beneficiary complaint, etc.

Please see **Attachment # 4 for a listing of #'s of sanctioned agents, disciplinary measures, type of action and source**. This listing covers information sought in item #n and #o.

p. What is your procedure for conducting investigations against agents and brokers?

Humana has a policy for investigating alleged sales practice violations. A unit of compliance analysts (outside of sales operations) conducts these investigations. The compliance analyst may receive these allegations/complaints from customer service, regulatory agencies, etc. These allegations are logged into a database. The analyst contacts the beneficiary/designee to obtain additional information and collects relevant data including, but not limited to enrollment application, verification control number/recording, written disenrollment request, copies of claims, checks, customer service calls, member correspondence, statements from other involved parties, power of attorney or other documentation if relevant, sales agent statement, etc. The analyst also reviews the database for any previous allegations. The analyst then makes a determination. A copy of the finding is kept in the agent's file. If there are any questions or concerns with reaching a determination, the analyst may ask for the relevant Compliance Director to review as well. The investigation should be completed within 30 days of initiation. If the finding is a major violation, the agent is terminated from selling MA and/or PDP products and pursuant to state laws, may be reported to the relevant state Department of Insurance. If the allegation is unfounded, not major, or is inconclusive, the agents are counseled, coached, retrained and/or re-evaluated.

q. For each of the MA plans offered by your company, please provide enrollment numbers for years 2006 and 2007.

	Dec 06	1Q07
MA Enrollment		
HMO	457,900	462,100
PFFS	473,000	586,700
PPO	71,700	64,600
	1,002,600	1,113,400

r. Please provide a copy of any comments that your company submitted during the public comment period for the 2008 Call Letter.

Humana did not submit any comments.

s. Do you maintain a hotline dedicated to inquiries from SHIPs, and if so, has this hotline number been provided to each of the SHIP directors in the states where you offer MA and Part D plans?

Yes. It has been provided by Humana and through our trade association, America's Health Insurance Plans to the Health Assistance Program association.

t. For the period January 2005 through May 2007, how many MA sales are attributable to employed sales agents, and how many sales are attributable to independent agents/brokers?

Submitted MA Sales for Plan Years 2005-2007

	2005	2006	2007
Captive	148,177	423,092	239,396
Delegated	56,778	134,314	53,591

u. Do you utilize a secret shopper program to oversee MA and/or Medicare Part D sales?

Not yet. We have begun work to identify outside vendors to implement a secret shopper program in the near future.

v. Do you conduct licensing and background checks on all agents/brokers, including independent agents/brokers? Please explain.

Yes, we conduct a background check at the time of hire or contract to check that an agent has a valid license. Additionally, we conduct a background and criminal record check

w. Please identify the field marketing organizations (FMOs) with which you contract.

RESPONSES TO SENATOR LINCOLN'S QUESTIONS FROM HEIDI MARGULIS

Question. I have heard from my state office that about 25% of the complaints we receive about Medicare Part D are from people who have signed up for a managed care type plan without understanding that their providers aren't participating. The salespeople are telling the seniors that the plan they represent is as good or is better than the plan the senior is enrolled in.

How is Humana handling this situation and how does your company reign in salespeople who are misleading seniors about the plans?

Answer. Within Humana's sales agent training program, we train agents to fully and fairly disclose to beneficiaries that Private Fee for Service enrollees may see any provider that is willing to accept Humana's payment terms and conditions. Our CMS-approved sales presentation includes this information and our enrollment verification scripting (please see Attachment #1) addresses this issue as well. During the verification process, we specifically inform the member of this rule and that the member should confirm their provider's willingness to accept the plan. Additionally, agents can forward provider information to our Provider Relations' education staff to request they communicate with providers about the PFFS plan, in the event the provider is unaware of how a PFFS plan works and how they will be paid. We have a team of Provider Relations representatives who conduct educational sessions in communities for providers and who provide ongoing outreach to them. Providers can also directly contact this staff.

Humana has a sales investigation unit outside our Medicare Sales department that investigates all allegations that come to our attention. Specific remedial actions are in place, including termination and reporting to state Departments of Insurance for those findings of statutory cause. Further, for many years, we have had a policy in place that incents best practice selling and disincents bad sales practices. Agents do not receive commission for members who disenroll within the first 90 days of enrollment—this is known as our "chargeback policy."

Question. What evidence do you have that the corrective action plans have been effective?

Answer. Agent complaints are tracked and agent files maintained with investigation reports and findings. Agent personnel files also contain monitoring, corrective actions and other remedies. If repeat allegations on the same topic or related allegations occur, further disciplinary action, up to and including termination may be warranted.

Question. I am concerned that some cognitively impaired persons are being taken advantage and signed up for plans that they did not understand. Agent Mowell noted in her testimony that one agent went to a facility and signed up individuals who were mentally disabled for Part D and then switched them to a MA plan without the knowledge of the patient or their guardian.

How does Humana ensure that agents are not taking advantage of beneficiaries with mental disabilities? You noted in your written testimony that Humana has a verification system, which is used to ensure that the beneficiary or authorized representative understands the MA plan and the basic rules. Can you please walk me through this system and how it works?

Answer. Our sales training program includes a section on senior vulnerabilities. We also monitor sales through our verification process, local management and through sales-related complaints. Our sales program does not target specific groups of vulnerable beneficiaries and cold-calling without an appointment or agreement on the part of relevant parties violates our sales practice policies.

HUMANA'S MEDICARE ADVANTAGE ENROLLMENT VERIFICATION PROCESS

- Since 1991, Humana has used an enrollment verification process to confirm a beneficiary's intent to enroll in a Medicare Advantage (MA) plan and his/her understanding of plan rules. This process has been updated over time to reflect new requirements, new technology and better approaches to beneficiary health literacy needs.
- Following a beneficiary's completion of an enrollment application, the agent phones a toll-free number that connects with an interactive voice response (IVR) system. The beneficiary has the option of completing the verification through the IVR system or by speaking directly with a customer care representative (verification staff are not in the sales organization). Both the IVR system and the customer care representative (verification staff are not in the sales organization). Both the IVR system and the customer care representative utilize a CMS-approved script that includes questions related to plan rules as well as confirms the beneficiary's under-

standing that the plan in which they are enrolling is not a Medicare Supplement plan, that the plan is not a stand-alone prescription drug plan and that the beneficiary's providers must accept Humana payment terms and conditions (Humana pays the same as what Medicare pays). Telephonic verifications are recorded.

- During the verification process, if the IVR detects hesitation or a negative response, the system automatically transfers the beneficiary to a live customer care representative. If the customer care representative detects hesitation or the beneficiary negatively responds or the beneficiary does not understand a provision, the verification system is stopped and the agent is instructed to explain the relevant provisions to the beneficiary. If, at a later time, the beneficiary wants to enroll, the verification process begins anew.
- Humana tries to verify all sales. If for some reason, the verification is not completed telephonically, or the application is completed online without a sales representative, an outbound call is made to the beneficiary by a customer care representative after the application is processed. If the beneficiary cannot be reached, a letter is mailed to the beneficiary.
- All telephonic enrollments are recorded and the recording serves as the verification. These enrollees also receive a verification letter.
- Stand-alone PDB enrollees receive an outbound verification letter.
- The Verification Unit is staffed Monday-Sunday: 8AM–11PM ET. The IVR line is available 24/7.
- Beginning within the next months, Humana will be implementing an outboud verification system with a customer service representatives contacting members post-sale in accordance with new CMS guidance. As well, Humana is in the process of designing a secret shopper program to evaluate sales experiences.
- In addition to our verification process, Humana has had in place for many years a commission chargeback policy. This policy stipulates that agents do not receive commissions on sales that terminate prior to the first 90 days of enrollment. This policy was designed to promote best-practice techniques.

Senate Special Committee on Aging Hearing
"Medicare Advantage Marketing & Sales: Who Has The Advantage?"
May 16, 2007

Questions for the Hearing Record
Gordon H. Smith, Ranking Member

Responses Submitted June 27, 2007

Question 1 – National Registry for Agents/Brokers

QUESTION:

Please elaborate on the concept of a national registry of agents, and explain your thoughts on what entity is best suited to maintain the registry, what types of data the registry would contain, what types of complaints and/or disciplinary actions would result in an agent being placed on the registry, what parties would have access to the registry, and what the cost might be of implementing and maintaining such a measure?

We support the idea of establishing a national registry of all agents and brokers licensed and certified to market Medicare Advantage (MA) products on a state-by-state basis. The objective is to prevent brokers who are terminated or suspended for misconduct in the selling of one plan from going on to sell for another company either in the same state or another. We want only well-trained and highly ethical brokers selling plans to beneficiaries – whether for us or for other companies. We believe that any type of registry would need to include a mechanism to ensure there is fair process for brokers to review and challenge the information that is entered into the registry.

The registry would identify agents currently in "good standing" and agents with actions/sanctions against their license. It could build on models similar to the national databases maintained by external vendors and law enforcement agencies, whereby member organizations would submit complaints and disciplinary actions taken against agents. The database would contain the data necessary to identify an agent and the agency(ies) for which he or she works or has worked and nature of the activity for which they are on watch/suspended/terminated. That database could then serve as a central source for background checks when agents move, re-affiliate with brokerage/marketing agencies, or change product lines. The database could be expanded to include other information that would be useful to all parties involved, and we would be amenable to considering options related to that.

We are interested in working with the Centers for Medicare & Medicaid Services (CMS), National Association of Insurance Commissioners (NAIC), America's Health Insurance Plans (AHIP) and other interested stakeholders to determine and develop the best structure and processes for establishing and maintaining a registry that would meet the needs of consumers, plans, regulatory authorities and other interested stakeholders. We are open to discussion about different models (including who has access to the database) – but the key is to ensure that it is efficient, easy to use and maintained rigorously. We believe it could be reasonable for the cost of such a database to be borne across the industry through some sort of user fee.

Question 2 – CMS' Marketing Guidelines

QUESTION:

Do CMS' marketing guidelines provide sufficient protections for beneficiaries? In your response, please indicate your opinion regarding whether the marketing guidelines allow any unacceptable practices.

CMS' marketing guidelines are comprehensive and are based on, and an extension of, Medicare regulations. They are updated regularly by CMS in consideration of developments in the Medicare program and questions posed by Medicare health plans. CMS does allow for and encourages both industry and public comment on draft guidance. We do not believe that the marketing guidelines allow any unacceptable practices. However, as outlined above in our answer to Question 1, we do support a national registry of all agents and brokers who are licensed and certified to market Medicare Advantage (MA) products on a state-by-state basis. This would be a welcome enhancement that would help prevent brokers who are terminated or suspended for misconduct in the selling of one plan from going on to sell for another company, either in the same state or another.

Question 3 – Marketing, Training and Complaints

STARTING QUESTION:

Do you provide your agents/brokers with beneficiary contact information (e.g., lead lists) from Part D or other programs, to use in generating leads for MA enrollments?

We have not typically provided beneficiary contact information in this way, although in principle we do believe it is important that agents work to assess the needs of Medicare beneficiaries and offer them products that may match those needs, both today and as those needs change over time.

On occasion we have used information gathered from traditional marketing sources to contact prospective members who have expressed interest in our Medicare products. For example, we have provided appointment and community requests (i.e., leads) to our sales force as a result of beneficiary responses to marketing initiatives, such as those involving direct mail, advertising inserts, and outbound calls.

FOLLOW-UP QUESTIONS:

a. **Should agents/brokers be allowed to engage in cross-selling of MA plans with other products?**

We believe that agents and brokers should be permitted to provide information on all health products that may be valuable or helpful to beneficiaries. This is particularly important, recognizing that health care needs often change over time. As such, it is important that sales agents be able to talk with beneficiaries about their needs as they evolve and about the range of Medicare options that we offer and that could address those needs. In fact, the agent licensure process typically requires a commitment from the agent to act in this manner.

Ensuring that beneficiaries have complete information is critical to empowering them to make an informed choice. Indeed, in Question 3c below, the Committee seems to suggest as much when it

asks, "[w]hat protocols do you use to ensure that beneficiaries are getting enrolled in the plan that best suits their needs...."

b. **I understand that most plans use computer or class room training, and have various certification requirements for their agents. While training and certification is critical, this does not provide the direct oversight necessary to observe abuses and misrepresentations that occur during agents' sales pitches. What steps does your company take to ensure that each and every agent/broker selling your products is observed a minimum number of times per year directly in the environments in which the agent/broker is selling to beneficiaries, such as in homes, at seminars or in retail establishments?**

We employ a range of oversight practices to ensure the quality of internal and external agents and brokers, including face-to-face observation and training. We monitor the performance of agents, external brokers and Field Marketing Organizations, and work with the FMO leadership to address any issues that arise. The processes and methods we find effective include:

1) *Our National Quality Assurance Team, which is dedicated to our distribution channel.* These employees work full-time to ensure our policies, procedures and training are accurate and updated; monitor performance of brokers and FMOs; and make certain that the Company delivers what it promises to beneficiaries. The Team's activities are tightly coordinated with the results of the Post Sale Verification call process, described below.

2) *A Post Sale Verification call process for PFFS plans.* Beginning in fall 2006, we instituted an outbound Post Sale Verification call process. We engaged an external vendor to conduct post-sale interviews with beneficiaries who selected a PFFS plan. A series of questions was developed and approved by CMS to gain insight into the beneficiary's understanding of how the plan works, the "Deeming" process for providers, and the differences between PFFS plans and other Medicare options. The process also helps us determine whether a beneficiary has agreed to be enrolled in the PFFS plan. If the process reveals that a beneficiary believes he/she has been wrongly enrolled in a PFFS plan, we work with CMS to disenroll them expeditiously. (See our answer to Question 3f below for more detail.)

   The data from those surveys are collected, reviewed and presented to internal distribution oversight groups, which in turn, make operational modifications to our oversight programs as necessary. In a May 25, 2007 letter, CMS encouraged all plans to begin implementing similar calls immediately, and all plans must have this process in place before marketing begins for 2008. We have already begun implementation based on CMS' guidance.

3) *A review process flowing from our Post Sale Verification calls, which could lead to direct observation of particular agents if necessary.* If it is determined, based on the review of data collected from these calls, that there is a need for onsite review or additional training, our National Quality Assurance Team may take a range of steps, including: conducting face-to-face training and refresher sessions with the agents; reviewing the sales materials as presented to the beneficiary; and conducting ride-along visits where a member of our Team attends appointments with the agent and provides additional education as necessary.

4) *Our Distribution Oversight Committee.* The Committee reviews the activity of all sales agents (both employed and external) on a monthly basis and in turn is overseen by an Executive Distribution Oversight Committee that meets at least quarterly and has authority to take action at an executive level.

5) *Investments in additional regionally-focused training, education and outreach resources to increase hands on training and direct sales observation*. Our Market Executive Directors, Regional Training Managers and National Quality Assurance Specialists are integrating and combining resources to improve education, training and oversight. A series of education modul is currently under development to provide additional assessment skills and tools for the agent to best meet the needs of the beneficiary, regardless of the type of plan offering.

6) *A "Quality Assessment Initiative," which is a secret shopper program we are planning to launch leading up to 2008*. This will consist of a two-pronged approach. First, senior "ambassadors" (comprised of current members of our plans) will attend community and sales meetings to evaluate our agents/brokers and report on the sales approach, tactics and clarity of presentation. Second, Quality Assurance Specialists will randomly attend community and sales meetings to evaluate agents/brokers for compliance based on CMS marketing and sales guidelines. This initiative will be linked with the Post Sale Verification call process and overseen by our Nationa Quality Assurance Team, Distribution Oversight Committee and Executive Distribution Oversight Committee. All of this will help us enhance our training and oversight efforts nationwide.

We believe that training and education are a critical element of the oversight equation and this is why they are integrated throughout the processes described above. In addition, we are always evaluating our programs for ways to improve their effectiveness. We have taken steps over the last year to refine and expand certification and training programs for agents/brokers. Our training for external brokers has evolved beyond a primarily on-line process to include a greater emphasis on face-to-face training, proctored examinations and refresher training where necessary, as well as more frequent distribution of printed material.

We also are supportive of the development of industry-wide standards for written tests for agents/brokers that would demonstrate their familiarity with the Medicare program in general, as well as the specific PFFS plans and other products they are selling. This will build somewhat on what our company already requires, and we look forward to working with CMS, AHIP and others on this effort.

(Note: Before being certified to sell SecureHorizons products, agents/brokers must not only be licensed by each State to sell Medicare products, but also successfully complete our certification training course specific to the product or products they sell and be recertified on an annual basis.)

c. What protocols do you use to ensure that beneficiaries are getting enrolled in the plan that best suits their needs, even if that plan is not accompanied by high commissions or is not one offered by your company?

In more than 20 years of serving senior and disabled beneficiaries through our Ovations division, UnitedHealth Group has learned that the needs of Medicare beneficiaries are varied and often unique. In order to meet those needs, we offer a very broad portfolio of Medicare products – the broadest, we believe, of any plan sponsor. Therefore, it is not consistent with our mission for brokers to enroll beneficiaries in one of our Medicare Advantage plans versus another.

Accordingly, we pay external brokers contracted under a Field Marketing Organization (FMO) the same commission rate for all of our Medicare Advantage plans in all states except one

(California), where, consistent with industry standards, the rates are moderately higher for non-PFFS Medicare Advantage plans. Independent Career Agents ("ICA" – independent brokers who sell our plans exclusively) are currently all paid the same commission rates for all Medicare Advantage plans across the country. Until the recent past, commissions paid to ICAs for non-PFFS plans were moderately higher then those paid for PFFS plans.

In general, in those instances where we have varied the commission between PFFS and other MA plans, the variation has related to the complexity of the plan (coordinated care plans typically being more complex then PFFS in terms of benefit structure), and our efforts to retain a commission structure that is competitive with industry standards. Remaining competitive with industry standards is important to ensure that brokers continue to focus on enrolling beneficiaries in the plan that is right for them, without regard to the particular commission that is being paid by any particular plan sponsor.

With respect to protocols, as mentioned above in our answer to Question 3b, we implemented a Post Sale Verification call process last fall to ensure new enrollees understand the PFFS product and agree to be enrolled in it. We also established a National Quality Assurance Team, a Distribution Oversight Committee and an Executive Distribution Oversight Committee who ensure our policies, procedures and training are accurate and updated; monitor and assess the performance of the sales channel; ensure CMS compliance beneficiary understanding so they can make informed choices. Also, as detailed above in the same answer, the Post Sales Verification call process feeds into a review process, which could lead to direct observation of particular agents if necessary.

In addition, also as mentioned above in our answer to Question 3b, we put considerable effort and time into training, education and certification, teaching agents about: Medicare, our company, and the specific plans they are selling. Agents are also trained so that they are able to talk with beneficiaries about their health needs and clearly and simply present information about health plans in their area (whether ours or those offered by another sponsor) that may match the beneficiaries' needs.

That said, we continue to make improvements to the certification, training and education processes, based on input from beneficiaries and family caregivers, CMS, state regulators and advocacy groups.

d. One frequent complaint concerns the aggressive marketing of private-fee-for-service (PFFS) plans to dual eligibles. How many duals have been enrolled in your PFFS plans, and is there any component in your agent/broker training that focuses on recruiting duals?

We have identified a little over 15,000 dual-eligible beneficiaries who are enrolled in our PFFS plans. Our PFFS plans do not encourage the recruitment of dual-eligible beneficiaries. However, our training includes modules and information to ensure understanding of the unique circumstances of dual eligibles so that agents can take that into consideration when helping beneficiaries assess whether one or another plan is right and appropriate for them.

Investments are being made in regionally-focused training, education and outreach resources to increase hands on training and direct sales observation and oversight. And, other improvements are being made to certification, training and education; for example a series of specific education modules to provide additional assessment skills and tools, designed to help agents to better meet the needs of a beneficiary, regardless of the type of plan offering, will be available this summer.

e. **For your PFFS plans, what steps do you require your agents/brokers to take, prior to enrolling a beneficiary, to ensure that a beneficiary's physicians will accept the plan's payment terms?**

We have developed specific training and materials to address the "Deeming" process. These materials and training are used with agents certified to market our PFFS plans to ensure that they are educated about "Deeming" and the concept of "Deemed" providers, and understand their responsibilities in discussing this with Medicare beneficiaries. A "Deemed" provider is one who:

- ... is Medicare eligible, meaning s/he is state-licensed, is not barred from or sanctioned by Medicare, and has not opted out of the traditional Medicare program;
- ... knows that the individual is enrolled in a SecureHorizons MedicareDirect plan before beginning treatment; and
- ... agrees to accept the payment rates and terms and conditions of the plan.

We provide a list of "undeemed" providers (those who are not accepting our plan's terms and conditions) to all our agents for their review prior to their engaging in a sales event (e.g., community meeting, sales visit upon beneficiary invitation.) It is worth noting that an ongoing challenge is keeping an updated listing of "undeemed" providers that is accurate. This is because, following statute, the rules governing "Deeming" permit a provider to accept the terms and conditions of PFFS plans on a visit-by-visit basis. However, in addition to providing a list of "undeemed" providers to our agents, we use the Post Sale Verification call process described previously (and below in the answer to Question 3f) to confirm that the enrollee understood the plan and intended to enroll in it.

f. **Do you utilize either inbound or outbound verification calls for MA or Part D enrollments, and if so, with what results?**

Outbound calls:
Beginning in fall 2006, we instituted an outbound Post Sale Verification call process. We engaged an external vendor to conduct post-sale interviews with beneficiaries who have selected a PFFS plan. A similar process was developed for new enrollees in certain Evercare dual eligible Special Needs Plans. A series of questions was developed and approved by CMS to gain insight into the beneficiary's understanding of how the plan works, the "Deeming" process for providers, and the differences between PFFS plans and other Medicare options.

In regards to the current process, six telephone call attempts are made over the 30-day period following the beneficiary's election to join the plan; a "We've been trying to reach you..." letter is sent after the sixth attempt if efforts to contact the beneficiary fail.

- If a call reveals that a beneficiary believes he/she has been wrongly enrolled in a PFFS plan, we work with CMS to disenroll them expeditiously.

- If it is determined, based on the review of data collected from these calls, that there is a need for onsite review or additional training, our National Quality Assurance Team may take a range of steps, including: conducting face-to-face training and refresher sessions with the agents; reviewing the sales materials as presented to the beneficiary; and

conducting ride-along visits where a member of our Team attends appointments with the agent and provides additional education as necessary.

We are modifying our Post Sales Verification call process based on a May 25, 2007 letter from CMS that provides specific guidance for marketing and sales of PFFS plans.

Recent New Actions:
In addition to the above, we are taking three steps to encourage new PFFS plan enrollees to participate in the Post Sale Verification call survey:

- *"Non-reachable" letter:* To enhance the six-attempt Post Sale Verification call process, we have begun sending letters to those for whom we had telephone numbers, but who could not be reached, either because of no answer or non-working telephone numbers, encouraging them to call us to participate in the survey.

- *Letter encouraging "refusals" or incomplete survey to participate:* We have begun sending letters to new PFFS enrollees who refused to participate in the survey the first time, or who did not fully complete the survey, to encourage them to complete the survey. The goal is to confirm that they are satisfied with their plan and comfortable that they understand their benefits and how to use them. Moving ahead, such letters will continue to be sent as matter of course to new PFFS plan members who initially refuse to complete the survey or whose survey was incomplete.

Results:
Of those beneficiaries found to have working and active telephone numbers and who agreed to participate in the survey, typically fewer than 5% go on to disenroll once their questions have been addressed.

Inbound calls:
We have had experience doing sale verification at the time of sale and found it is not as effective. Beneficiaries told us they were not comfortable providing complete and truthful answers about the sales process conducted by a broker in the agent's presence. This feedback is consistent with concerns expressed by groups like NAIC. Therefore, we feel the most effective timing is soon after the enrollment takes place. An exception could be made for inbound calls conducted at the time of sale for brokers who are on a watch list, as AHIP has proposed; we support this initiative.

g. Please provide a copy of any scripts used by call center customer service representatives during inbound and/or outbound enrollment verification and/or confirmation calls.

See Appendices A, B and C for CMS-approved scripts.

h. [1.] For the period January 2006 through May 2007, broken down by month, how many sales-related and enrollment complaints have you received from CMS, beneficiaries, SHIPs and/or other advocacy groups? [2.] Of the foregoing complaints, how many resulted in a beneficiary request to disenroll from the MA plan? [3.] Of the foregoing disenrollment requests, how many disenrollments were successfully completed?

See Appendix D for data relating to Part 1 of this question. With respect to Parts 2 and 3 of the question, we do not have a reliable estimate of how many beneficiaries requested to disenroll from a MA plan as a result of their having made a sales-related or similar enrollment complaint.

The main challenge is that we do not typically receive a detailed reason for a beneficiary's disenrollment. Moreover, most disenrollments occur during the annual enrollment period where beneficiaries are encouraged to compare plan options and consider plan changes. Consequently, it is especially difficult to draw inferences about the specific reasons behind a disenrollment received during this period, which for Medicare Advantage ran from November to May for 2006 and from November to March for 2007.

i. **By dollar amount, please list the average sales commission paid to individual sales agents/brokers for beneficiary enrollment in each of the following types of plans: PFFS, HMO, PPO, Regional PPO, Special Needs Plans, Part D, and MA-PD. Please also set forth your policy for recapturing commissions from agents.**

Medicare Advantage Plans:
As discussed above in our answer to Question 3, we use a range of external brokers to sell our plans. The commissions we pay to our external sales force – which includes external brokers contracted under Field Marketing Organizations (FMO) and Independent Career Agents (ICA), who are independent brokers who sell our plans exclusively – range from $150-$400 per enrollee application, with exception of California, where the high end of the range is $550 per application.

The key variables determining the level of the commission are related to the amount of administrative (e.g., overhead, personnel, etc.) and other support (e.g., leads, referrals, etc.) that external agents receive from the FMO under which they work or from us directly.

Often, where an agent is contracted as part of an FMO arrangement, the FMO may receive the commission payment from us and be responsible for determining the compensation that the writing agent receives. In other cases, we pay external agents their commissions directly.

As noted above in the response to Question 3c, the commissions paid through FMOs are at the same rate for *all* Medicare Advantage plans in all but one state (California), where, consistent with industry standards, the rates are moderately higher *for non-PFFS Medicare Advantage plans*. ICAs currently are *all* paid the same commission rates for *all* Medicare Advantage plans across the country.

Part D Plans:
For the Medicare Prescription Drug Program (Part D), we pay brokers and agents a commission for each new application that is sold. The broker/agent who actually enrolls the prospect receives in the range of $70-$75 for each new application. This amount is the same in all 50 states, regardless of where the potential enrollee's primary residence is located.

Recapturing Commissions/Chargebacks:
CMS Guidelines require that Medicare Advantage Organizations recover commissions paid on members who rapidly disenroll from the product. This is one method to discourage brokers from selling products that are not suitable to potential enrollees. CMS defines rapid disenrollment as someone who disenrolls within 60 days of the policy effective date.

To provide enhanced consumer protection, Ovations has expanded the definition of rapid disenrollment to anyone who disenrolls *within 90 days*. Any commission paid on a policy that is a rapid disenrollment will be charged back in full to all levels that were paid for that policy. First year chargebacks are recovered from the next available check. If there is not enough new business to offset this chargeback, the balance of the chargeback is rolled to the next week's commission statement. This continues until the chargeback is repaid in full.

j. What is the percentage and dollar amount of your company's portfolio revenue that is comprised by MA products? By Part D products?

Medicare Advantage	Approximately, 17% of UnitedHealth Group Revenue
Part D	Approximately, 8% of UnitedHealth Group Revenue

k. How many in-house sales agents (also referred to at times as "captured agents" or "employed agents") do you employ?

SecureHorizons currently employs approximately 275 Independent Sales Representatives (ISRs). These are employees of the organization. We also deploy exclusive arrangements with approximately 115 Independent Career Agents (ICAs), who are contracted, but considered part of our "captive organization," as result of the exclusive arrangement and internal management oversight.

l. Set forth by state for each state in which you offer a MA plan, how many independent sales agents/brokers comprise your sales force?

There are a total of 10,915 active, contracted agents with an existing state licensure who are certified in at least (one) SecureHorizons product. Agents cannot market a SecureHorizons product unless they are certified in that product. *(Note: When reviewing the tables below, please keep in mind that the figures reflect the number of licensed brokers representing our products in each state. A broker can be licensed in more than one state and therefore may be representing our products in more than one state. Consequently, the count for brokers operating in each state will add up to more than 10,915.)*

	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID
Cert	10	152	195	327	886	302	36	8	21	583	540	77	240	227

	IL	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO	MS	MT	NC
Cert	579	807	118	134	133	74	120	69	384	103	450	112	41	846

	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC	SD
Cert	120	181	42	77	54	119	87	625	216	373	433	33	380	76

	TN	TX	UT	VA	VT	WA	WI	WV	WY
Cert	284	1,386	167	598	13	393	701	149	35

m. Do your training requirements differ between independent agents/brokers and in-house employed/captured agents? If so, please explain.

No. Training requirements do not differ between independent brokers/agents and in-house employed/captive agents for SecureHorizons products.

n. **For the period January 2006 to May 2007, please provide both monthly and yearly totals of the number of in-house employed agents and independent agents/brokers that have been sanctioned, and for each instance, what the disciplinary measures have entailed, e.g., suspension, termination, warnings, commission revocation, etc.? Please set forth your answer by state, for each state in which you offer a MA plan.**

See Appendix E.

o. **For the agent disciplinary actions accounted for in paragraph "n" above, please indicate the nature of the conduct that resulted in disciplinary actions, including but not limited to door-to-door sales, misrepresentations, using unapproved marketing materials, forging signatures, and/or selling without a valid license. In your response, please specify how the agent/broker misconduct was brought to your company's attention (e.g., by CMS, by state department of insurance, direct beneficiary complaint, etc.).**

See Appendix F.

p. **What is your procedure for conducting investigations against agents and brokers?**

See Appendix G.

q. **For each of the MA plans offered by your company, please provide enrollment numbers for years 2006 and 2007.**

(SecureHorizons and Evercare – *Enrollment in thousands)*

	2006 (as of end Q4)	2007 (as of end Q1)
HMO	1,104	1,083
Local PPO	34	30
Regional PPO	30	32
PFFS	187	100
SNP (includes dual, chronic, and institutional)	87	94

r. **Please provide a copy of any comments that your company submitted during the public comment period for the 2008 Call Letter.**

See Appendix H.

s. **Do you maintain a hotline dedicated to inquiries from SHIPs, and if so, has this hotline number been provided to each of the SHIP directors in the states where you offer MA and Part D plans?**

Yes. To assist SHIP offices with questions or issues that may arise related to a beneficiary's coverage through our PFFS plans, in October 2006, we established a dedicated toll-free number ([redacted] for SHIPs to contact us. This number was provided to all SHIP directors with

a request for them to share it with their staffs as appropriate. We have recently expanded the use of this number to include issues that SHIPs may want to raise with us related to all our Medicare Advantage plans; we will be making a formal announcement to SHIPs about this within the next two weeks.

In addition, in Fall 2006, we established a dedicated toll-free number (, for SHIPs to contact us for Part D and other PDP issues that were not resolved through our established toll-free customer service phone line and consumer resolution process. That dedicated phone line was communicated to all SHIP offices in November 2006. If a MA and/or MA-PD issue arises and comes through our Part D line for SHIPs by mistake, the issue is "triaged" to the appropriate line/person for handling.

We are dedicated to serving the needs of our customers and remain confident that our SHIP hotlines will continue to help accomplish that end.

t. For the period January 2005 through May 2007, how many MA sales are attributable to employed sales agents, and how many sales are attributable to independent agents/brokers?

For the period January 2005 through March 31, 2007 (the latest data available), approximately 50 percent of our MA sales were attributable to employed sales agents and approximately 50 percent were attributable to independent agents/brokers.

u. Do you utilize a secret shopper program to oversee MA and/or Medicare Part D sales?

We are planning to launch a "Quality Assessment Initiative," which will serve as a secret shopper program for our Medicare Advantage plan, as described above in our response to Question 3b(6). This will consist of a two-pronged approach. First, senior "ambassadors" (comprised of current members of our plans) will attend community and sales meetings to evaluate our agents/brokers and report on their sales approach, tactics and clarity of presentation. Second, Quality Assurance Specialists will randomly attend community and sales meetings to evaluate agents/brokers for compliance based on CMS marketing and sales guidelines.

This initiative will be linked with the Post Sale Verification call process and overseen by our National Quality Assurance Team, Distribution Oversight Committee and Executive Distribution Oversight Committee, and action will be taken as appropriate. A series of enhanced education modules is currently under development to provide additional assessment skills and tools for the agent to best meet the needs of the beneficiary, regardless of the type of plan offering. All of this is helping us to enhance our training and oversight efforts nationwide to the benefit of consumers.

For our Part D plans, a formal quality monitoring program is in place to listen, evaluate, and provide feedback on telephonic sales calls. This program helps to identify training and coaching opportunities for call center agents and provides a mechanism for giving agents feedback and improvement suggestions on an on-going basis.

v. **Do you conduct licensing and background checks on all agents/brokers, including independent agents/brokers? Please explain.**

Yes. We oversee this process and retain a company to assist us with both. The submission of licensing applications for agents and brokers is managed through a contracted vendor, with SecureHorizons staff maintaining management oversight of the vendor. When an agent submits an application expressing interest in representing SecureHorizons Medicare Advantage products, a current copy of his/her state licensure must be attached. In addition, the agent must list any other state in which they are licensed along with the expiration date for each state. During the data input process, the expiration dates are logged into the database and annual requests for proof of renewal are sent to the agents. In addition to license expiration registration, a background check is conducted on all applying agents through the Interstate Background Research Company at www.ibrinc.com via the internet. This site references a national producer database that houses complaints registered against licensed agents.

w. **Please identify the Field Marketing Organizations (FMOs) with which you contract.**

See Appendix I for a list of FMOs with which SecureHorizons contracts.

Additional Comment: On June 15, 2007, we agreed to participate in a "Voluntary Pledge of Compliance" with CMS concerning the marketing of our PFFS plans. Consistent with the Pledge, we have voluntarily agreed to suspend temporarily the marketing of these plans in the non-group individual market. This action provides us time to demonstrate to CMS that we have the systems and management controls in place to meet the conditions specified in various CMS guidance documents, and we expect to do so expeditiously. We believe our efforts under the Pledge coupled with our other ongoing activities such as those described here will reduce the potential for broker misconduct and ensure that if any misconduct does occur that it is quickly and effectively addressed.

# # #

Senate Special Committee on Aging Hearing
"Medicare Advantage Marketing & Sales: Who Has The Advantage?"
May 16, 2007

Questions for the Hearing Record from
Gordon H. Smith, Ranking Member

Panel Three- Joint questions to Humana, WellCare and UnitedHealth Group

Question 1 - Marketing, Training and Complaints

QUESTION:

Do you provide your agents/brokers with beneficiary contact information (e.g., lead lists) from Part D or other programs, to use in generating leads for MA enrollments?

ANSWER:

Yes. WellCare does provide agent/brokers lead lists of both WellCare PDP (Part D) members and Medicare eligibles from a third party marketing database to use in generating leads for MA enrollment.

Follow up:

a. Should agents/brokers be allowed to engage in cross-selling of MA plans with other products?

ANSWER:

Yes, if the product is appropriate for the beneficiary and the approach is done within CMS marketing guidelines and applicable state laws. This provides useful information to beneficiaries about choices available to them and what is best suited to their needs.

b. I understand that most plans use computer or class room training, and have various certification requirements for their agents. While training and certification is critical, this does not provide the direct oversight necessary to observe abuses and misrepresentations that occur during agents' sales pitches. What steps does your company take to ensure that each and every agent/broker selling your products is observed a minimum number of times per year directly in the environments in which the agent/broker is selling to beneficiaries, such as in homes, at seminars or in retail establishments?

ANSWER:

WellCare, like other major MA health plans, uses an independent distribution channel, as well as its own employee sales force. We use several means of proactive sales oversight that include:

- deployment of a secret shopper service to pose as potential beneficiaries to experience the sales process/presentation;
- completion of mandatory training and testing for all sales agents;
- revocation of selling privileges for sales agents who do not complete the training and score 100% on the required testing;
- follow-up calls to all beneficiaries enrolled by any terminated sales agent to confirm the beneficiary's enrollment decision or to facilitate disenrollment;
- monitor sales data for potential issues and to educate or even terminate agents based on the findings, with emphasis on proactive resolution of issues; and
- monitor a confidential compliance Hot Line where members, associates and government regulators can report concerns about potential marketing misconduct.

Since we have implemented our new efforts including mandatory testing/retesting and passage with 100% passage, we have significantly reduced the number of our independent sales agents.

c. What protocols do you use to ensure that beneficiaries are getting enrolled in the plan that best suits their needs, even if that plan is not accompanied by high commissions, or is not one offered by your company?

ANSWER:

WellCare trains its employed sales representatives and independent agents, educating them on CMS Medicare Marketing Guidelines, our products, and the markets these products are designed to serve. Applying this knowledge, our representatives assist beneficiaries in making the appropriate choice for their individual situations. To ensure beneficiaries are satisfied with their selection, we will have a PFFS inbound telephone enrollment and verification process.[1] This system will allow prospective enrollees an additional opportunity to verify their understanding of plan benefits, acknowledge that they received all the information needed to make an informed decision before joining a Medicare Advantage program, and confirm their voluntary election to select the plan terms. The phone call verification will be digitally voice recorded at the point of enrollment for Medicare Advantage beneficiaries. With this new enrollment process, WellCare will implement a real-time verification and quality assurance process. The inbound verification program will be in addition to the 100% outbound callback program already in place for new members. This mandatory new member call-backs to 100% of new Medicare Advantage enrollees is done to confirm that their sales experience was positive and that they understand their benefits.

[1] We have not yet implemented this new inbound verification program in light of the temporary moratorium on sales and marketing of PFFS products.

d. One frequent complaint concerns the aggressive marketing of private-fee-for-service (PFFS) plans to dual eligibles. How many duals have been enrolled in your PFFS plans, and is there any component in your agent/broker training that focuses on recruiting duals?

ANSWER:

As of June 1, 2007, we have:
Total PFFS Members: 47,156
Total Dual Members: 36,994

Dual eligibles represent approximately 18% of the overall Medicare eligible market. These beneficiaries face significant economic issues in obtaining healthcare beyond that provided by Medicaid. WellCare's products have proved very popular among dual eligibles because of the incremental value they offer, particularly in the dental, hearing and vision benefits, and over the counter health-related products. WellCare's PFFS products also feature some important care management and health risk assessment programs that improve health outcomes for enrollees.

e. For your PFFS plans, what steps do you require your agents/brokers to take, prior to enrolling a beneficiary, to ensure that a beneficiary's physicians will accept the plan's payment terms?

ANSWER:

Prior to the launch of our PFFS product on January 1, 2007, we undertook significant outreach to provider groups in counties we were approved to serve. Per a CMS approved application change, WellCare collects the known providers of prospective members on the applications. We then undertake aggressive outreach to these providers to ensure that they agree to accept WellCare's PFFS product including mailing of provider kits outlining requirements. We have seen tremendous success in our outreach efforts. To date, over 32,000 providers have now submitted claims and been paid for services offered to our PFFS members.

f. Do you utilize either inbound or outbound verification calls for MA or Part D enrollments, and if so, with what results?

ANSWER:

During the first 5 months of 2007 we have been able to complete over 50,000 calls with a successful contact rate of 60%. In these calls we have found that over 80% of our members are satisfied with their experience.

For PFFS products and to ensure beneficiaries are satisfied with their selection, we will have an inbound telephone enrollment and verification process. This system will allow prospective enrollees an additional opportunity to verify their understanding of plan benefits, acknowledge that they received all the information needed to make an informed decision before joining a Medicare Advantage program, and confirm their voluntary election to select the plan terms. The phone call verification will be digitally voice recorded at the point of enrollment. With this new enrollment process, WellCare will implement a real-time verification and quality assurance process. The inbound verification program will be in addition to the 100% outbound callback program already in place for new members. This mandatory new member call-backs to 100% of new Medicare Advantage enrollees is done to confirm that their sales experience was positive and that they understand their benefits.

g. Please provide a copy of any scripts used by call center customer service representatives during inbound and/or outbound enrollment verification and/or confirmation calls.

ANSWER:

Please see Appendix for our scripts.

h. For the period January 2006 through May 2007, broken down by month, how many sales-related and enrollment complaints have you received from CMS, beneficiaries, SHIPs, and/or other advocacy groups. Of the foregoing complaints, how many resulted in a beneficiary request to disenroll from the MA plan? Of the foregoing disenrollment requests, how many disenrollments were successfully completed?

ANSWER:

While there may be various ways to track complaints, we generally monitor and track those contained in the CMS system while also rapidly responding to others that we learn of that may come from other sources.

The chart below reflects our PFFS tracked complaints. We have 162 member complaints associated with broker activitiy. We have terminated 18 brokers based upon investigation, and have processed 228 disenrollments related to those brokers.

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
CASES	1	4	3	4	13	18	22	22
BROKERS	1	3	4	5	13	18	23	22
MEMBER COMPLAINTS	1	4	10	3	17	47	24	55

The chart below includes complaints on sales and marketing for all Medicare plans that have been reported to our Company's Compliance Department -- the Trust Program. In certain instances, some complaints we have received may not have reached the level that required reporting to the Trust Program. We can not give final disenrollment information at this time.

The Trust Program
Sales and Marketing Complaints by Month

Year	Month	Product	Number of Complaints
2006	Jan	Medicare	3
2006	Feb	Medicare	11
2006	Mar	Medicare	4
2006	Apr	Medicare	4
2006	May	Medicare	9
2006	Jun	Medicare	8
2006	Jul	Medicare	20
2006	Aug	Medicare	42
2006	Aug	PDP	1
2006	Sep	Medicare	18
2006	Oct	Medicare	29
2006	Nov	Medicare	24
2006	Nov	PFFS	2
2006	Dec	Medicare	10
2006	Dec	PFFS	1
2007	Jan	Medicare	16
2007	Jan	PFFS	5
2007	Feb	Medicare	16
2007	Feb	PDP	7
2007	Feb	PFFS	5
2007	Mar	Medicare	25
2007	Mar	PDP	5
2007	Mar	PFFS	17
2007	Apr	Medicare	25
2007	Apr	PDP	6
2007	Apr	PFFS	14
2007	May	Medicare	44
2007	May	PDP	3
2007	May	PFFS	17

i. By dollar amount, please list the average sales commission paid to individual sales agents/brokers for beneficiary enrollment in each of the following types of plans: PFFS, HMO, PPO, Regional PPO, Special Needs Plans, Part D, and MA-PD. Please also set forth your policy for recapturing commissions from agents.

ANSWER:

With regards to WellCare's PFFS, HMO, SNP, MAPD, and PDP products, we are at or below other comparable product's commissions.

Independent Agent/Broker commission for:

PFFS = $250 first year or 2-2.5% of premium; $100 renewal (Independent Agents)
HMO, SNP and MA-PD = $250; no renewal commission (In-House Agents)
PDP = $50 first year; $25 renewal (Independent Agents)

In the industry, it is our understanding that MedSup commissions are roughly 20% of the premium in the 1st year ($360 commission on a $1600 premium).

At WellCare, if a member disenrolls from PFFS or PDP within the first 93 days, there is a 100% chargeback - that is, we recapture the entire commission. If a member disenrolls after 93 days, commission is charged back on a pro-rata basis for PFFS and PDP (e.g., if a member disenrolls after 7 months of coverage, we chargeback the agent/broker for 5 months' commission). Prorated recapture also applies in the renewal periods for the duration of the enrollment.

j. What is the percentage and dollar amount of your company's portfolio revenue that is compromised by MA products? By Part D products?

ANSWER:

MA products revenue was $790,343,000 for the full year ended December 31, 2006 and $320,936,000 for the quarter ended March 31, 2007. For 2006, MA product revenue represents 21.3% and 21.0% of premium revenue and total revenue, respectively. For the first quarter of 2007 MA product revenue represents 26.3% and 25.9% of premium revenue and total revenue, respectively.

Part D (PDP) revenue was $995,086,000 for the full year ended December 31, 2006 and $264,435,000 for the quarter ended March 31, 2007. For 2006 Part D (PDP) revenue represents 26.8% and 26.4% of premium revenue and total revenue, respectively. For the first quarter of 2007 Part D (PDP) revenue represents 21.6% and 21.3% of premium revenue and total revenue, respectively.

k. How many in-house sales agents (also referred to at times as "captured agents" or "employed agents") do you employ?

ANSWER:

We employ 250 captured (in-house) agents to represent our Medicare product lines.

l. Set forth by state for each state in which you offer a MA plan, how many independent sales agents/brokers comprise your sales force?

ANSWER:

We currently are contracted with a total of 4,181 licensed agents who are certified to sell WellCare plans.

State	Total Number of Agents
AL	70
AR	93
AZ	23
CA	232
CO	62
CT	8
DC	3
DE	3
FL	1,008
GA	343
HI	10
IA	30
ID	29
IL	52
IN	39
KS	18
KY	26
LA	86
MD	29
MI	103
MN	13
MO	97
MS	180
NC	286
NE	2
NJ	15
NM	23
NV	9
NY	139
OH	224
OK	4
OR	52
PA	61
SC	154
TN	46
TX	358
UT	31
VA	103
WA	41
WI	61
WV	15
Grand Total	**4,181**

m. Do your training requirements differ as between independent agents/brokers and in-house employed/captured agents? If so, please explain.

ANSWER:

Yes, captured (in-house) agents receive in-house training. Broker training can be done on-line or in a group setting. We provide additional training to the captured (in-house) agents including: WellCare New Hire, Personal Sales Skills, Territory and Market Management, Prospective and Lead Management, Selling the WellCare Way, Role-play from NEADS to Presentation, Enrollment and Member Service.

Training for independent agents focuses on Medicare Marketing Guidelines (a.k.a. Compliance), product knowledge, and how to do business with WellCare. We conclude training with a knowledge test. Agents are given two opportunities to pass this test before their contract to represent WellCare PFFS is suspended. With regard to PFFS, in February, 2007, after agents had completed their initial online training, we launched an instructor-facilitated retraining for agents and required that they also pass a retest with 100%.

n. For the period January 2006 to May 2007, please provide both monthly and yearly totals of the number of in-house employed agents and independent agents/brokers that have been sanctioned, and for each instance, what the disciplinary measures have entailed, e.g., suspension, termination, warnings, commission revocation, etc.? Please set forth your answer by state, for each state in which you offer a MA plan.

ANSWER:

State	Agent Type	Disciplinary Action	Date	Nature of Inappropriate Conduct	Source of Complaint	Product
FL	Independent	Terminated	1/1/07	Sales/Marketing Violation	Internal	Coordinated Care
IL	In-House	Terminated	1/11/07	License Violation	Internal	Coordinated Care
LA	Independent	Terminated	2/16/07	Compliance Violation.	Internal	Coordinated Care
LA	Independent	Terminated	2/19/07	License Violation	Internal	Coordinated Care
LA	Independent	Terminated	4/9/07	Aggressive Sales Tactics	Internal	Coordinated Care
NY	In-House	Terminated	3/7/07	Compliance Violation	Internal	Coordinated Care
NY	In-House	Terminated	3/7/07	Failed to Abide by PIP Requirements	Internal	Coordinated Care
NY	Independent	Terminated	5/16/07	Misconduct	Internal	Coordinated Care
CA	Independent	Terminated	1/26/07	Unapproved Marketing Materials	Advocacy Group	PFFS
CA	Independent	Terminated	1/26/07	Unapproved Marketing Materials	Advocacy Group	PFFS
CA	Independent	Terminated	1/24/07	Unapproved Marketing Materials	Advocacy Group	PFFS
GA	Independent	Terminated	3/1/07	Fraudulent enrollment	DOI	PFFS
GA	Independent	Terminated	5/3/07	Unapproved Marketing Materials	Internal	PFFS
[illegible]	Independent	Terminated	3/7/07	Licensure & Marketing Violation	DOI	PFFS
MI	Independent	Terminated	3/3/07	Door-to-Door	DOI	PFFS
MI	Independent	Terminated	3/7/07	Door-to-Door	Internal	PFFS
MI	Independent	Terminated	4/13/07	Door-to-Door	DOI	PFFS
MS	Independent	Terminated	3/7/07	Door-to-Door	Internal	PFFS
MS	Independent	Terminated	4/24/07	Licensure & Marketing Violation	DOI	PFFS
MS	Independent	Terminated	4/24/07	Licensure & Marketing Violation	DOI	PFFS
MS	Independent	Terminated	4/23/07	Fraud enrollment	DOI	PFFS
NC	Independent	Terminated	3/21/07	Door-to-Door	Advocacy Group	PFFS
NC	Independent	Terminated	5/29/07	Fraud enrollment	Advocacy Group	PFFS
NY	Independent	Terminated	5/16/07	Compliance Violation	Internal	PFFS
NY	In-House	Terminated	6/1/06	Sales and Marketing	Internal	Coordinated Care
NY	Independent	Terminated	7/1/06	Sales and Marketing	Internal	Coordinated Care
FL	Independent	Terminated	7/1/06	Misrepresentation	Member	Coordinated Care
FL	Independent	Terminated	8/1/06	Misrepresentation	Member	Coordinated Care
GA	In-House	Terminated	12/1/06	Licensing	DOI	Coordinated Care
GA	In-House	Terminated	12/1/06	Misrepresentation	Internal	Coordinated care
GA	Independent	Terminated	12/6/06	Fraudulent enrollment	Internal	PFFS
GA	Independent	Terminated	12/6/06	Fraudulent enrollment	Internal	PFFS

Please see the chart below for this information.

o. For the agent disciplinary actions accounted for in paragraph "n" above, please indicate the nature of the conduct that resulted in disciplinary actions, including but not limited to door-to-door sales, misrepresentations, using unapproved marketing materials, forging signatures, and/or selling without a valid license. In your response, please specify how the agent/broker misconduct was brought to your company's attention, e.g., by CMS, by state department of insurance, direct beneficiary complaint, etc.

ANSWER:

Please see the chart under question "n" for this information.

p. What is your procedure for conducting investigations against agents and brokers?

ANSWER:

WellCare employs a team of investigators coordinated through the Corporate Compliance Department. When a complaint regarding an agent or broker comes to the Plan, it is immediately logged into a customized data platform to ensure effective tracking. An investigator is assigned to the case and their first priority is to work with Customer Service to ensure resolution to any outstanding Beneficiary concern. An investigation into a complaint then proceeds with data gathering and analysis of all the relevant documents if any, and the interviews with the parties involved. Once an investigation is concluded, a determination is made regarding the continued association with the agent/broker. WellCare has a "zero-tolerance" policy for agent/broker misconduct and will terminate its relationship where an investigation has concluded that wrongdoing occurred.

q. For each of the MA plans offered by your company, please provide enrollment numbers of years 2006 and 2007.

ANSWER:

The following table presents MA membership information as of the year ended December 31, 2006:

2006 (Coordinated Care)			
State	SNP	Non-SNP	Total
Florida	8,320	56,679	64,999
New York	5,276	8,573	13,849
Connecticut	923	1,591	2,514
Illinois	1,203	4,473	5,676
Louisiana	591	2,250	2,841
Georgia	465	932	1,397
Total	**16,778**	**74,498**	**91,276**

The following table presents MA membership information as of the quarter ended March 31, 2007.

2007 (Coordinated Care)			
State	SNP	Non-SNP	Total
Florida	9,444	57,065	66,509
New York	6,810	10,879	17,689
Connecticut	918	1,960	2,878
Illinois	1,216	6,022	7,238
Louisiana	680	2,497	3,177
Georgia	522	1,291	1,813
Total	**19,591**	**79,713**	**99,304**

PFFS Membership by Plan As of 3/31/2007	
Plan	Members
Duet	29,564
Concert	1,520
Freedom	642
Summit	280
Total	**32,006**

r. Please provide a copy of any comments that your company submitted during the public comment period for the 2008 Call Letter.

ANSWER:

WellCare worked collaboratively with AHIP to develop feedback on the draft Call Letter. Then AHIP submitted comments directly to CMS, on behalf of their many member health plans, including WellCare. We did not submit comments directly to CMS from WellCare.

s. Do you maintain a hotline dedicated to inquiries from SHIPs, and if so, has this hotline number been provided to each of the SHIP directors in the states where you offer MA and Part D plans?

ANSWER:

Yes, WellCare does have a separate and distinct SHIP hotline for all 50 states, plus Washington DC, for all of our Medicare lines of business. The hotline number has been provided to each of the SHIP Directors.

t. For the period January 2006 through May 2007, how many MA sales are attributable to employed sales agents, and how many sales are attributable to independent agents/brokers?

ANSWER:

During this time period, there was enrollment of 175, 566, of which 36% were attributable to independent agents, and 64% were attributable to in-house agents.

	2005	2006	YTD 2007	TOTAL FOR PERIOD	
ALL	40,103	50,368	85,095	**175,566**	
Independent Agent	2,248	3,814	57,110	**63,172**	**36.0%**
In-House	37,855	46,554	27,985	**112,394**	**64.0%**

u. Do you utilize a secret shopper program to oversee MA and/or Medicare Part D sales?

WellCare will use an independent organization to anonymously monitor the compliance of Medicare Advantage sales agents. This national program began its rollout just before the announced voluntary suspension of the marketing for PFFS plans. Once WellCare meets the benchmarks outlined in the agreement with CMS and resumes marketing, the program will continue its phased nationwide rollout. The results of WellCare's secret shopper program will be reported directly by the independent organization to WellCare's corporate compliance department generally on a same day or next day basis.

QUESTION:

v. Do you conduct licensing and background checks on all agents/brokers, including independent agents/brokers? Please explain.

ANSWER:

Yes, WellCare conducts licensing and background checks on all brokers/agents, including independent brokers/agents. For independent agents/brokers, we conduct a federal and county of residence criminal background investigation, state insurance licensure verification and OIG and GSA exclusion list search upon initial application to contract and prior to assigning a producer ID. In addition, we perform a licensing and background on all of our contracted agents annually.

w. Please identify the field marketing organizations (FMOs) with which you contract.

ANSWER:

We are pleased to discuss this issue with the committee. However, given the proprietary nature of this information, we do not want to submit it for the Record.

Panel 2 and Panel 3 - Questions to all witnesses on Panels 2 and 3

Question 1 - National Registry for Agents/Brokers

Question:

Please elaborate on the concept of a national registry of agents, and explain your thoughts on what entity is best suited maintain the registry, what types of data the registry would contain, what types of complaints and/or disciplinary actions would result in an agent being placed on the registry, what parties would have access to the registry, and what the cost might be of implementing and maintaining such a measure.

ANSWER:

A national data base would provide information about agents and brokers that have been sanctioned by a state or terminated by a health plan. While most agents are ethical and professional in their marketing, a national data base would allow plans to track and quickly report any issues with rogue agents -- who sometimes seek to sell in other states when their bad behavior is discovered in one state. A national registry would provide a uniform process and criteria for reporting misconduct by licensed brokers, agents, and plan marketing staff in a timely fashion. This information would assist the Health Plans and States in promoting conduct that is in compliance with federal and state requirements. We are interested in working through AHIP and in cooperation with CMS and the NAIC on the design of the database.

Question 2 - CMS' Marketing Guidelines

Question:

Do CMS' marketing guidelines provide sufficient protections for beneficiaries? In your response, please indicate your opinion regarding whether the marketing guidelines allow any unacceptable practices.

ANSWER:

We believe that the marketing guidelines provide sufficient protection for beneficiaries. We believe that CMS' marketing guidelines are more thorough and restrictive than state laws or regulations regarding the sale of insurance. The guidelines detail comprehensive requirements for pre and post sale conduct, activities and materials and prohibit any unacceptable marketing practices.

Senator Blanche L. Lincoln Witness Questions
Hearing: Marketing and Sales of Medicare Advantage Plans

May 16, 2007

For Gary Bailey, WellCare

3. In your testimony, you mentioned using a "secret shopper" program to monitor compliance of sales agents. How exactly does this work? If the agent has done something unethical, how will he or she be penalized? Will you contact the seniors who were the agent's clients on that day and previous clients to make sure they were not misled into signing up for a Medicare plan that was not useful to them?

ANSWER:

WellCare has engaged an independent organization to anonymously monitor the compliance of Medicare Advantage sales agents. This national program began its rollout just before the announced voluntary suspension of the marketing for PFFS plans. WellCare provides a list of brokers by state to the vendor who randomly selects a broker to "shop." A questionnaire that was specifically designed for the PFFS program is filled out by the "evaluator" upon completion of the sales presentation. That questionnaire is emailed within 24 hours to WellCare where it is reviewed for two areas in particular. First, were there any compliance issues with the initiation of the visit, including but not limited to, sales tactics? Second, were the benefits explained clearly in a fashion that would not leave the prospective enrollee unsure of the product and its benefits? If WellCare receives an evaluation that suggests "unethical" behavior, it will be investigated and a sanction determination will be made, which includes termination of the broker contract. Once WellCare meets the benchmarks outlined in the agreement with CMS and resumes marketing, the program will continue its phased nationwide rollout. The results of WellCare's secret shopper program will be reported directly by the independent organization to WellCare's corporate compliance department generally on a same day or next day basis.

REPORT OF EXAMINATION

(Limited Market Conduct)

*** Modified ***

of

HUMANA INSURANCE COMPANY

NAIC COMPANY CODE 73288

As of

September 15, 2006

Medicare Parts C and D Coverage Plans

By the Oklahoma Insurance Department

TABLE OF CONTENTS

SALUTATION

December 4, 2006

Honorable Kim Holland
Insurance Commissioner
State of Oklahoma
2401 NW 23rd Street, Suite 28
Oklahoma City, Oklahoma 73107

Commissioner Holland:

Pursuant to your instructions and in compliance with the provisions of Title 36 of the Oklahoma Statutes, rules, regulations and procedures of the Oklahoma Insurance Department, and the procedures established by the National Association of Insurance Commissioners, a limited scope examination of the market conduct activities has been conducted of:

Humana Insurance Company
500 West Main Street
Louisville, Kentucky 40202

The report thereon, as of September 15, 2006, is herein respectfully submitted.

FOREWORD

This limited market conduct examination report reflects the Oklahoma insurance activities of Humana Insurance Company (hereinafter referred to as the "Company"). The examination is, in general, a report by test, wherein each test applied during the examination is stated and the results are reported, whether favorable or unfavorable. The Commissioner of Insurance of the State of Oklahoma is hereinafter referred to as the "Commissioner" and the Insurance Department of the State of Oklahoma is hereinafter referred to as the "Department."

HISTORY AND BACKGROUND

The Company is one (1) of the United States' largest health services companies providing governmental and commercial coverage. It offers coordinated health insurance coverage and related services to employer groups, government qualified beneficiaries and individuals. The Company utilized health maintenance organizations [HMO], preferred provider organizations [PPO], and administrative service only [ASO] programs.

The Company had been selected by the Centers for Medicare and Medicaid Services [CMS] as a national Medicare provider. The Company provided Medicare Part C programs via Medicare Advantage [MA] and Regional PPO [RPPO] products. The Company provided prescription drug coverage via Medicare Part D Prescription Drug Plan [PDP] programs. Hybrid Medicare Advantage plus prescription drug coverage plans were also offered; designated MA-PD.

The Company commenced the sale of MA and RPPO products in Oklahoma in the second half of 2005. The latter product was available in a limited geographic area and less than 100 contracts had been sold. The Part D plans were to become effective on January 1, 2006 and solicitation of these plans had commenced on November 15, 2005 in accordance with CMS guidelines. The plans were available to persons qualified for Medicare by reason of age, disability or medical status. These Medicare Qualified Persons are hereinafter referred to as "MQP" or "Persons."

The current examination was called by the Department to evaluate the Company's performance in marketing these new Medicare products to Oklahoma residents. It was triggered, in part, by an increase in complaints received by the Department specifically related to the sales of these products.

SCOPE OF EXAMINATION

The examination was conducted at the Company's offices located at 1100 Employers Boulevard, DePere, Wisconsin 54115. The period of review was July 1, 2005 through September 15, 2006. The on-site portion of the examination commenced June 27, 2006 and concluded on October 19, 2006.

The purpose of the examination was to determine Company compliance with Oklahoma insurance laws and regulations, and to determine if the Company's operations were consistent with the public interest. As mentioned above, the examination was limited to the Company's sales and marketing of Medicare Part C and D plans to MQP resident in Oklahoma.

Aspects of sales, marketing and claims practices of the Company may not subject to the jurisdiction of the Oklahoma Insurance Commissioner due to the fact that the examination is limited to Medicare Part C and D plans sold to MQPs. The violations set out in this examination report, other than those relating to licensing, may be preempted by federal law. If the Company's activities in marketing Medicare Part C and Part D were subject to Oklahoma Insurance Department jurisdiction, the violations set out in this report would be applicable to the Company.

The examination was conducted in accordance with the guidelines and procedures recommended by the National Association of Insurance Commissioners (NAIC), the rules, regulations and directives of the Oklahoma Insurance Department. In reviewing material for this report, the examiner relied on records and materials maintained by the Company, and the producer licensing and appointment records maintained by the NAIC on its I-SITE database.

The examiners' review of records was based on systematically selected records from computer data files provided by the Company. Upon review of each file, any concerns or discrepancies were noted on preliminary finding or inquiry forms and delivered to Company personnel identified by management as knowledgeable about the files. Once the Company was advised of a finding contained in a comment form, the Company was given an opportunity to respond.

This examination included the following areas of the Company's operations:

- Marketing and Agent Training
- Department of Insurance Complaints
- Consumer Complaints
- Presidential Complaints
- Agent Production and Licensing

MARKETING, PRODUCTS AND TRAINING

MARKETING

The Company utilized several marketing plans, programs and arrangements to solicit its Medicare Part C and D plans.

- Company licensed agent/employees sold these plans as the result of incoming telephone calls to Direct Marketing Services [DMS] company offices in Tampa and Miramar [greater Miami] Florida.

- Resident Humana MarketPoint [captive] and delegated [independent] agents solicited these plans within Oklahoma. The Company had entered a nationwide marketing agreement with Wal-Mart, and Wal-Mart affiliated stores. These resident agents staffed informational booths within these Wal-Mart locations to provide information and enroll MQP in the Company's Medicare plans. Texas resident captive and delegated agents had also solicited Oklahoma resident MQP under these programs.

- Resident agents of the State Farm group of insurance companies offered the Company's Part D PDP plans to their clients under a marketing agreement between the two (2) insurers.

- Texas resident agents of the USAA group of insurance companies solicited the Company's Medicare plans to their Oklahoma clients under a marketing agreement between the two (2) insurers. The two (2) companies had a history of business arrangements over the years and Humana provided group health insurance to USAA employees.

- MQP were also able to enroll in the Company's Medicare programs via the Company website on the Internet with or without agent involvement.

- Because participation in a Part D plan was mandated by CMS for MQP, some Persons were assigned to the Company by CMS as their designated PDP plan provider. No agent was generally involved in these assigned enrollments.

PRODUCTS

The Company offered a Medicare Part C regional PPO product, Humana Choice PPO, with three (3) benefit levels. The monthly premiums for these three (3) plan levels were $76, $117 and $126. Due to limited geographic availability and cost, only about 100 of these plans had been sold. The agent's annual commission for selling one (1) of these plans was $250.

The Company sold a Medicare Advantage Part C plan, Humana Gold Choice PFFS, with two (2) benefit levels. This product was geographically priced with a lower and higher premium structure. The lower price plans were available in fifteen (15) counties in Oklahoma, primarily in the northeastern section of the State surrounding Tulsa. The monthly premiums for these two (2)

levels were $13.79 and $19. The balance of the State's counties was sold the same product at higher premiums. The monthly premiums for these two (2) plans were $59 and $64.

All of these plans included prescription drug coverage when sold after January 1, 2006. The agent's annual commission for selling one of these plans was $250.

Effective in 2006, the Company sold Medicare Part D prescription drug plans; PDP. Three (3) plans were offered statewide in Oklahoma and were designated PDP Standard, PDP Enhanced and PDP Complete. The monthly premiums for these plans were $10.07, $16.67 and $57.85 respectively. These were statewide premiums with no regional adjustments. The agent's annual commission for selling one (1) of these plans was $50.

TRAINING

The Company provided two (2) levels of agent training programs. Both of these programs met CMS standards, and had been approved by CMS.

Company agent/employees working in the DMS offices in Florida, and agents recruited to be captive Humana MarketPoint sales representatives received a three (3) week training course. This training consisted of three (3) segments; Certification, Computer Training and Presentation Training, each lasting a week. Certification was product knowledge, Medicare requirements, ethics and compliance. Computer Training was learning the Company's data systems and how to process applications, research data, etc. Presentation Training was how to use the Company's sales materials, make a sales call, reply to an applicant's questions/concerns, etc.

Delegated agents, i.e. independent agents, were required to complete a mandatory sixteen (16) hour training course. This training course was segmented as follows:

- three (3) hours of self-study on Medicare and ethics;
- a one (1) day, nine (9) hour, class for Certification;
- and two (2), two (2) hour Post-Certification telephone conference calls.

Although approved by CMS, this training program did not appear to be sufficiently comprehensive to fully cover a topic as complex as Medicare and the products which these agents would be selling. Most of the complaints submitted, which alleged agent solicitation problems, occurred with agents who had received this "short course" training.

DEPARTMENT OF INSURANCE COMPLAINTS

According to the records of the Oklahoma Insurance Department, the Company had received fifty-six (56) complaints from members or providers during the examination period. Ten (10) of these complaints involved non-Medicare related products and were not included in this examination. The Company stated that it had no record of receiving three (3) of the complaints. The remaining forty-three (43) complaints were the subject of the following analysis.

Processing response times could be determined for thirty-six (36) of the forty-three (43) complaints. The processing time was calculated by measuring the interval of calendar days from the date the complaint was received by the Company to the date of the reply letter. The mean processing response time was sixteen and seven tenths (16.7) days; the median response time was seventeen and five tenths (17.5) days; and the mode response time was eighteen (18) days.

Title 36, Section 1250.4(B) of the Oklahoma Statutes establishes a response time limit of twenty (20) days to reply to any inquiry from the Commissioner. The following thirteen (13) complaints took more than the mandated response time.

DOI FILE #	RECEIVED	RESPONSE	DAYS
06 11 02324	7/17/2006	9/7/2006	52
06 18 01492	4/27/2006	6/1/2006	34
06 12 02167	6/28/2006	7/26/2006	28
06 11 01540	5/1/2006	5/26/2006	25
06 18 02770	8/7/2006	9/1/2006	25
06 12 01655	5/15/2006	6/9/2006	25
06 12 03232	9/18/2006	10/12/2006	24
06 12 02828	8/14/2006	9/7/2006	24
06 18 02989	8/28/2006	9/20/2006	23
06 18 02829	8/14/2006	9/5/2006	22
06 21 00675	3/6/2006	3/28/2006	22
06 12 01617	5/9/2006	5/31/2006	21
06 11 02860	8/17/2006	9/7/2006	21

Additionally, the Company failed to reply to the Department on seven (7) complaints that had been sent to its Louisville office. In most cases, the Company had attempted to resolve the complaint directly with the member, but no final response letter was sent to the Department. This is also a violation of Section 1250.4(B) of Title 36 of the Oklahoma Statutes. The Company violated 1250.4(B) of Title 36 of the Oklahoma Statutes on twenty (20) of the forty-three (43) Department complaints, an error ratio of 46.51%.

The Company did not have a centralized operation for the receipt and tracking of Department complaints. Most complaints were received at its Green Bay office and then assigned to the appropriate office for reply. Some complaints had been received directly from the Department at the Company's Louisville office. The Green Bay office was not aware of these complaints and did not record them on the register maintained in Green Bay.

As a result, the Examiner had to secure additional documentation from the Department to assist the Company in identifying the complaints against it. The Company's complaint register in this regard was incomplete in that it did not reconcile with the register maintained by the Oklahoma Department of Insurance. Three (3) complaints that had been registered against the Company by the Department could not be located by the Company.

Numerous files concerned allegations of improper agent sales practices and the Company initiated a Section A investigation of these allegations against the agent. These Section A investigations were conducted by the Company's regional office in Kansas City. No procedure was in place to consolidate the Section A documents and the complaint documents into a complete and final file. In every case, the examiner had to make a second request for the Section A documents in addition to the original complaint documents.

The Company's failure to maintain a complete record of all complaints received is a violation of Section 1250.5(14) of Title 36 of the Oklahoma Statutes.

The following fifteen (15) of the forty-three (43) complaint files reviewed, an error ratio of 34.88%, warranted comments primarily for the actions of the soliciting agent selling insurance for the Company. Such actions are a violation of Sections 1204(1) and (2) as well as 1435.13(A)(5) and (8) of Title 36 of the Oklahoma Statutes.

1. OK File # 06 21 00675, the agent completed an application for a PDP for the member on 11/29/2005.

At this time the member was insured under a Medicare Advantage policy issued by another insurer. The actions of the agent in enrolling this member caused the cancellation of this Medicare Advantage plan in accordance with CMS disenrollment guidelines. This PDP enrollment was not in the member's best interests as it resulted in cancellation of existing coverage and reversion to traditional Medicare Parts A and B. The agent knew, or should have known this.

The cancellation of the MA coverage was effective 1/1/2006 and the member incurred medical expenses on 1/30/2006 which were denied by the former insurer. The Company also denied coverage for these expenses in its letter of 3/21/2006. The agent's failure to properly advise the member resulted in the member's liability for these medical charges.

2. OK File # 06 24 00851, the agent completed an application for a PFFS MA plan for the member on 10/28/2005.

This member was satisfied with their traditional Medicare Parts A & B and a Medicare supplement policy and only wanted to purchase "drug coverage". This enrollment occurred prior to the initial enrollment date of 11/15/2005 for Part D prescription drug plans. The agent couldn't sell the drug coverage the member wanted but sold the member a MA plan that replaced her traditional Medicare plans. The member subsequently incurred hospital/medical expenses in February 2006 that the member believed were still covered by traditional Medicare and the Medicare supplement plan. The member believed that the agent had sold the "drug coverage" that was requested. The member stated that they specifically asked the agent if the Company's plan would have any effect on the existing coverage and the agent, according to the member, stated that it would not.

The Company responded to the member's complaint on 4/3/2006 and stated in this letter that an investigation and further review of the allegations against the agent would be conducted by the Company's Regulatory Compliance Department. A form requesting a Section A investigation of this agent was completed on 3/29/2006. This investigation was not commenced however.

The Section A investigation of this agent did not begin until the file was reviewed during the current examination and the investigation results were requested. Based upon the member's allegations of lying and fraud by the agent, the Company conducted a Section A investigation and obtained an agent's statement. The Section A investigation was conducted in August 2006.

The Company concluded that the member's allegations were "unfounded", but did note that the agent had used an older application form to enroll the member that didn't contain some of the disclosures that the current form did. The agent was directed to always use the most current application form and destroy any older forms on hand.

The Section A investigation failed to address the impact this sale had on the member's level of coverage of the expenses incurred in February other than to state generically that coverage would be provided in accordance with the terms of the Company's policy. The agent's failure to properly provide the coverage the member requested was not in the member's best interests. The PDP plan desired by the member was not available at the time of solicitation and the member should have been so advised.

3. OK File # 06 18 01416, the agent completed an application for a PFFS MA plan for the member on 11/12/2005.

This complaint was filed by the member's Medicaid case manager. The member had lifelong mental conditions which had resulted in prior hospitalizations and current treatment in an out-patient counseling program. Serious allegations against the agent were expressed in the initial complaint documents including compromises of the member's physical and mental health and treatment. The Company responded to the case manager/complainant and the Department that an AOR form [Appointment of Representative] needed to be completed for the Company to proceed with the complaint. This form was never received and the file remained dormant. The Company apparently felt no obligation to pursue the allegations without an AOR form.

At the request of the examiner upon reviewing this file during the current examination, a Section A investigation was conducted. It was clear from this investigation that the member was confused as to what she had purchased and how it would work. Carlene Marra, Director, Regulatory Compliance for the Company, upon listening to the verification recording made the following observations and statements in the Section A documents:

"Upon review of the recording, [member] is noticeably confused when comparing the Medicare Advantage plan to a Medicare Supplement plan and then confused everyone on the call (agent was on the call, as well) when she kept referring to her Social Security disbursement as 'my Medicare' throughout the call....[Member] was lucid and interactive with the agent and the verifier. It is unclear from the recording whether or not she truly understood the plan she was purchasing although she acknowledged that she did."

An email message from Ms. Marra to George Hammontree/Kansas City/Humana dated 8/1/2006 further stated:

"George- I just finished listening to the sales verification tape on this one. While I really don't think the member understood what kind of policy she was purchasing, I heard no signs of diminished capacity. I'm not sure she really understood the plan but she was not enrolled against her will or without her knowledge. She was lucid and interactive."

The complainant never alleged that the member was enrolled against her will or without her knowledge of the act, only that she didn't understand what she was purchasing and how it would work in lieu of traditional Medicare Parts A & B and in conjunction with her Medicaid eligibility. The Company's training material defines acts or situations which constitute Major Section A Violations. One (1) of these examples is; "The sale of an MA product to a person who is obviously unable to understand the product". This is clearly what occurred with this member, and the agent, and the Company telephone verifier knew this and did not void the transaction pursuant to Company guidelines. Despite the serious allegations of the complaint, this case would have remained dormant unless this examination was conducted and the examiner requested a Section A inquiry. Even then, the Company viewed this case as an "unfounded, lesser Section A" matter. It was clear that the Section A investigation was conducted more to mitigate, justify and defend the actions of the agent and the Company than to rectify the actions of the agent in enrolling this confused and impaired member. An agent's statement was requested, but never received.

The Company drew conclusions based upon administrative lag times and disenrollment problems, when this member should have never been sold this product to begin with. She was subjected to serious compromises of her physical and mental well-being due solely to the acts of the agent in proceeding with the sales transaction in direct violation of the Company's own sales and training standards. What should have occurred is clearly stated in the Company's training manual;

"The ability of a prospect to comprehend a Humana MA plan and how to use it is an important ethical consideration." Agents "CANNOT [Company's emphasis] take enrollment applications from individuals who do not have the ability to comprehend the plan and how to use it."

4. OK File # 06 18 01492, the agent completed an application for a PFFS MA plan for the member on 9/6/2005.

This complaint was filed by the office manager of the member's physician. The member was being treated in an out-patient program for dementia and receiving home health care. Member's recollection was that a man came to her home and sold her something. The member's home health care expenses were not being paid correctly and some prescription drug charges had gone unpaid.

These allegations had been informally researched in March 2006 in response to a telephone inquiry from the OK SCHIP office. Upon receipt to this formal complaint, and a properly completed AOR form, the Company commenced a Section A investigation. A brief agent's statement was obtained from the agent that contained the following statement; "She seemed to fully comprehend everything and I would never enroll someone who appeared to not understand." Clearly, however, that is exactly what occurred.

The medical professionals who were treating the member indicated she had dementia. The agent, nor the verifier, nor the Company personnel who conducted the Section A investigation were medically trained. When these allegations were presented, regardless of the impressions of the agent or Company personnel, an immediate disenrollment should have been processed. Enrollments cannot be processed for members with mental impairment, and discovery of diminished mental capacity after the fact must void the prior enrollment.

5. OK File # 06 11 01540, the agent completed applications for PFFS MA plans for the member and his wife on 10/27/2005.

This complaint was filed by the member's daughter-in-law. Serious allegations against the agent were expressed in the initial complaint documents including misrepresentation in completing the two (2) enrollment forms. The agent had used the member's son's address in the lower rated area of Oklahoma to obtain the lower premium rate for these enrollments. The member's legal residence was in the higher rated area of the state. On 5/3/2006, the Company responded to the complainant and the Department that an AOR form [Appointment of Representative] needed to be completed for the Company to proceed with the complaint. This form was never received and the file remained dormant. A final letter to the Department had been sent on 5/26/2006 which provided the current status of the policies, advised that the AOR form had not been received but did not address the agent allegations. The Company apparently felt no obligation to pursue the allegations against this agent without an AOR form.

Upon review of this complaint during the current examination, and at the request of the examiner on 7/13/2006, a Section A investigation was commenced. An agent's statement was requested but never received. The Section A investigation was completed on 7/19/2006 with a determination of a "Founded" Section A violation.

One (1) of the Company's stated Major Section A violations was, "Deliberate or negligent omission or falsification of significant information on any company form." Section 1435.13 (A)(5) of Title 36 of the Oklahoma Statutes prohibits "Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance." Violations of this Section are grounds for agent license suspension or revocation.

The Company stated,

"The Compliance Director's Section A investigation file on this agent, like any other Section A investigation file, is an investigation and recommendation only. It is not finalized until Legal reviews and renders their final determination. Due to the seriousness of the allegation, we feel the agent should have the opportunity to respond. As such, we are holding final judgment in order to allow the agent additional time to respond."

Three (3) months later, at the conclusion of this examination, the agent was still a licensed and appointed agent of the Company.

6. OK File # 06 12 01655, the agent completed an application for a PDP plan for the member on 12/23/2005.

Both the member and the agent noted that the wrong plan number had been placed on the enrollment form and both contacted the Company to note this error and ask for correction. When

the correction in plan type was not made, the member submitted a complaint to the Department. In addition to the error in plan type, the member also mentioned a problem with medication dosage and formulary limitations. The member made it clear in the letter that his complaint was not against the agent, but rather against Humana for failing to correct the error.

On 6/9/2006, the Company responded to the Department on the complaint, which resolved the prescription drug issue, but did not address the enrollment form error in plans. The caption of this letter does indicate that the correct plan was implemented on 4/1/2006, but that the incorrect plan was in force from 1/1/2006 to 3/31/2006. A retroactive correction was what the member had requested from the Company in the complaint.

Upon review during the current examination, the examiner advised the Company of this omission in its letter of 6/9/2006. The Company concurred with this oversight and contacted the member for direction on how best to resolve the issue. The member asked for a premium refund and the Company agreed. The complaint was finalized by the Company's letter of 7/24/2006.

The enrollment form was completed by the agent on 12/23/2005, but she was not appointed to represent the Company until 2/22/2006, two (2) months later. Section 1435.15 of Title 36 of the Oklahoma Statutes requires that a licensed insurance producer obtain an appointment with any insurer with which he/she places insurance and otherwise acts as agent of the insurer within forty-five (45) days of submitting an application. The Company stated that it had made an electronic appointment request on 1/20/2006 and that a check for the appointment fee was mailed three (3) days later. The Company maintained that the appointment request was timely, and that the delay occurred with the Department processing.

7. OK File # 06 12 01734, the agent completed an application for MA PFFS plan for the member on 10/12/2005.

The member had, at the time of this enrollment, traditional Medicare Parts A & B and a Medicare supplement policy with Blue Cross/Blue Shield of Oklahoma. Enrolling this member in the Company's MA plan replaced his traditional Medicare and invalidated his Medicare supplement coverage. The Blue Cross/Blue Shield plan would only supplement traditional Medicare, not Medicare Advantage plans. The agent did not explain this to the member prior to enrollment. The member's plan became effective 11/1/2005 and he incurred hospital and medical expenses in November 2005 and January 2006.

These claims were paid by Humana, but remaining balance was denied by Blue Cross/Blue Shield as stated above. The member had to borrow against his house to pay for these uninsured hospital and medical expenses. This was solely due to the failure of the agent to properly explain his existing coverages and the impact thereon of purchasing a Medicare Advantage plan.

8. OK File # 06 08 02672, the agent completed an application for MA PFFS plan for the member on 12/7/2005.

The member had traditional Medicare Parts A & B and was also covered by Medicaid, which, when combined, provided complete coverage for hospital and medical expenses. The member had a number of serious, chronic medical conditions which required continuing medical care. The member wanted to purchase a PDP plan to compliment the other coverage. The agent sold the

member a Medicare Advantage plan instead. The agent was not an English speaking native. There were questions of whether he could adequately explain complex Medicare programs so that the member could fully understand the product. Clearly, the member was not sold the product they desired. No telephone verification of this sale was on file, so the member's understanding of what was purchased could not be determined. The member stated that because of the enrollment in the Company's MA plan, some claims incurred in March 2006 had not been fully paid. The Company's letter to the Department of 8/8/2006 failed to address these unpaid claims allegations.

The member remained in the MA plan from 1/1/2006 to 4/1/2006, and then was disenrolled from this plan. Effective 4/1/2006, the member was enrolled in a PDP plan as originally desired. A Section A investigation was conducted of the agent's solicitation activities, but the Company reached an "inconclusive" determination and closed the investigation. An agent's statement was obtained but it too was inconclusive, non-specific and written in broken grammar.

A Company statement in the Section A documents stated, "Given written statement from agent, communication may be a problem between this agent & senior population. Recommend retraining if agent is to continue."

It appeared that a retro-active total disenrollment from the MA plan should have been considered, and the PDP coverage, that the member wanted, put in place effective 1/1/2006. If this was implemented, the unpaid/underpaid claims situation might have also been resolved.

9. OK File # 06 12 02167, the agent completed an application for MA PFFS plan for the member on 3/13/2006.

The member stated he was "quite satisfied" with his existing coverage, which included Medicaid. The member wanted to discuss the Company's plan with his pharmacist before making a decision to buy. The agent asked the member to complete an enrollment form at the time of his visit so that the agent would not have to make a return trip to enroll the member. The agent told the member he could just call to disenroll if he didn't want the plan. A post-sale telephone verification was not conducted. Agents are specifically instructed not to hold enrollment forms as part of the Company's agent training program. This is mentioned because this agent had a pattern of accepting pending enrollment forms from members as will be discussed further.

The member then made numerous attempts to disenroll in the plan, contacting both the Company and the agent. The Company, after investigating the member's concerns, processed a retroactive disenrollment which voided all Humana coverage. The agent's act of accepting a pending enrollment form was the basis for the comments relative to this solicitation.

10. OK File # 06 11 02388, the agent completed an application for MA PFFS plan for the member on 1/13/2006.

Member had traditional Medicare A & B plan and was eligible for VA care and benefits and wished to purchase a PDP plan. Agent sold member a MA plan as stated above which became effective 2/1/2006. This sale was not verified pursuant to Company sales procedures. On 3/1/2006 member called Company to have MA plan cancelled and replaced with the PDP coverage because this is what was wanted/needed due to existing coverage. The Company stated that member was told to complete an AEF [abbreviated enrollment form] to request this change in

writing. This form was never received by the Company. It wasn't clear from the file documents if the Company had provided the member with an AEF form to complete. Note in file indicated that the change needed to be effected through the Company's Benefits and Enrollment department but wasn't referred to this department for thirty (30) days.

The member was subsequently scheduled for surgery, but was advised that under the MA coverage a copayment of $2500 would have to be paid. Under the former coverage no copayment would have been charged and richer benefits would have probably been available. This agent was criticized for not selling the coverage desired by the member, not acting in the member's best interests considering the existent coverage and failing to obtain a sales verification. An agent's statement was requested but never received, and the Section A investigation was closed as "unfounded". The Section A documents stated: "While still pending the receipt of the agent's statement, my preliminary finding is that this is a frivolous allegation of misrepresentation on the part of the member to avoid lock-in."

Again, it appeared that the intent of the Section A investigation was to mitigate, justify and defend the actions of the agent to the detriment of the member.

11. OK File # 06 11 02827, the agent completed an application for MA PFFS plan for the member on 2/22/2006.

The member had traditional Medicare Parts A & B as well as a Medicare supplement policy with another insurer. The member initially was going to purchase a PDP plan but was convinced by the agent to purchase the MA plan instead. The premium for the PDP plan would have been $16.67 per month and the agent's commission was $50. The premium for the MA plan that was sold was $13.79 per month and the agent's commission was $250. The premium for the Medicare supplement was $1670 per year. This sale was not verified telephonically.

The member alleged that the agent stated that the member could keep the Medicare supplement along with the MA plan. Subsequent claims were paid by the MA plan, but the Medicare supplement insurer refused to pay because it supplemented traditional Medicare only, not MA plans. The member had continued to pay premiums for the Medicare supplement coverage based upon the statements of the agent that he could continue this existing coverage.

As the result of this complaint being reviewed during the current examination, the Company conducted a Section A investigation. An agent's statement was requested but never received. The finding of the Section A investigation was "inconclusive". The MA plan was subsequently terminated as of 5/31/2006 and a PDP enrollment became effective 6/1/2006. This is the coverage the member had initially wanted.

12. OK File # 06 12 02828, the agent completed an application for MA PFFS plan for the member on 2/6/2006.

The member and his wife were retired from Tulsa and now resided in Delaware county. On a PDP enrollment form completed 12/21/2005 the member's address is listed as Delaware county and that he had lived there more than 90 days. On the MA enrollment form completed on 2/6/2006, the agent had initially entered the Delaware county address, but then crossed through it and entered an address in Tulsa county. The agent indicated that the member had lived at the Tulsa address for

more than ninety (90) days, even though forty-seven (47) days earlier the PDP enrollment form had indicated residency in Delaware county. The premium difference was about $45 per month, with the plan less expensive at the Tulsa county address. In his complaint to the Department, and all other correspondence, the member indicated that his address was in Delaware county.

One (1) of the Company's stated Major Section A violations was, "Deliberate or negligent omission or falsification of significant information on any company form." Section 1435.13 (A)(5) of Title 36 of the Oklahoma Statutes prohibits "Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance."

Additionally, the agent indicated that he would hold the enrollment form for the member for a week while he made up his mind. The reason given by the agent for doing this was to save him the time and expense of a return trip to the member's home to secure an enrollment form. Agents are specifically instructed not to hold enrollment forms as part of the Company's agent training program.
As a result of the current examination a Section A investigation of the agent was commenced on 8/28/2006. An agent's statement was obtained but did not address the allegation of holding the enrollment form. The situation of the changed address was not mentioned in the member's complaint to the Department because the member was not aware of the regulatory importance of this change. Notes in the Section A investigation file made reference to "several open files for the agent" and "not the first allegation like this for this agent". The Section A investigation was closed on 9/12/2006 as "inconclusive". The Company ultimately cancelled the member's unwanted plans and placed him in the Standard PDP plan that he desired.

13. OK File # 06 18 02829, the agent completed an application for MA PFFS plan for the member on 11/8/2005.

Member stated that he had been initially contacted to enroll in a PDP plan, but when the agent arrived he was sold a MA plan, which the member characterized as an "HMO" plan. This enrollment occurred prior to the initial PDP start-up date of 11/15/2006. The PDP plan that the member wanted was not available for purchase yet, but the agent did not inform the member of this fact. This sale had been verified by an outbound telephone call on 11/10/2005, but the verifier was no longer employed by the Company and the recording was no longer available. When the member became aware of the plan he had actually been sold, he and his family members made numerous attempts to effect a disenrollment. The Company's letter of 9/5/2006 denied the member's request to disenroll and informed him that he was locked into his coverage until 11/15/2006.

As a result of the current examination, a Section A investigation of the agent was commenced on 8/28/2006. An agent's statement was obtained but was not specific to the member's allegations.
The Section A investigation was closed on 9/12/2006 as "unfounded". However, a recommendation to allow a retro-active disenrollment was suggested as there was sufficient information in the file to support the member's prior attempts at disenrollment.

At no time during this investigation did the questions of the agent selling the member an unwanted plan, or the use of "bait and switch" tactics to secure the initial invitation into the member's home were considered. The agent should have informed the member that the PDP plan he wanted was not yet available and possibly scheduled a return appointment.

On 8/16/2006, the agent contacted the Department regarding the number of complaints against him. He told the Department that he felt that Humana "was the only company he was having trouble with due to the fact most of the hospitals and doctors in Northeastern Oklahoma would not accept Humana". While this was correct earlier in 2006, most providers had agreed to accept all Medicare Advantage plans, not just Humana's, effective 5/16/2006. The agent was clearly uninformed about the facts of this situation and his ability to properly advise members could reasonably be questioned.

14. OK File # 06 12 03232, the agent completed an application for MA PFFS plan for the member on 6/14/2006.

The member was covered by traditional Medicare Parts A & B and had a Medicare supplement policy as well. At the time of enrollment, the member was not eligible for coverage.
The agent sold, and the verifier certified, the sale of the MA plan. Both the member and spouse had prior coverage under a Humana PDP plan at the time of this solicitation.

The member submitted the complaint alleging agent misrepresentation of the product and how it worked. The member was confused because they had "lost" their traditional Medicare benefits. But they were still paying Medicare premiums for the MA plan. As a result of this complaint, a Section A investigation was conducted and an agent's statement obtained. The investigation resulted in the allegations of misrepresentation being "dismissed".

However, during the processing of the complaint it was determined by the Company that the enrollment had been done in error, so the member was disenrolled from the MA plan and re-enrolled in the Company's PDP plan. The member was returned to the insurance status they had been in prior to the enrollment of 6/14/2006.

This file was chosen for comment because the agent should have been aware that the member was not eligible for enrollment. Also of note was the following Company comment in the Section A documents; "It is unfortunate that the lock-in can be potentially 'unlocked' with a sales agent allegation. I am trying to review these at the onset to determine whether I accept them as a Section A or if they are truly a frivolous request in hopes of getting out of lock-in." Carlene Marra was the author of this statement on 8/31/2006. The examiner felt that it was indicative of the general Company attitude toward conducting Section A investigations of agent misrepresentation and inappropriate sales practice allegations and complaints.

15. OK File # 06 18 03297, the agent completed an application for MA PFFS plan for the member on 6/15/2006.

The member had an existing PDP with the Company that had been purchased in January 2006 from another agent. The member was then contacted by the agent who enrolled the member in the MA plan. The member alleged that the agent stated that the MA plan offered the same level of drug coverage as the existing PDP plan and additional coverage for hospitals, doctors and other providers. When the member had prescriptions filled in July 2006 she discovered that the level of coverage was not the same with the MA plan.

Member filed a grievance with the Company on 7/26/2006, requesting cancellation of the MA plan and reinstatement of the prior PDP plan. The Company replied on 8/14/2006, advising the member that the allegations of agent misrepresentation were being referred to the Regulatory Compliance Department "for review and further investigation". This was not correct; no agent investigation was commenced at this point. The Member's request for cancellation of the MA plan and reinstatement of the PDP plan was not addressed by the Company at all.

On 9/25/2006, the Company received the member's complaint via the Oklahoma Insurance Department containing the same concerns as the prior grievance. The company replied to the Department on 10/6/2006, providing a copy of its grievance response of 8/14/2006, advising that the agent misrepresentation allegations were being investigated. It denied the member's request for cancellation of the MA plan and reinstatement of the PDP plan on the basis that it was not timely. A statement from the agent was provided but it was generic and the agent could not remember any specific details of the member's enrollment which he stated occurred in January 2006. The enrollment occurred on 6/15/2006.

The member originally had traditional Medicare Parts A & B, the Humana PDP plan and a Medicare Supplement policy. As such, she was entitled to a "trial period" under the MA plan, during which time disenrollment was allowed. The Company subsequently recognized this fact in response to an inquiry from the examiner, and on 10/12/2006 processed a retroactive disenrollment from the MA plan. The Section A investigation of the agent was finally opened on 9/27/2006, two (2) days after receipt of the complaint from the Department. The Company closed the Section A investigation on 10/17/2006 as "unfounded".

CONSUMER COMPLAINTS

A sample of ninety-eight (98) consumer complaints, received by the Company during the examination period, was selected for review. Fourteen (14) of these consumer complaints were also Department of Insurance complaints and were included in the preceding section of this examination. Of the remaining eighty-four (84) complaints reviewed, forty-two (42) fifty percent (50%) of these complaints related to questions regarding prescription drug coverage and formulary, FDA or CMS limitations/restrictions.

The processing time for these complaints was calculated by measuring the interval of calendar days from the date the complaint was received by the Company to the date of the reply letter. The mean processing response time was fifteen and five tenths (15.5) days and the median response time was eight (8) days.

Section 1250.4(C) of Title 36 of the Oklahoma Statutes establishes a response time limit of thirty (30) days to reply to pertinent written communications. The following twelve (12) of the forty-two (42) complaints, an error ratio of 28.57%, took more than the mandated response time.

RECEIVED	RESPONSE	DAYS	CASE NUMBER
2/16/06	6/5/06	110	901724510310
2/1/06	4/11/06	69	967592453117
3/28/06	5/31/06	65	553694270015
1/17/06	3/20/06	62	979513084217
3/31/06	5/25/06	56	565375093009
2/15/06	4/4/06	48	263149132018
08/10/06	09/26/06	47	765395582509
08/02/06	09/15/06	39	145821090111
3/22/06	4/28/06	37	409571085012
1/17/06	2/23/06	36	294643312915
07/27/06	08/30/06	35	176907243404
07/12/06	08/12/06	32	381263440716

The review of the following complaint warranted comments primarily for the actions of the soliciting agent selling insurance for the Company. Such actions are a violation of Sections 1204(1) and (2) as well as 1435.13(A)(5) and (8) of Title 36 of the Oklahoma Statutes.

Complaint # 176907243404, the agent completed an application for MA PFFS plan for the member on 12/29/2005.

The member was a "moderately mentally challenged" young woman, twenty-one (21) years old with a mental age of five (5), according to her parents. She was eligible for Medicare because of her disability and her parents were attempting to secure Part D coverage for her. The member and her mother were enrolled by the agent at a Wal-Mart and alleged that the agent "rushed them

horribly and explained nothing". They said that the agent stated that they were his last customers for the day and that he was in a hurry to complete the enrollment and leave. Although the member's parents wanted only Part D coverage, the agent completed a Part C MA PD enrollment form over the objections of the member's mother.

The mother stated that they were only interested in Part D coverage for their daughter, and the agent allegedly stated that this was what they were purchasing and that there was no premium involved. The sale was not verified by telephone verification with the Company.

The Company commenced a Section A investigation of the agent's alleged misrepresentations on 8/1/2006. An agent's statement was not obtained because, according to his sales manager, his contract had been terminated. The Company closed the Section A investigation on 9/9/2006 with an "inconclusive" determination, due partially to a lack of an agent's statement. At the conclusion of this examination, the agent was still licensed and appointed with the Company. The Company retro-actively disenrolled the member from the MA PD plan and placed her in an appropriate Part D plan.

The following complaint also warranted comment.

Complaint # 604735100212 was submitted by the member on 8/4/2006.

The member was seeking approval of a prescription drug, **Limbrel**, for treatment of osteoarthritis. The Company replied on 8/8/2006 that **Librium** was in a specifically excluded class of drugs under the Social Security Act. The Company statement was correct; but inappropriate to this case in that it failed to address the member's complaint and request for consideration of **Limbrel**. Clearly, there was a mistake in reviewing the member's complaint that should be corrected.

PRESIDENTIAL COMPLAINTS

The Company provided four Presidential complaints for review. These were consumer complaints that had been addressed to the Company president or other executive officer. The processing time for these complaints was calculated by measuring the interval of calendar days from the date the complaint was received by the Company to the date of the reply letter.

Section 1250.4(C) of Title 36 of the Oklahoma Statutes establishes a response time limit of thirty (30) days to reply to pertinent written communications. Two (2) of four (4) complaints, an error ratio of 50%, had taken longer than the mandated thirty (30) days for response.

Complaint # 716159520110 was received 2/20/2006 and replied to 3/31/2006, thirty-nine (39) days later. Complaint # 293899062914 was received 2/7/2006 and replied to 5/5/2006, eighty-seven (87) days later.

No other comments were warranted.

AGENT PRODUCTION AND LICENSING

The Company utilized both captive and delegated independent agents to solicit its Medicare plans. It also operated two (2) DMS customer service centers in Tampa and Miami, Florida to process incoming telephone requests from Persons interested in purchasing Medicare plans. The staff members at these service centers were Company employees and licensed/appointed agents. Other captive agents operated via the Humana MarketPoint agency system. Independent agents were also recruited by the Company to offer its products to the Medicare eligible market.

The Company had marketing arrangements with the State Farm insurance group and the USAA insurance group to utilize agents of these two (2) companies to market its Medicare products. The State Farm agents only sold the Part D PDP products, primarily to their existing clients from their traditional agency offices within the State of Oklahoma.

Section 1435.4 of Title 36 of the Oklahoma Statutes requires persons to obtain an insurance license prior to selling, soliciting or negotiating insurance. Section 1435.14 of Title 36 of the Oklahoma Statutes prohibits payment of commissions or other valuable consideration by an insurer to an agent that is not licensed. Section 1435.15 of Title 36 of the Oklahoma Statutes requires that a licensed insurance producer obtain an appointment with any insurer with which he/she places insurance and otherwise acts as agent of the insurer.

The current examination reviewed all agents who had solicited the Company's Medicare plans to Oklahoma residents during the examination period. The Company's records and the NAIC I-SITE agent licensing data base provided the basis for conducting this review. Each agent's licensing and appointment status was ascertained from the NAIC database and then compared with his/her solicitations of the Company's Part C and D plans to MQP resident in Oklahoma.

The production of approximately 950 agents was reviewed. The following chart summarizes the findings of this review. The chart indicates 955 findings because some agents had violations in more than one category.

A total of 656 agents' solicitations were in full compliance with all applicable insurance laws related to licensing and appointment. The examiner made no evaluation of compliance with CMS or other Federal laws or requirements.

A total of 123 agents, an error ratio of 12.88%, conducted solicitations prior to obtaining a proper and timely appointment to represent the Company. Section 1435.15 of Title 36 of the Oklahoma Statutes provides that an appointment must be secured within forty-five (45) days of submitting the first application to the company or the execution of the agency contract. These agents were properly licensed to sell health insurance in the State of Oklahoma and were eventually properly appointed, but did sell, solicit and negotiate the Company's Medicare Part C or D plans more than forty-five (45) days prior to obtaining an appointment to represent the Company.

A total of 108 agents, an error ratio of 11.31%, were conducting solicitations without obtaining an appointment to represent the Company. These agents were properly licensed to sell health insurance in the State of Oklahoma but were not appointed by the Company at the time of review.

Sixty-eight (68) agents, an error ratio of 7.12% conducted solicitations of the Company's Medicare plans to Oklahoma residents without obtaining the proper producer licensing to sell health insurance in the State of Oklahoma at the time of review.

			Tampa	Miami	Oklahoma resident	State Farm	USAA	Texas Resident	All Others
In Compliance	**656**	**68.69%**	144	29	157	158	88	42	38
Delayed appoint.	**123**	**12.88%**	7	0	51	22	4	24	15
No appointment	**108**	**11.31%**	0	7	12	66	2	7	14
No OK license	**68**	**7.12%**	17	9	0	0	0	18	24
TOTAL	**955**	**100.00%**	168	45	220	246	94	91	91

In the detailed summaries following, the column headed "APPS" indicates the number of transactions where the agent failed to comply. This number is an approximation based upon the Company's records. Numerous policy records failed to contain the name of the writing agent. Others were noted as "Employers Health Ins House" which the Company stated was a "house account" which included orphaned cases, cases written without an agent, i.e. direct enrollments via the Internet, or other business assigned to the Company.

Due to time constraints, the examiner made no effort to determine the exact number of applications solicited by each agent, but relied on the information provided by the Company. An exact accounting would have required individual review of approximately 60,000 applications.

Tampa DMS Employee/Agents

Records for 168 employee/agents who worked in the Company's Tampa DMS service center were reviewed, 144 agents were determined to be in compliance. The following agents were determined to be non-compliant in one of three areas; delayed appointment, no appointment or no Oklahoma license.

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
EUGENE	LABONTE	7	TAMPA	977910	DELAYED APPT
LARRIE	LEPARD	4	TAMPA	974854	DELAYED APPT
BETTY	MCGEE	1	TAMPA	966722	DELAYED APPT
AMBREIA	MELTON	8	TAMPA	974777	DELAYED APPT
DIANA	PEREZ	4	TAMPA	974872	DELAYED APPT
AMY	RICHARDSON	2	TAMPA	976212	DELAYED APPT
ANN	TAYLOR	8	TAMPA	977896	DELAYED APPT
BRANDI	ALFORD-GERMAN	1	TAMPA		NO OK LICENSE
CHRISTIE	BALDWIN	1	TAMPA		NO OK LICENSE
ANGELEE	BEERSINGH	7	TAMPA		NO OK LICENSE
PAULA	BRYDER	1	TAMPA		NO OK LICENSE
KATHERYN	CUEVAS	1	TAMPA		NO OK LICENSE
JASON	DENNARD	1	TAMPA		NO OK LICENSE
WALDEN	FITZGERALD	1	TAMPA		NO OK LICENSE
JOSEPHINE	FOX	2	TAMPA		NO OK LICENSE
PATRICIA	GOODRIDGE	2	TAMPA		NO OK LICENSE

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
PATRICIA	JONES	3	TAMPA		NO OK LICENSE
SULTAN	MASHNI	3	TAMPA		NO OK LICENSE
BETTY	MCGEE	1	TAMPA		NO OK LICENSE
DILLANO	RAGBIRSINGH	1	TAMPA		NO OK LICENSE
JESSICA	RAJNUS	1	TAMPA		NO OK LICENSE
JOHANNA	ROUBA	2	TAMPA		NO OK LICENSE
KATASKA	ROZIER	1	TAMPA		NO OK LICENSE
GEORGE	WAGENER	1	TAMPA		NO OK LICENSE

Miami DMS Employee/Agents

Records for forty-five (45) employee/agents who worked in the Company's Miami DMS service center were reviewed, twenty-nine (29) agents were determined to be in compliance. The following agents were determined to be non-compliant in one (1) of two (2) areas; no appointment or no Oklahoma license.

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
TIFFANIE	DIXON	3	MIAMI	973951	NO APPOINTMENT
LISA-LASHA	FRANCIS	1	MIAMI	981478	NO APPOINTMENT
LIANA	GRANT	5	MIAMI	973946	NO APPOINTMENT
JOHN	JACKSON	2	MIAMI	975674	NO APPOINTMENT
BRENDA	LORENZO	13	MIAMI	975262	NO APPOINTMENT
ELIZABETH	MURILLO	4	MIAMI	974025	NO APPOINTMENT
JENNIFER	TORRES	4	MIAMI	974020	NO APPOINTMENT
JANICE	AUSTIN	2	MIAMI		NO OK LICENSE
NICOLA	CARROLL	1	MIAMI		NO OK LICENSE
LICETTE	GARCIA	5	MIAMI		NO OK LICENSE
MARILYN	KINGSBURY	3	MIAMI		NO OK LICENSE
CHERRIE	MCRAE	1	MIAMI		NO OK LICENSE
MAYRA	REYES	1	MIAMI		NO OK LICENSE
YAMILE	RODRIGUEZ	1	MIAMI		NO OK LICENSE
ALINA	SOTO	2	MIAMI		NO OK LICENSE
WIDLYYNE	TANELUS	1	MIAMI		NO OK LICENSE

Oklahoma Resident Agents

Records for 220 Oklahoma resident agents were reviewed, 157 agents were determined to be in compliance. The following agents were determined to be non-compliant in one (1) of three (3) areas; delayed appointment, no appointment or no Oklahoma license.

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
MYRON	ANDERSON	1	RESIDENT	008550	DELAYED APPT
JASON	ATWOOD	45	RESIDENT	194563	DELAYED APPT
REBECCA	AUTRY-ZARRABI	4	RESIDENT	197762	DELAYED APPT
FRED	BARNES	1	RESIDENT	102398	DELAYED APPT
ROBERT	BARNETT	20	RESIDENT	019053	DELAYED APPT
SUSANNE	BECKERT	3	RESIDENT	302510	DELAYED APPT

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
PAULA	BRASSFIELD	1	RESIDENT	003338	DELAYED APPT
KAREN	CAIN	1	RESIDENT	301476	DELAYED APPT
PETER	CARRELS	10	RESIDENT	199745	DELAYED APPT
LORETTA	COCHRAN	1	RESIDENT	193789	DELAYED APPT
JAMES	CROUSE	4	RESIDENT	402222	DELAYED APPT
MARK	DALY	83	RESIDENT	008983	DELAYED APPT
DAVID	EVANS	1	RESIDENT	193936	DELAYED APPT
CHRISTINA	FORD	1	RESIDENT	195236	DELAYED APPT
STEVEN	GLASS	1	RESIDENT	022761	DELAYED APPT
SCOTT	GRAVES	31	RESIDENT	301433	DELAYED APPT
TERRY	GRAY	363	RESIDENT	303695	DELAYED APPT
BETTY	HELM	7	RESIDENT	198553	DELAYED APPT
S BRUCE	HUGILL	2	RESIDENT	201017	DELAYED APPT
RICHARD	JENKINS	6	RESIDENT	006452	DELAYED APPT
JOSEPH	JOYCE	1	RESIDENT	406988	DELAYED APPT
GLENN	KIMES	7	RESIDENT	197920	DELAYED APPT
JOHN	LAMBERT	1	RESIDENT	004480	DELAYED APPT
BILL	LEWELLING	12	RESIDENT	231060	DELAYED APPT
MICHAEL	LIPPERD	2	RESIDENT	000793	DELAYED APPT
RICHARD	LLOYD	1	RESIDENT	409658	DELAYED APPT
JAY	MCMENAMY	6	RESIDENT	104865	DELAYED APPT
ROGER	MURRAY	8	RESIDENT	408914	DELAYED APPT
KRISTIE	MYERS	19	RESIDENT	193097	DELAYED APPT
JACK	OGLETREE JR	2	RESIDENT	105126	DELAYED APPT
TONI	PAXTON	53	RESIDENT	103755	DELAYED APPT
OMAR	PEREZ	1	RESIDENT	193602	DELAYED APPT
LINDA	PLUNKETT	3	RESIDENT	205999	DELAYED APPT
BENJAMIN	POCK	7	RESIDENT	193062	DELAYED APPT
RONALD	PROCTER	22	RESIDENT	003496	DELAYED APPT
DAVID	REED	61	RESIDENT	201830	DELAYED APPT
DONELL	ROGERS	29	RESIDENT	012071	DELAYED APPT
LEE	SANGER	6	RESIDENT	302057	DELAYED APPT
MICHAEL	SOKOL	19	RESIDENT	403944	DELAYED APPT
DEBORAH	STORY	2	RESIDENT	206250	DELAYED APPT
JACKIE	SWATZELL	177	RESIDENT	194929	DELAYED APPT
ELLA	TEDERS	18	RESIDENT	383104	DELAYED APPT
MARY	THOMPSON	1	RESIDENT	405149	DELAYED APPT
RICHARD	THOMPSON	5	RESIDENT	019880	DELAYED APPT
JACK	TODD	1	RESIDENT	103881	DELAYED APPT
VICTOR	TURNER	132	RESIDENT	195146	DELAYED APPT
RICHARD	WADSWORTH	1	RESIDENT	199008	DELAYED APPT
DAVID	WEATHERFORD	31	RESIDENT	399978	DELAYED APPT
HERBERT	WEAVER	2	RESIDENT	303635	DELAYED APPT
DAMON	WELLS	1	RESIDENT	194713	DELAYED APPT
WILLIAM	YOUNG	1	RESIDENT	408867	DELAYED APPT
GARY	BAUMWART	11	RESIDENT	004546	NO APPOINTMENT
BECKY	CARTER	42	RESIDENT	199684	NO APPOINTMENT
WILLIAM	COFFEY	14	RESIDENT	077100	NO APPOINTMENT
WILLIAM P	COFFEY	31	RESIDENT	403871	NO APPOINTMENT
MARY ANN	CONLEY	3	RESIDENT	006690	NO APPOINTMENT
KATHY Q	EVANS	205	RESIDENT	108422	NO APPOINTMENT

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
ROBERT	LEE	716	RESIDENT	406718	NO APPOINTMENT
DANIEL	MEEK	15	RESIDENT	105269	NO APPOINTMENT
RICHARD	PAYNE	14	RESIDENT	018722	NO APPOINTMENT
ROBIN	PERRY	166	RESIDENT	499769	NO APPOINTMENT
JOHNNIE	WALTERS	6	RESIDENT	197581	NO APPOINTMENT
SONIA	WEIDANZ	107	RESIDENT	102618	NO APPOINTMENT

Oklahoma State Farm Agents

Records for 246 Oklahoma State Farm agents were reviewed, 158 agents were determined to be in compliance. The following agents were determined to be non-compliant in one (1) of two (2) areas; delayed appointment, or no appointment.

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
TERRY	BENWAY	5	ST FARM	403319	DELAYED APPT
CYNTHIA	BOX	13	ST FARM	400509	DELAYED APPT
KYLA SUE	CUMMINGS	4	ST FARM	206271	DELAYED APPT
MICHAEL	DAY	13	ST FARM	407879	DELAYED APPT
DONALD	DEGAND	40	ST FARM	007718	DELAYED APPT
RONALD	FORREST	2	ST FARM	103310	DELAYED APPT
MICHAEL L	FUGETT	2	ST FARM	300156	DELAYED APPT
MARK	HODSON	18	ST FARM	002431	DELAYED APPT
CARLA	HOLZRICHTER	17	ST FARM	401373	DELAYED APPT
BRENT	JENSON	10	ST FARM	400283	DELAYED APPT
RANDALL	JOHN	5	ST FARM	408217	DELAYED APPT
TERESA	MARTIN	11	ST FARM	100180	DELAYED APPT
STEPHEN	MARX	1	ST FARM	400848	DELAYED APPT
JOE	MCADAMS	25	ST FARM	402592	DELAYED APPT
CHARLES	MCKINNEY	1	ST FARM	102348	DELAYED APPT
CHRISTOPHER	MIDDICK	1	ST FARM	105253	DELAYED APPT
MARK	MUSSER	1	ST FARM	103673	DELAYED APPT
DAVID	PUCKETT	6	ST FARM	317650	DELAYED APPT
ROBERT	SHURTLEFF	2	ST FARM	109124	DELAYED APPT
WILLIAM	VANN	22	ST FARM	200227	DELAYED APPT
DEBORAH	WILLIAMS	1	ST FARM	104201	DELAYED APPT
THOMAS	WORSHAM	2	ST FARM	203832	DELAYED APPT
KAREN	BOLLENBACH	13	ST FARM	25058	NO APPOINTMENT
MELVIN	BRADEN	2	ST FARM	000503	NO APPOINTMENT
ROBERT	BREITENSTEIN	9	ST FARM	044625	NO APPOINTMENT
TERRY	BROWN	7	ST FARM	006844	NO APPOINTMENT
TERRY	BRYANT	1	ST FARM	019356	NO APPOINTMENT
JERALD	BURTON	7	ST FARM	057147	NO APPOINTMENT
DON	CARPENTER	7	ST FARM	064235	NO APPOINTMENT
DON	CARPENTER JR	15	ST FARM	006589	NO APPOINTMENT
DORINDA	CHAPMAN	1	ST FARM	005004	NO APPOINTMENT
DENNIS	CHAUMONT	2	ST FARM	070315	NO APPOINTMENT
FREDERICK	CHEEK	2	ST FARM	070610	NO APPOINTMENT
WILLARD	CLINTON	4	ST FARM	075720	NO APPOINTMENT
WILLIAM	CLOVIS	4	ST FARM	008511	NO APPOINTMENT
RICHARD	COATES	6	ST FARM	007181	NO APPOINTMENT

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
ANNE	COLEMAN	7	ST FARM	002310	NO APPOINTMENT
HOPE	COLLIER	1	ST FARM	007697	NO APPOINTMENT
RALPH	COMPTON	2	ST FARM	080190	NO APPOINTMENT
KEVIN	CORY	70	ST FARM	002787	NO APPOINTMENT
STEPHEN	CROW	1	ST FARM	014400	NO APPOINTMENT
TAWNYA	CROWDER	6	ST FARM	000931	NO APPOINTMENT
MICHELL	DALLAL	4	ST FARM	093730	NO APPOINTMENT
GWENDOLYN	DECASSIOS	4	ST FARM	019646	NO APPOINTMENT
LINDA	DUNBAR	14	ST FARM	019615	NO APPOINTMENT
JAMES	DUNN	1	ST FARM	004640	NO APPOINTMENT
RODNEY	ESKRIDGE	12	ST FARM	119350	NO APPOINTMENT
CLIFFORD	ETHERIDGE	6	ST FARM	016774	NO APPOINTMENT
LYNN J	FARRIS	6	ST FARM	001214	NO APPOINTMENT
WILLIAM	FOSTER	4	ST FARM	006146	NO APPOINTMENT
JANICE	FRYE	1	ST FARM	008304	NO APPOINTMENT
JON	GIDDINGS	2	ST FARM	010893	NO APPOINTMENT
LARRY	GOSNEY	8	ST FARM	000511	NO APPOINTMENT
LARRY	GOSNEY JR	2	ST FARM	001910	NO APPOINTMENT
DAVID	GRISSETT	13	ST FARM	006979	NO APPOINTMENT
ANGELA	HAILE	13	ST FARM	006496	NO APPOINTMENT
DANA	HALEY	1	ST FARM	007378	NO APPOINTMENT
DONNA	HAYES	1	ST FARM	000401	NO APPOINTMENT
JIMMY	HOBBS	22	ST FARM	018306	NO APPOINTMENT
JIM	HOUK	1	ST FARM	002642	NO APPOINTMENT
LESLIE J	HOWE	4	ST FARM	002217	NO APPOINTMENT
VALERIE	HUFFMAN	5	ST FARM	005728	NO APPOINTMENT
CARL	MCADAMS	1	ST FARM	002535	NO APPOINTMENT
GREGORY	MCILVOY	1	ST FARM	023319	NO APPOINTMENT
JEANNE	MCRAE	7	ST FARM	001286	NO APPOINTMENT
DAVID	MICK	1	ST FARM	265247	NO APPOINTMENT
WILLIAM	MIDDLETON	6	ST FARM	007526	NO APPOINTMENT
DENNIS	MORRIS	28	ST FARM	003667	NO APPOINTMENT
FLOYD	MORRIS	1	ST FARM	006459	NO APPOINTMENT
CINDY	NASHERT	3	ST FARM	002543	NO APPOINTMENT
GLENDA K	OUTHOUSE	1	ST FARM	005587	NO APPOINTMENT
DONNA	POTTER	2	ST FARM	002559	NO APPOINTMENT
MATTHEW	PRYOR	2	ST FARM	005746	NO APPOINTMENT
JENNIFER	SCHECHTER	10	ST FARM	006266	NO APPOINTMENT
LEAH	SEIBEL	9	ST FARM	007604	NO APPOINTMENT
LINDA C	SPRINGER	21	ST FARM	000885	NO APPOINTMENT
TERRI	STRAHORN	2	ST FARM	007402	NO APPOINTMENT
STEVE	SWANN	5	ST FARM	002702	NO APPOINTMENT
KRISTI	TATE	12	ST FARM	003643	NO APPOINTMENT
JOSEPH	VICTERY	16	ST FARM	008498	NO APPOINTMENT
GARY	VOGEL	7	ST FARM	009436	NO APPOINTMENT
RITA	WALLENBERG	5	ST FARM	017517	NO APPOINTMENT
SHIRLEY	WEDER	18	ST FARM	009657	NO APPOINTMENT
CHARLES	WEEKS	4	ST FARM	003303	NO APPOINTMENT
KENNETH	WHITT	7	ST FARM	014191	NO APPOINTMENT
JUNE	WILLIAMS	3	ST FARM	193532	NO APPOINTMENT
JEREL	WRIGHT	2	ST FARM	004234	NO APPOINTMENT

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
NATALIE	YERBY ODELL	18	ST FARM	005520	NO APPOINTMENT

Texas Resident Agents

Records for ninety-one (91) Texas resident agents were reviewed, forty-two (42) agents were determined to be in compliance. The following agents were determined to be non-compliant in one (1) of three (3) areas; delayed appointment, no appointment or no Oklahoma license.

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
KRYSTAL	ARINGTON	3	TEXAS	973830	DELAYED APPT
JOHN	BRUCE	2	TEXAS	901464	DELAYED APPT
ROY	FRANKS	1	TEXAS	984933	DELAYED APPT
GLORIA	GARZA	1	TEXAS	973826	DELAYED APPT
ROBERT	HALCOMB	1	TEXAS	984366	DELAYED APPT
SHANTA	HENDERSON	2	TEXAS	973841	DELAYED APPT
ANTHONY	JACKSON	7	TEXAS	972822	DELAYED APPT
CHRISTY	JORDAN	3	TEXAS	972826	DELAYED APPT
JAMEEL	KALIMAH	3	TEXAS	971627	DELAYED APPT
DEMETRICIA	LANKFORD	9	TEXAS	972686	DELAYED APPT
LATONJA	MCKNIGHT	6	TEXAS	972814	DELAYED APPT
MELBA	MILES	5	TEXAS	972816	DELAYED APPT
DEIRDRE	MILLER	1	TEXAS	972070	DELAYED APPT
CHRISTOPHER	NACAR	2	TEXAS	972069	DELAYED APPT
SANDRA	OBI	1	TEXAS	971833	DELAYED APPT
DEVERY	PARKER	1	TEXAS	972082	DELAYED APPT
JAMES	PAYNE	4	TEXAS	994903	DELAYED APPT
BRON	RAYBURN	2	TEXAS	983696	DELAYED APPT
SARITA	RICHARD	4	TEXAS	972007	DELAYED APPT
REGINA	ROBINSON	1	TEXAS	973816	DELAYED APPT
CARL	STANDRIDGE	3	TEXAS	969244	DELAYED APPT
CECILIA	TIBAY	4	TEXAS	972250	DELAYED APPT
CHARLES	WEAKLEY	5	TEXAS	972083	DELAYED APPT
MARGARET	WRIGHT	5	TEXAS	972009	DELAYED APPT
SCOTT	CLAYTON	1	TEXAS	934760	NO APPOINTMENT
ANNIE	HIDER	1	TEXAS	969098	NO APPOINTMENT
SHERI	HOLLAND	1	TEXAS	972687	NO APPOINTMENT
NORMAN	LORENTZ	1	TEXAS	972694	NO APPOINTMENT
HORACE	MELTON	2	TEXAS	914732	NO APPOINTMENT
LARRY	PETTEY	1	TEXAS	978198	NO APPOINTMENT
JERRY	RUYLE	37	TEXAS	973513	NO APPOINTMENT
JACOB	BACCUS	2	TEXAS		NO OK LICENSE
DORIS	DOUGLAS	6	TEXAS		NO OK LICENSE
DAVID	FARABEE	1	TEXAS		NO OK LICENSE
GEORGIA	FOSTER	1	TEXAS		NO OK LICENSE
LUCILLE	GARCIA	2	TEXAS		NO OK LICENSE
DONALD	HALLUM	1	TEXAS		NO OK LICENSE
DAVID	HARDEE	1	TEXAS		NO OK LICENSE
GRADY	HENDRICKS	1	TEXAS		NO OK LICENSE
JAMES	HOWELL	4	TEXAS		NO OK LICENSE
CARY	PATTERSON	2	TEXAS		NO OK LICENSE

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
SHERRY	PEEPLES	2	TEXAS		NO OK LICENSE
KEITHAN	PERDUE	1	TEXAS		NO OK LICENSE
RONALD	POLITTE	3	TEXAS		NO OK LICENSE
HEIDI	POOL	2	TEXAS		NO OK LICENSE
ROBERT	ROONEY	3	TEXAS		NO OK LICENSE
MICHAEL	SCHULZ	1	TEXAS		NO OK LICENSE
CARL	STANDRIDGE	17	TEXAS		NO OK LICENSE
VEOLA	WASHINGTON	2	TEXAS		NO OK LICENSE

Texas USAA Agents

Records for ninety-four (94) Texas resident USAA agents were reviewed, eighty-eight (88) agents were determined to be in compliance. The following agents were determined to be non-compliant in one of two areas; delayed appointment, or no appointment.

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	COMMENTS
KATHLEEN O	EVANS	6	USAA	952807	DELAYED APPT
BARBARA	GUTIERREZ	2	USAA	951502	DELAYED APPT
VINH	TU	3	USAA	980110	DELAYED APPT
CHRISTOPHER	WICK	6	USAA	943836	DELAYED APPT
JOHN	MCMAHAN	1	USAA	951760	NO APPOINTMENT
LEONARDO	PACCIONE	2	USAA	950648	NO APPOINTMENT

Other Non-Resident Oklahoma Agents

Records for ninety-one (91) other non-resident Oklahoma agents were reviewed, thirty-eight (38) agents were determined to be in compliance. The following agents were determined to be non-compliant in one (1) of three (3) areas; delayed appointment, no appointment or no Oklahoma license.

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
SAMUEL	AKINRINDE	2	LOUISIANA	971690	DELAYED APPT
LAURIE	BENNETT	3	TENNESSEE	972018	DELAYED APPT
MARCIA	COLEMAN-SMITH	8	VIRGINIA	971879	DELAYED APPT
DAVID	COURTNEY	19	ARKANSAS	988853	DELAYED APPT
MINDY	DOUGHERTY	2	KANSAS	940778	DELAYED APPT
RICHARD	FALKNER	4	ARKANSAS	907448	DELAYED APPT
PORTER	GUTTERY	1	KANSAS	909611	DELAYED APPT
JAMES	HERBIG	3	ARKANSAS	918775	DELAYED APPT
JENNIFER	HOFFMAN	1	VIRGINIA	971882	DELAYED APPT
RANDY	HOFFMAN	39	KANSAS	972799	DELAYED APPT
MILTON	KLEINBERG	4	NEBRASKA	911888	DELAYED APPT
BILL	MANKIN	3	KANSAS	942911	DELAYED APPT
VICKI	MYERS	1	VIRGINIA	971869	DELAYED APPT
ALBA	RAMOS	3	KENTUCKY	971433	DELAYED APPT
DONNA	YOUNG	6	ARKANSAS	913533	DELAYED APPT
MATT	BACHTOLD	10	MISSOURI	972435	NO APPOINTMENT
RONALD	BAKER	4	ARKANSAS	986554	NO APPOINTMENT
NATHANIEL	BREIER	1	ARKANSAS	971271	NO APPOINTMENT
RAYMOND	EVANS	1	ARKANSAS	926035	NO APPOINTMENT
LARRY	FENNELL	8	ARKANSAS	970597	NO APPOINTMENT
EDWARD	HOGAN	10	ARKANSAS	900512	NO APPOINTMENT
TOMMY	MAYS JR	16	ARKANSAS	985446	NO APPOINTMENT
STEVEN	MORSE	13	ARKANSAS	977796	NO APPOINTMENT
JAMES	PHILLIPS	1	KANSAS	918215	NO APPOINTMENT
JEFFREY	REEVES	1	ARKANSAS	988997	NO APPOINTMENT
MAX	ROBERTS	1	ARKANSAS	970666	NO APPOINTMENT
MAX	SNODGRASS	1	KANSAS	904170	NO APPOINTMENT
GLENN	THOMAS	123	ARKANSAS	905686	NO APPOINTMENT
GLENN	WACHOB	2	ARKANSAS	970769	NO APPOINTMENT
CALVIN	BAYNE	1	KENTUCKY		NO OK LICENSE
PHILIP	BIZIER	1	MASS'SETTS		NO OK LICENSE
RICHARD	BRONSTEIN	1	CALIFORNIA		NO OK LICENSE
JOHNNY	COLLINS	1	ARKANSAS		NO OK LICENSE
DAVID	DOYLE	1	ILLINOIS		NO OK LICENSE
SABRINA	EDWARDS	7	ARKANSAS		NO OK LICENSE
JAMES	EISENGART	4	PENN'VANIA		NO OK LICENSE
MICHAEL	FARRAN	1	KANSAS		NO OK LICENSE
DANNY	GARNER	3	ARKANSAS		NO OK LICENSE
MARY	HUGHES	2	ARKANSAS		NO OK LICENSE
MATTHEW	HUGHES	2	ARKANSAS		NO OK LICENSE
RICHARD	HUGHES	2	CALIFORNIA		NO OK LICENSE
RICKY	IVERSON	1	CALIFORNIA		NO OK LICENSE
MALVIN	JONES	1	ARKANSAS		NO OK LICENSE

FIRST NAME	LAST NAME	APPS	LOCATION	LIC #	CRITICISM
SANDY	LEGER	1	LOUISIANA		NO OK LICENSE
TERESA	MACFEE	1	MISSOURI		NO OK LICENSE
LISA KAY	MATILE	2	KANSAS		NO OK LICENSE
DEBORAH	MOHLINE	1	ARKANSAS		NO OK LICENSE
MONTE	MONROE	1	KANSAS		NO OK LICENSE
MARK	PHILLIPS	1	PENN'VANIA		NO OK LICENSE
COLIN	RUTTINGER	1	ARIZONA		NO OK LICENSE
ROBERT	STIVERS III	3	KENTUCKY		NO OK LICENSE
CURTIS	SWARM	1	IOWA		NO OK LICENSE
ALAN	THROWER	1	MISSISSIPPI		NO OK LICENSE

Internet Web Site

The Company maintained an Internet website at www.humana.com. It also maintained a website at www.humana-medicare.com for the products subject to this examination. The sites provided information about the Company and its products. The main site provided access for agents, providers and commercial members and employers with password protection. MQP could review Medicare Part C and D plans available in their geographic area. Enrollments could also be completed on-line with or without the assistance of an agent.

Agent Terminations

The Company terminated the appointments of twenty-one (21) individuals and one agency during the examination period. The examiner reviewed all termination records to determine the reason for termination and timeliness of notification to the Commissioner and producer. All terminations had been reported in a timely, compliant manner via NIPR reports.

The reasons for the terminations were as follows:

Agent failed to renew contract	13 cases	59.1%
No longer employed by Humana	5 cases	22.7%
Agent's license expired	3 cases	13.6%
Firm reorganized; changed name and FEIN	1 case	4.5%

The examiner noted that no agents had been terminated for cause and/or as the result of the findings of Section A investigations. None of the agents cited above for selling without a license or proper Company appointment had been terminated either.

SUMMARY

CONCLUSION

The market conduct examination report on Humana Insurance Company is respectfully submitted to the Honorable Kim Holland, Insurance Commissioner of the State of Oklahoma.

This examiner wishes to express his appreciation for the courteous cooperation and assistance given by the officers and employees of the Company.

Sincerely,

Jay E. Hodges, CIE
Market Conduct Examiner-In-Charge
Representing the Oklahoma Insurance Department
State of Oklahoma

AFFIDAVIT

STATE OF OKLAHOMA.....)
)ss
COUNTY OF OKLAHOMA.....)

Jay E. Hodges, of lawful age, being first duly sworn, upon oath state that I have been charged with examining **Humana Insurance Company** as of **September 15, 2006** that I have prepared and read the foregoing Report of Market Conduct Examination, that I am familiar with the matters set forth therein, and I certify the Report is true and complete to the best of my knowledge and belief.

Jay E. Hodges
(SIGNATURE)

Subscribed and sworn to before me this 9th day of March, by

NOTARY PUBLIC Jacquelyn Campbell

My Commission Expires: 10/10/09

(SEAL)

JACQUELYN CAMPBELL
Notary Public
State of Oklahoma
Commission # 05009402 Expires 10/10/09

MEDICARE MARKETING GUIDELINES FOR:

Medicare Advantage Plans (MAs)

Medicare Advantage Prescription Drug Plans (MA-PDs)

Prescription Drug Plans (PDPs)

1876 Cost Plans

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Published: August 15, 2005
Revised: November 1, 2005
2nd Revision: July 25, 2006

EXHIBIT
B

- Not include payments by persons performing marketing to beneficiaries.

- Withhold or withdraw payment if an enrollee disenrolls in an unreasonably short time frame (i.e., rapid disenrollment). An "unreasonably short time frame" is defined as less than 60 days after enrollment but may be a longer time period if a plan sponsor determines it to be a longer period of time.

An organization may directly employ or contract with a person to market a plan if the organization:

- Complies with all applicable MA and/or Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.

- Conducts monitoring activities to ensure compliance with all applicable MA and/or Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines.

- Uses a state licensed individual to perform marketing. An organization must utilize only a state licensed, certified, or registered individual to perform marketing, if a state has such a marketing requirement. This requirement applies to any individual that performs marketing on behalf of an organization, whether as an employee or under contract directly or downstream.

Because CMS, through its Medicare Marketing Guidelines, explicitly addresses the use of marketing representatives, state marketing agent appointment laws will not apply to organizations. However, because an organization is required to use only a state licensed, registered, or certified individual to market a plan, if a state has such a requirement, CMS expects an organization to comply with a reasonable request from a state insurance department, or other state department that licenses individuals for the purpose of marketing insurance plans, which is investigating a person that is marketing on behalf of a organization, if the investigation is based on a complaint filed with the state insurance or other department. CMS also encourages an organization to report a person that markets on the plan's behalf to the appropriate state entity, if an organization believes that the person is violating a state's licensing, registration, certification, insurance or other law.

If a state has a law that requires an organization to report to the state:

- The identity and other information of a marketing representatives that is marketing the organization's plan(s), the organization must ensure that its marketing representative is reported to the state, in a format required by the state; and

- The termination of a marketing representative's employment or contract, an organization must report a termination for cause to the appropriate state agency or ensure that its subcontractor(s) or downstream subcontractor(s) reports the

premiums belonging to insurers and all unearned premiums belonging to insureds received by an insurance producer licensee under this article shall be treated by the insurance producer licensee in a fiduciary capacity.

1. All premiums received less commissions, if authorized, shall be remitted by the insurance producer licensee to the insurer or its agent entitled thereto on or before the contractual due date or, if there is no contractual due date, within forty-five (45) days after receipt.

2. All returned premiums received from insurers or credited by insurers to the account of the insurance producer licensee shall be remitted to or credited to the account of the licensee entitled thereto within thirty (30) days after receipt or credit.

3. An insurer or its agent shall promptly report to the Commissioner in writing the failure of any insurance producer to account for any collected premium to the insurer entitled to the accounting or to the insurer's agent entitled thereto for more than forty-five (45) days after the contractual due date or, if there is no contractual due date, more than ninety (90) days after receipt.

B. Every insurer shall remit unearned premiums to the insured or the proper agent or shall otherwise credit the account of the proper insurance producer licensee as soon as is practicable after entitlement thereto has been established but in no event more than forty-five (45) days after the effective date of any cancellation or termination effected by the insurer or after the date of entitlement thereto as established by notification of cancellation or of termination or as otherwise established. Any insurance producer licensee having knowledge of a failure on the part of any insurer to comply with this subsection shall promptly report such failure to the Commissioner in writing.

C. No insurance producer licensee under this article shall commingle premiums belonging to insurers and returned premiums belonging to insureds with the personal funds of the insurance producer licensee or with any other funds except those directly connected with the producer licensee's insurance business.

D. Any insurer that delivers in this state a policy of insurance to an insurance producer licensee representing the interest of an insured upon the application or request of the insurance producer licensee shall be deemed to have authorized the producer to receive any premium due upon issuance or delivery of the policy on behalf of the insurer.

E. 1. An insurance producer licensee or surplus line producer convicted of knowingly misappropriating or knowingly converting to his or her own use or wrongfully withholding fiduciary moneys in the amount of One Hundred Fifty Dollars ($150.00) or less is guilty of a misdemeanor punishable by a fine not to exceed One Thousand Dollars ($1,000.00) or by imprisonment in the county jail for a term not to exceed one year or by both such fine and imprisonment.

2. An insurance producer licensee or surplus line producer with a second or subsequent conviction for knowingly misappropriating or knowingly converting to his or her own use or wrongfully withholding fiduciary moneys in the amount of One Hundred Fifty Dollars ($150.00) or less or who is convicted of knowingly misappropriating or knowingly converting to his or her own use or wrongfully withholding premiums in an amount in excess of One Hundred Fifty Dollars ($150.00) is guilty of a felony punishable by a fine not to exceed Five Thousand Dollars ($5,000.00) or by imprisonment in the custody of the Department of Corrections for a term not to exceed five (5) years or by both such fine and imprisonment.

F. The Commissioner may promulgate rules for the implementation of this section.

Laws 2006, c. 264, § 48, eff. July 1, 2006.

§ 1435.15. Appointment of producer as agent of insurer—Notice of appointment—Discrimination among producers—Penalties

A. An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

B. To appoint a producer as its agent, the appointing insurer, or an authorized representative of the insurer, shall file, in a format approved by the Insurance Commissioner, a notice of appointment within forty-five (45) days from the date the agency contract is executed or the first insurance application is submitted. For purposes of this section, an "authorized representative of the insurer" means a person or entity licensed by the Insurance Commissioner pursuant to the laws of this state who is authorized in writing by the appointing insurer to file appointments for the appointing insurer. A copy of said written authorization shall accompany each notice of appointment filed by an authorized representative of the insurer. An insurer or authorized representative of an insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

C. Upon receipt of the notice of appointment, the Insurance Commissioner shall verify within a reasonable time not to exceed thirty (30) days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the Insurance Commissioner shall notify the insurer and the authorized representative of the insurer within five (5) days of its determination.

D. An insurer or authorized representative of an insurer shall pay a biennial appointment fee, in the amount and method of payment set forth in Section 1435.23 of this title, for each insurance producer appointed by the insurer for each insurer for which the insurance producer is appointed.

E. It shall be unlawful for any insurer to discriminate among or between the insurance producers it has appointed. Any person or company convicted of violating the provisions of this section shall be guilty of a misdemeanor and shall be punished by the imposition of a fine of not more than Five Hundred Dollars ($500.00) or imprisonment in the county jail for not less than six (6) months nor more than one (1) year, or be punished by both said fine and imprisonment. Laws 2001, c. 156, § 15, eff. Nov. 1, 2001; Laws 2002, c. 307, § 17, eff. Nov. 1, 2002.

Laws 2002, c. 307 was presented to the Governor and became law without his signature pursuant to Const. Art. 6, § 11. It was filed in the Office of the Secretary of State May 23, 2002.

§ 1435.20. Limited lines producers—Qualification for license—Travel accident and baggage policies

A. A limited lines producer may receive qualification for a license in one or more of the following categories:

1. As a ticket-selling agent of a common carrier who acts only with reference to the issuance of insurance on personal effects carried as baggage, in connection with the transportation provided by such common carrier;

2. To engage in the sale of only limited travel accident insurance;

3. To engage in the sale of motor vehicle insurance at a vehicle rental counter or at any other point of sale at which motor vehicle insurance is offered or sold in connection with the short-term renting or leasing of motor vehicles; provided, the branch manager of the rental or leasing company shall hold the license under which the employees working for the rental or leasing company operate;

4. To engage in the sale of limited line credit insurance;

5. To engage in the sale of nonfiling insurance relating to mortgages and security interests arising under the Uniform Commercial Code, Section 1-101 et seq. of Title 12A of the Oklahoma Statutes;

6. Prepaid legal liability insurance, which means the assumption of an enforceable contractual obligation to provide specified legal services or to reimburse policyholders for specified legal expenses, pursuant to the provisions of a group or individual policy;

7. Crop hail and multiperil crop hail insurance; and

8. Prepaid dental insurance, provided the individual selling the prepaid dental insurance has been appointed by the prepaid dental plan organization to sell such insurance.

B. 1. An insurance producer or limited lines producer may solicit applications for and issue travel accident policies or baggage insurance by means of mechanical vending machines supervised by the insurance producer or limited lines producer only if the Insurance Commissioner shall determine that the form of policy to be sold is reasonably suited for sale and issuance through vending machines, that use of vending machines for the sale of said policies would be of convenience to the public, and that the type of vending machine to be used is reasonably suitable and practical for the sale and issuance of said policies. Policies so sold do not have to be countersigned.

2. The Commissioner shall issue to the insurance agent or limited insurance representative a special vending machine license for each such machine to be used. The license shall specify the name and address of the insurer and licensee, the kind of insurance and type of policy to be sold, and the place where the machine is to be in operation. The license shall expire, be renewable, and be suspended or revoked coincidentally with the insurance agent license or limited representative license of the licensee. The license fee for each vending machine shall be that stated in the provisions of Section 23 of this act. [1] Proof of existence of the license shall be displayed on or about each machine in such manner as the Commissioner may reasonably require.

Laws 1997, c. 418, § 60, eff. Nov. 1, 1997; Laws 1999, c. 36, § 1, eff. Nov. 1, 1999; Laws 1999, c. 333, § 1, eff. July 1, 1999; Laws 2000, c. 353, § 9, eff. Nov. 1, 2000. Renumbered from Title 36, § 1424.11 and amended by Laws 2001, c. 156, §§ 20, 35, eff. Nov. 1, 2001. Laws 2003, c. 150, § 4, eff. Nov. 1, 2003.

1 O.S.L.2001, c. 156, § 23 [Title 36, § 1435.23].

§ 1435.22. Application for customer service representative license or license renewal—Written appointment—Surety protection

A. Application for a customer service representative license or license renewal shall be accompanied by a written appointment, which shall remain in effect until expressly terminated in writing, signed by the insurance agent or broker who will supervise the customer service representative, on forms prescribed by the Insurance Commissioner.

B. 1. Prior to issuance of a license as an insurance consultant or surplus lines insurance broker, the applicant shall file with the Commissioner and thereafter, for as long as the license remains in effect, shall keep in force a bond in an amount of not less than Five Thousand Dollars ($5,000.00) and not more than Forty Thousand Dollars ($40,000.00) with an authorized corporate surety approved by the Commissioner. The exact amount of the bond shall be determined pursuant to the rules of the Commissioner and shall be based upon the actual or reasonably estimated premium for policies issued in connection with the services of the licensee. The surety shall notify the Commissioner of any changes in the bond of any licensee. The aggregate liability of the surety for any and all claims on a bond required by the provisions of this subsection shall in no event exceed the amount of the bond. No such bond shall be terminated unless at least thirty (30) days' prior written notice of the termination is given by the surety to the licensee and the Commissioner. Upon termination of the license

06-1895-CIR

MEMORANDUM OF UNDERSTANDING AND AGREEMENT CONCERNING REGULATORY COOPERATION AND INFORMATION SHARING BETWEEN THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND THE OKLAHOMA INSURANCE DEPARTMENT

1. Purpose

(a) This Memorandum of Understanding and Agreement (Memorandum) is made and entered into as of _____, 200_, between the Centers for Medicare & Medicaid Services (CMS) and the Department of Insurance (DOI) of the State of Oklahoma (State). It is subject to, and controlled by, applicable law. The purpose of this Memorandum is to promote cooperation, supervisory coordination, and the sharing of information between CMS and the DOI concerning the conduct of companies and persons engaged in Medicare Managed Care and the Medicare Prescription Drug Benefit. This Memorandum does not cover any information on the performance of companies and persons in the Medicare Part A or B program.

(b) The parties agree to share, in the manner described below, certain Confidential Information and non-Confidential Information concerning the conduct of companies and persons engaged in Medicare Managed Care and the Medicare Prescription Drug Benefit as it relates to the Agencies' regulatory responsibilities, and to only use information received under this Memorandum for purposes relevant to the regulation of Regulated Entities or Persons. Each Responding Agency retains the discretion to release this information to the Requesting Agency. Nothing in this Memorandum limits the ability of the Agencies to exchange non-Confidential Information if permitted by applicable law.

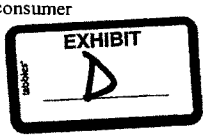
2. Defined Terms

As used throughout this Memorandum, the following terms have the meaning set forth below:

(a) Affiliate means any company that controls, is controlled by, or is under common control with another company or is a downstream subcontracted entity. Companies or entities are "affiliated" if they have an Affiliate relationship with each other

(b) Agency or *Agencies* means CMS or the DOI, individually or collectively.

(c) Confidential Information means: (i) for CMS, all exempt information, as defined in the Freedom of Information Act at 5 U.S.C. 552(b); (ii) for the DOI, information confidential by law or privilege, including, draft examination reports, examination work papers, analyses of financial condition, reports of fraudulent activity, and complaints filed by consumers with DOI; (iii) any consumer



complaint described in this Memorandum; (iv) any information protected or prohibited from disclosure under applicable federal or state law (including, without limitation, federal or state statutes, rules, case law, and privileges); and (v) any other information either Agency determines to be non-public in nature.

(d) Medicare Managed Care is defined as programs which offer managed care services to Medicare enrollees through one of the following: Medicare Advantage Health Maintenance Organizations (HMO), Cost Plans, Demonstration Projects, Private Fee for Service, Preferred Provider Organizations (PPO), Regional Preferred Provider Organizations (R-PPO), Special Needs Plans (SNP), Medical Savings Accounts (MSA), Program for the All-Inclusive Care for the Elderly (PACE), Provider Sponsored Organization (PSO) and other managed care plans.

(e) Medicare Prescription Drug Benefit Program is defined as a program which offers the Part D prescription drug benefit to enrollees through one of the following: stand alone Prescription Drug Benefit plans (PDPs) or any of the above defined "Medicare Managed Care" plans that offer a Part D benefit.

(f) Regulated Entity (Entities) or Person(s) means a company or person engaged in insurance activities subject to the regulatory authority of the DOI or CMS, under Medicare Managed Care or Medicare Prescription Drug Benefit or which should be subject to the regulation authority of DOI or CMS given the nature of the activity.

(g) Requesting Agency means the Agency seeking information.

(h) Responding Agency means the Agency responding to a request for information.

(i) Responding Agency Confidential Information means all Confidential Information furnished by, belonging to, or derived directly or indirectly from the Responding Agency.

3. Information Sharing

(a) Routine Compliance Information

(i) The Agencies will give due consideration and promptly respond to requests from one another for routine compliance information, which includes confidential information regarding (1) complaints made by individuals or entities regarding a Regulated Entity or Person, (2) the safety, soundness, or financial condition of a Regulated Entity or Person, (3) other insurance activities of a Regulated Entity or Person and (4) preliminary information such as requests for corrective action. The decision to share this information is at the sole discretion of each Agency.

(ii) Each Agency may also, in its sole discretion and if permitted by applicable law, provide the other Agency other types of information relating to the activities of Regulated Entities or Persons when doing so (1) is necessary or appropriate to permit the other Agency to administer and enforce laws applicable to the Regulated Entities or Persons over which it has jurisdiction, or (2) will promote coordination and general awareness of the respective supervisory policies, positions, and practices of the Agencies.

(iii) The Agencies will request Confidential Information only if it is relevant to their lawful exercise of regulatory authority of a Regulated Entity or Person or an Affiliate of a Regulated Entity or Person, and will use Confidential Information they receive under this Memorandum only for those purposes.

(iv) Requests for information should to the extent practicable be written (requests may be made by e-mail) and, should describe with reasonable particularity the specific information sought, and may cover multiple documents.

(v) The Agencies shall make a good faith effort to communicate information as early as practicable.

(b) Enforcement Activities

(i) CMS, in its sole discretion and if permitted by applicable law, will notify the DOI of any enforcement action CMS takes against a Regulated Entity or Person domiciled or having a resident license in the State if the enforcement action: (1) pertains to a violation of any CMS Rule or Regulation; or (2) might have a material impact on the financial condition or operations of the Regulated Entity or Person the DOI supervises. Specific communications may include: letters regarding the imposition of civil monetary penalties and/or intermediate sanctions (e.g., freezing marketing and enrollment activity), and CMS's intent to terminate or non-renew a Medicare Managed Care plan or Medicare Prescription Drug Benefit plan.

(ii) The DOI, in its sole discretion and if permitted by applicable law, will notify CMS of any enforcement action the DOI takes, or knows has been taken by another DOI, against a Regulated Entity or Person subject to regulation by CMS, or a subsidiary of such an entity, domiciled or having a resident license in the State if the enforcement action: (1) pertains to a violation of any state statute or regulation; or (2) might have a material impact on the financial condition or operations of the Regulated Entity or Person CMS supervises. Specific communications may include: any consumer complaints (including the name of the consumer/individual, name of the health plan or insurance agent, and copies of any correspondence and documents with consumers and insurance companies or agents); copies of adjudicated enforcement actions (e.g., cease and desist orders,

orders of forfeiture, stipulated agreements, imposition of fines or other public disciplinary action); and copies of adopted examination reports of health plans.

c) Consumer Complaints

(i) CMS will, if permitted by applicable law, and at the Agency's discretion promptly forward to the DOI for its attention and handling information pertaining to any consumer complaint it receives from a consumer residing, or receiving services, in the State or relating to the insurance activities of any Regulated Entity or Person the DOI supervises or has the authority to examine. The DOI will, if permitted by applicable law, promptly forward to CMS a copy of any consumer complaint it receives relating to the activities regarding the sale, solicitation, advertising, or offers of any Medicare Managed Care or Medicare Prescription Drug Benefit insurance products to a consumer by a Regulated Entity or Person.

(ii) If the DOI decides to exercise its discretion and investigate or seek resolution of consumer complaints it forwards to or receives from CMS under paragraph 3(c)(i), the DOI will, to the extent practicable, coordinate its efforts with CMS, and will advise CMS of the outcome of those consumer complaints. If CMS decides to exercise its discretion and investigate or seek resolution of consumer complaints it forwards to or receives from the DOI under paragraph 3(c)(i), CMS will, to the extent practicable, coordinate its efforts with the DOI, and will advise the DOI of the outcome.

(iii) Consumer complaints forwarded by the Agencies will be treated with the same confidentiality as other Responding Agency Confidential Information under this Memorandum, however: (1) to the extent permitted by applicable law personally identifiable information about the complainant and other Confidential Information contained in the complaint may be disclosed to the extent necessary to investigate or resolve a complaint; and (2) aggregate information regarding complaints may be disclosed as long as personally identifiable information about the complainant is not revealed.

4. Confidentiality

(a) The Responding Agency will identify any Responding Agency Confidential Information when sharing information under this Memorandum.

(b) All Responding Agency Confidential Information belongs to, and will remain the property of, the Responding Agency. The Requesting Agency will, in accordance with applicable federal or state law, take all actions reasonably necessary to preserve, protect, and maintain the confidentiality of Responding Agency Confidential Information and any privileges associated therewith.

(c) The Requesting Agency will restrict access to Responding Agency Confidential Information to those employees at the Requesting Agency, and agents of the

Requesting Agency under its direct supervision and control (including, for example, outside counsel, accountants, and consultants), who have a need for such information consistent with, and directly related to, the purposes for which the information was requested. However, the DOI may share Confidential Information obtained from CMS under this Memorandum with another state insurance department if: (i) the information is relevant to that department's supervisory or examination responsibilities; (ii) that department has entered into an agreement with CMS substantially similar to this Memorandum or has agreed in writing with the DOI to comply with the confidentiality provisions of this Memorandum; and (iii) CMS consents to the Confidential Information being shared. CMS will share Confidential Information obtained from the DOI with the appropriate federal law enforcement agency if such information potentially implicates federal fraud, waste, and abuse laws or regulations (e.g., the Anti-Kickback Act, the False Claims Act, Stark Law, and Prohibition on Inducements to Beneficiaries). CMS will notify the DOI if this information is shared.

(d) Except as provided in paragraphs 4(f) and 4(g), the Requesting Agency will not, without the express written consent of the Responding Agency, do anything, whether by action or omission, the effect of which would be to limit, waive, or jeopardize the confidentiality of Responding Agency Confidential Information or any privileges associated therewith.

(e) If the Requesting Agency receives a request from a third party for Responding Agency Confidential Information, or testimony related thereto, or is served with a subpoena, order, or other process requiring production of such information or testimony, the Requesting Agency will:

(1) unless prohibited by law, immediately notify the Responding Agency of such request, subpoena, order, or other process and furnish copies thereof as well as any documents related thereto, as well as the date by which the requesting Agency is expected to produce documents;

(2) afford the Responding Agency the opportunity to take whatever action it deems appropriate to preserve, protect, or maintain the confidentiality of Responding Agency Confidential Information or any privileges associated therewith;

(3) cooperate fully with the Responding Agency to preserve, protect, and maintain the confidentiality of Responding Agency Confidential Information and any privileges associated therewith;

(4) notify the party seeking Responding Agency Confidential Information it was obtained from the Responding Agency and requests for such information must be made directly to the Responding Agency in accordance with applicable federal or state law (including but not limited to, the Freedom of Information Act (5 U.S.C. 552), 45 C.F.R. Part 401, and 45 C.F.R. Parts 2 and 5, with respect to

CMS, and Section 306 of Title 36 of the Oklahoma Statutes, with respect to the DOI);

(5) to the extent allowed by law resist production of Responding Agency Confidential Information, and testimony related thereto, pending written consent of the Responding Agency, except as provided in the next paragraph; and

(6) consent to application by the Responding Agency to intervene in any action in order to preserve, protect, or maintain the confidentiality of Responding Agency Confidential Information or any privileges associated therewith.

(f) Nothing in this Memorandum will prevent the Requesting Agency from complying with a legally valid and enforceable order by a court of competent jurisdiction compelling production of Responding Agency Confidential Information, or testimony related thereto, provided the Requesting Agency immediately notifies the Responding Agency of its intent to comply with the order and any actions it takes in compliance with the order, and the Requesting Agency:

(1) reasonably determines efforts to quash, appeal, or resist compliance with the order would be unsuccessful or against its interests or,

(2) attempts, to the extent practicable, to secure a protective order to preserve, protect, and maintain the confidentiality of Responding Agency Confidential Information and any privileges associated therewith.

(g) It is expressly agreed and understood if a member, agency or committee of the U.S. Congress or the Legislature of the State of Oklahoma with authority to request and receive such information requests Confidential Information, CMS or the DOI may comply with the request only if compliance is deemed compulsory. In complying with the request, the Requesting Agency will use its best efforts to obtain from the requestor a commitment to maintain the confidentiality of the information and advise the legislative body the information to be produced belongs to the other Agency. The Agency receiving the request agrees to advise the other Agency as promptly as is reasonably possible of such a request prior to complying with any such request.

(h) No privileges or confidentiality associated with Responding Agency Confidential Information, or with respect to any matters relating in any way to any aspect of such information, will be waived as a result of any (i) sharing of such information pursuant to this Memorandum, (ii) compulsory disclosure of such information to third parties, or (iii) disclosure of such information contrary to the terms of this Memorandum.

5. Contacts

Each Agency will designate, as soon as possible after entering into this Memorandum, the official(s) who will be the contact(s) for the purposes of sharing

information under this Memorandum, and will promptly notify the other if there is any change in the designated contacts.

6. Termination

This Memorandum may be terminated by either Agency upon thirty (30) days written notice. Termination will not in any way affect (i) the rights or obligations of either Agency with respect to Responding Agency Confidential Information, (ii) the confidentiality of such information, or (iii) any privileges associated with such information.

IN WITNESS WHEREOF, the parties hereto have caused this Memorandum of Understanding and Agreement to be executed by their duly authorized representatives as of the date first above written.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

By:

Name:
Title:
Date: 2/5/07

OKLAHOMA INSURANCE DEPARTMENT

By:

Name: Kim Holland
Title: Insurance Commissioner
Date: December 19, 2006

06-1177-COR

GOVERNOR
BRAD HENRY

INSURANCE COMMISSIONER
KIM HOLLAND

INSURANCE COMMISSIONER
STATE OF OKLAHOMA

August 9, 2006

Mary Jane Collard **By regular mail and facsimile (214) 767-6428**
FOIA Service Center / FOIA Public Liaison
CMS
1301 Young St., Room 714
Dallas, Texas 75202

Re: Freedom of Information Act Request by the Oklahoma Insurance Department

Dear Ms. Collard,

On behalf of Kim Holland, Insurance Commissioner, State of Oklahoma, and the Oklahoma Insurance Department, this request for records of CMS is made pursuant to the Freedom of Information Act, 5 U.S.C. § 552.

This request is for copies of the following:

1. Notice of Approval of Single-State Licensure Waiver for Prescription Drug Plan for the State of Oklahoma regarding Applicant HealthSpring of Alabama, Inc. & Health Spring, Inc., Contract Number S5932, Authorization Number S5932; and
2. All letters, memoranda, reports, proposals, supporting documentation and any and all written correspondence between CMS and Applicant HealthSpring of Alabama, Inc. and Health Spring, Inc. related to the approval by CMS of the above referenced Notice of Approval of Single-State Licensure Waiver for Prescription Drug Plan.

Please mail the copies to my attention at the Oklahoma Insurance Department at the address below. Please feel free to call me if you have any questions.

Sincerely,

KARL F. KRAMER
First Assistant General Counsel
Oklahoma Insurance Department
P. O. Box 53408
Oklahoma City, OK 73152-3408
405 521-2746 or 405 521-6653
Fax 405 522-0125

EXHIBIT
E1

06-1172-COR

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N2-20-16
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of Strategic Operations and Regulatory Affairs / Freedom of Information Group

Refer to: C06FOI2682 (VEH)

SEP 15 2006

RECEIVED
OKLAHOMA INSURANCE DEPARTMENT
SEP 18 2006
Legal Division

Karl F. Kramer
First Assistant General Counsel
Oklahoma Insurance Department
P.O.Box 53408
Oklahoma City, OK 73152-3408

Dear Mr. Kramer:

This is in response to your August 9, 2006, Freedom of Information Act (5 U.S.C. § 552)(FOIA) request addressed to the Centers for Medicare & Medicaid Services Dallas Regional Office for "Notice of Approval of Single-State Licensure Waiver for Prescription Drug Plan for the State of Oklahoma regarding Applicant HealthSpring of Alabama, Inc. & Health Spring, Inc., Contract Number S5932, Authorization Number S5932; and all letters, memoranda, reports, proposals, supporting documentation and any and all written correspondence between CMS and the Applicant HealthSpring of Alabama, Inc. and HealthSpring, Inc. related to the approval by CMS of the above referenced Notice of Approval of Single-State Licensure Waiver for Prescription Drug Plan." Our Atlanta Regional Office forwarded your request to this Group for search and disposition because of my responsibilities in administering FOIA in CMS.

Because we receive a very heavy volume of FOIA requests, we have had to establish a policy of "first in, first out" case processing. This policy is consistent with court decisions regarding FOIA's time limits. Please be assured that a search has been initiated for records falling within the scope of your request. If any such records are located, they will be reviewed as soon as possible, and you will be notified of our decision regarding release or non-release of those documents.

If you believe that your request should be expedited for any reason; i.e., such as a court date involving litigation, deadline for commenting on proposed regulations or other urgent matters, please notify us in writing and provide as much relevant information as possible. When submitting this additional information, please refer to the case number listed at the top left-hand corner of this letter, and send it to: Freedom of Information Group, N2-20-16, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

EXHIBIT
E 2

Karl F. Kramer

We are authorized by law to collect fees for responding to FOIA requests and assume that you are willing to pay the fees we charge for processing this request. If at anytime the costs for processing your request are estimated to exceed $250, we will send you an invoice for the full estimated costs and suspend further processing until payment of the invoiced amount is received. If estimated processing costs do not exceed $250, then we will send you an invoice for actual costs with our response.

Sincerely yours,

Michael S. Marquis
Director
Freedom of Information Group

NOTE: Any questions regarding the status of this request should be directed to: Vernell Henderson at (410) 786-3625.

BEFORE THE INSURANCE COMMISSIONER OF THE STATE OF OKLAHOMA

IN RE:	TEMPORARY LICENSING – MEDICARE PRESCRIPTION DRUG PLAN ENROLLMENT	)) Case No. 05-1417-PRJ)

GENERAL ORDER

COMES NOW the State of Oklahoma, ex rel. Kim Holland, Insurance Commissioner, and issues her order based upon the following findings and conclusions of law, to-wit:

JURISDICTION

Kim Holland is the Insurance Commissioner of the State of Oklahoma and as such is charged with the duty of administering and enforcing all provisions of the Oklahoma Insurance Code, 36 O.S. §§ 101-6951, including the Oklahoma Producer Licensing Act, 36 O.S. § 1435.1, et seq.

FINDINGS OF FACT

1. Oklahoma's Senior Health Insurance Counseling Program (SHICP) is a federally funded program. Through volunteer counselors, SHICP and other partner organizations provide accurate and objective counseling and assistance regarding benefits related to Medicare, Medicaid, Medicare Supplements, Medicare Advantage, Medicare Savings Programs, Long-Term Care and other related health plans for Medicare beneficiaries, their representatives, or persons soon to be eligible for Medicare. These volunteer counselors do not currently assist in enrollment of Medicare beneficiaries in insurance plans.

2. The Center for Medicare and Medicaid Services of the Department of Health and Human Services (CMS) is currently encouraging SHICP and other CMS partner organizations to organize volunteer counselors (CMS volunteer counselors) to assist Medicare beneficiaries with enrollment in a Medicare Prescription Drug Plan (Part D of Medicare). Enrollment is

accomplished by the Medicare beneficiary applying for benefits with a CMS approved commercial insurance product or health plan.

3. The Oklahoma Insurance Commissioner recognizes the importance of facilitating the achievement of the goals of CMS in promoting the enrollment of Medicare beneficiaries in a Medicare Part D Prescription Drug Plan.

4. The Oklahoma Insurance Code requires licensure of all persons who sell, solicit, or negotiate insurance contracts in this state. See 36 O.S. § 1435.4.

5. The public interest will best be served by the issuance of a temporary license to CMS volunteer counselors to facilitate the enrollment of Medicare beneficiaries in a Medicare Part D Prescription Drug Plan, and said temporary license should not be subject to appointment provisions of the Oklahoma Insurance Code including 36 O.S. § 1435.15.

6. The Insurance Commissioner deems it necessary to grant temporary licenses to CMS volunteers pursuant to 36 O.S. § 1435.12, subject to the following requirements and limitations:

a. CMS volunteer counselors shall have received CMS training or other similar training acceptable to the Insurance Commissioner on enrollment of Medicare beneficiaries in Medicare Part D prior to obtaining a temporary license pursuant to this order;

b. Each CMS Partner organization shall register with the Department by submission of a list of CMS volunteer counselors who intend to enroll Medicare beneficiaries in Medicare Part D, which shall include the address and phone number of each volunteer;

c. The list of CMS volunteer counselors provided by CMS Partner organizations shall be accompanied by a description of the training received by each CMS volunteer counselor, along with the signature of each volunteer acknowledging the following: "I have received and read the Medicare Part D Prescription Drug Plan training materials and

understand that the authority granted by a temporary license issued to me by the Insurance Commissioner of Oklahoma is strictly limited to my service as a CMS volunteer counselor enrolling Medicare beneficiaries in Medicare Part D Prescription Drug Plans."

d. CMS Partner organizations and volunteer counselors shall not receive commissions or other valuable consideration of any kind whatsoever from insurance entities or health plans or enrollees for the enrollment of Medicare beneficiaries in Medicare Part D.

e. The authority granted by said temporary licenses is limited to providing enrollment assistance to Medicare beneficiaries through the following process:

(1) Ask essential questions about a person's specific situation. If Medicare beneficiaries are enrolled in a Medicare Advantage Prescription Drug plan (MA-PD), a Medigap policy with drug coverage, TRICARE, VA or FEHBP, the CMS volunteer counselor refers the Medicare beneficiaries to the insurer, health plan or other proper organization that provides the MA-PD, Medigap policy with drug coverage, TRICARE, VA or FEHBP.
(2) Use the answers to those questions to explain to the person his or her options for obtaining Medicare drug coverage, and any decisions the person must make;
(2) If the person with Medicare wishes to proceed with choosing a plan, explain how to compare plans;
(3) If the person chooses a plan and wishes to enroll, help the person fill out the necessary forms, or explain where to go for further assistance.

CONCLUSIONS OF LAW

1. Pursuant to 36 O.S. § 1435.12(A)(4), the Insurance Commissioner may issue a temporary license for a period not to exceed one hundred eighty (180) days without requiring an examination if the Insurance Commissioner deems that the temporary license is necessary for the servicing of an insurance business in any circumstance in which the Insurance Commissioner deems that the public interest will best be served by the issuance of the license.

2. Pursuant to 36 O.S. § 1435.12(B), the Insurance Commissioner may by order limit the authority of any temporary license in any way deemed necessary to protect insureds and the public.

3. Pursuant to 36 O.S. § 1435.12(E), no temporary licenses issued shall be effective for more than one hundred eighty (180) days unless renewed once upon proper application and for good cause.

ORDER

IT IS THEREFORE ORDERED by the Insurance Commissioner that temporary licenses shall be granted to CMS volunteer counselors subject to the following requirements and limitations:

1. CMS volunteer counselors shall have received CMS training or other similar training acceptable to the Insurance Commissioner on enrollment of Medicare beneficiaries in Medicare Part D prior to obtaining a temporary license pursuant to this order. Temporary licenses shall not be granted if training is not acceptable to the Insurance Commissioner;

2. Each CMS Partner organization shall register with the Oklahoma Insurance Department by submission of a list of CMS volunteer counselors who intend to enroll Medicare beneficiaries in Medicare Part D, which shall include the address and phone number of each volunteer;

3. The list of CMS volunteer counselors provided by CMS Partner organizations shall be accompanied by a description of the training received by each CMS volunteer counselor, along with the signature of each volunteer acknowledging the following: "I have received and read the Medicare Part D Prescription Drug Plan training materials and understand that the authority granted by a temporary license issued to me by the Insurance Commissioner of Oklahoma is strictly limited to my service as a CMS

volunteer counselor enrolling Medicare beneficiaries in Medicare Part D Prescription Drug Plans."

4. CMS Partner organizations and volunteer counselors shall not receive commissions or other valuable consideration of any kind from insurance entities, health plans or enrollees for the enrollment of Medicare beneficiaries in Medicare Part D.

5. The authority granted by said temporary licenses is limited to providing enrollment assistance to Medicare beneficiaries exclusively through the following process:

(a) Ask essential questions about a person's specific situation. If Medicare beneficiaries are enrolled in a Medicare Advantage Prescription Drug Plan (MA-PD), a Medigap policy with drug coverage, TRICARE, VA or FEHBP, the CMS volunteer counselor refers the Medicare beneficiaries to the insurer or health plan or other proper organization that provides the MA-PD, Medigap policy with drug coverage, TRICARE, VA or FEHBP.
(b) Use the answers to those questions to explain to the person his or her options for obtaining Medicare drug coverage, and any decisions the person must make;
(c) If the person with Medicare wishes to proceed with choosing a plan, explain how to compare plans;
(d) If the person chooses a plan and wishes to enroll, help the person fill out the necessary forms, or explain where to go for further assistance.

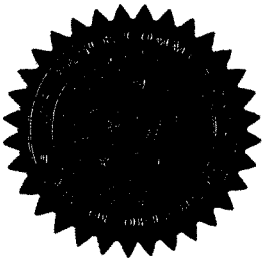
IT IS FURTHER ORDERED by the Insurance Commissioner that the temporary license issued pursuant to this order shall not be subject to appointment provisions of the Oklahoma Insurance Code including 36 O.S. § 1435.15.

IT IS FURTHER ORDERED by the Insurance Commissioner that the Agent Licensing Division of the Oklahoma Insurance Department shall maintain a list of all temporary licenses issued pursuant to this order.

IT IS FURTHER ORDERED by the Insurance Commissioner that any CMS volunteer counselor who agrees to receive or does receive commissions or other valuable consideration of

any kind whatsoever from insurance entities, health plans or enrollees in payment for enrolling Medicare beneficiaries in Medicare Part D shall first meet all licensing requirements of and obtain a license pursuant to the applicable provisions of the Oklahoma Insurance Code and Regulations.

WITNESS My Hand and Official Seal this 11 day of October, 2005.



KIM HOLLAND
Insurance Commissioner
State of Oklahoma Insurance Department

Statement for the

United States Senate
Select Committee on Aging

Regarding

Medicare Advantage Marketing and Sales: Who Has the Advantage?

Submitted by

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters
2000 North 14th Street
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Arlington, VA 22201
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National Association of Health Underwriters

America's Benefits Specialists

May 15, 2007

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers, representing more than 20,000 health insurance producers nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage. We have thousands of members all across the country who specialize in the sale of "senior products," and we are extremely concerned about ethical sales practices concerning all Medicare-related insurance products, including Medicare Advantage plans.

NAHU is well aware of some recent publicity depicting a few "bad apples" in our industry who have been behaving in what appears to be an unethical manner. However, it is important to note the vast majority of health insurance producers work very hard every day to find quality and appropriate health coverage at the best possible price for millions of employers, individuals and families..

Professional health insurance producers like those who are members of NAHU are bound by a strict Code of Ethics that states they must, "respect my clients' trust in me and to never do anything which would betray their trust or confidence." NAHU members are of the highest caliber; therefore, it is unfair to label all agents selling Medicare Advantage plans as dishonest because of the outrageous behavior of a few unethical individuals.

NAHU members are committed to education. As a result, our association has spent considerable time, effort and resources educating our membership about the rules concerning Medicare-related product sales, and we will continue to do so. To ensure that NAHU members are equipped with the most up-to-date and accurate information on marketing Medicare plans, during the past year NAHU, along with America's Health Insurance Plans (AHIP), established a four-part education program on Medicare, Medicare Part D and Medicare Advantage. The NAHU/AHIP course teaches the marketing rules and responsibilities of each program and, like all of NAHU's many education programs, it covers and encourages ethical professionalism. This class has been approved for continuing-education credit in more than 40 states, and we are actively promoting the course to both NAHU members and non-members alike.

NAHU is also committed to working with the Centers for Medicare and Medicaid Services (CMS) and individual states on producer education, as we feel that there are a large number of producers out there who may not specialize in Medicare or senior

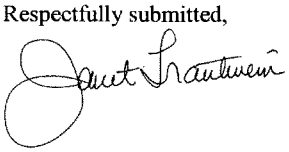
products and who are not NAHU members. To try to reach these producers, NAHU has published a vast amount of Medicare-related product sales information on our website, which is open to the public. We would also be happy to post any additional information on our site that CMS or state departments of insurance develop, as well as link to other sites or reach out to non-member producers for education purposes in collaboration with CMS and state departments of insurance.

While NAHU commends the Committee for taking up this important issue, we hope that in the course of its work the Committee does not undertake any actions that would limit the ability of seniors to access either Medicare Advantage plans or the services of licensed professional health insurance producers. While Medicare Advantage products may not be the right choice for every senior, there are many Medicare beneficiaries who are very happily insured under these plans. It is not surprising that seniors with no supplemental coverage on a fixed income find these plans particularly attractive and that sales have increased over the past year. NAHU feels that is very important that all Americans, including Medicare beneficiaries, have a wide range of health plan choices available to them.

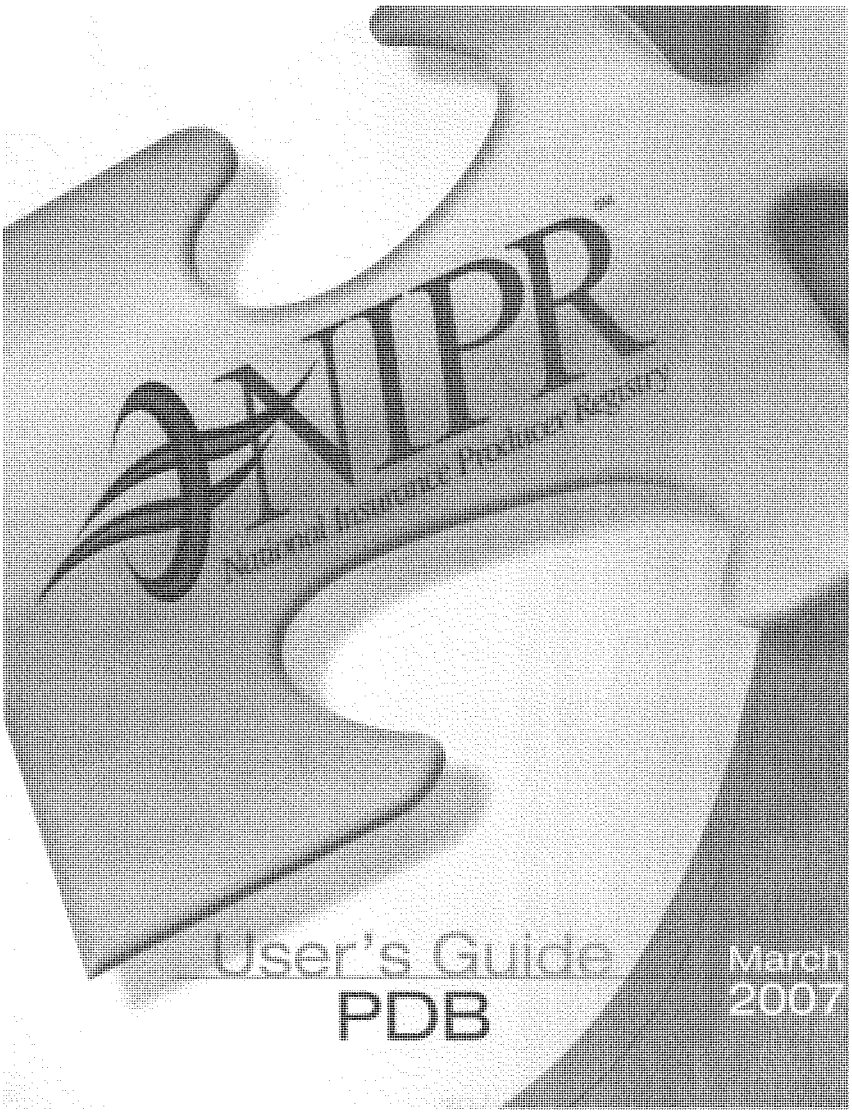
NAHU also thinks it is crucial that all Americans have the ability to use licensed health insurance professionals to help them choose the health plan products that best meet their specific needs. The vast majority of licensed producers who sell Medicare Advantage plans to seniors specialize in this unique market. These professionals spend countless hours advising their clients, answering questions and helping to select the best possible plan options based on their clients' budgets and personal preferences. It would be a disservice to the thousands of high-caliber health insurance producers out there, and their millions of happily insured senior clients, if access to licensed health insurance producers was in any way limited. The actions of a dishonest few should not be interpreted as representative of our entire industry.

Thank you for the opportunity to provide comment on the marketing of Medicare Advantage plans. If you have any questions, or if NAHU can be of further assistance, please do not hesitate to either contact me (703-276-3800 or jtrautwein@nahu.org) or our vice presidents of congressional affairs, Peter Stein (703-276-3801 or pstein@nahu.org) and John Greene (703-276-3807 or jgreene@nahu.org).

Respectfully submitted,



Janet Trautwein
Executive Vice President and CEO


AMBER
User's Guide
PDB
March
2007

NIPR PDB GUIDE

Welcome to the NIPR Producer Database (PDB). We appreciate your business and would like to help you become acquainted with the available information. This guide will help you through your first few times working with the PDB. If you should have any questions, please call us at (816) 783-8467 or email at marketing@nipr.com.

What is the PDB?

The PDB is a repository of comprehensive producer license information provided by the State Insurance Departments. It is designed to assist insurers in exercising due diligence in the monitoring of producers to reduce the incidence of fraud.

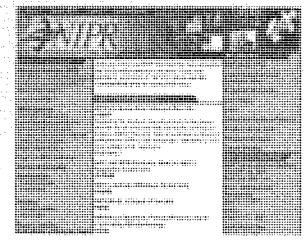
PDB Products:

There are five products that will be covered in this Guide.

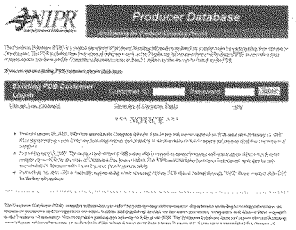
- **Detail Report** – a repository of information for a specific agent/producer or agency. Information includes demographics, license information and appointments/terminations. Regulatory Actions are included when applicable. Batch processing is also available.
- **Company Specialized Report (CSR)** – useful when a full PDB report is not needed. The Company Specialized Report allows the user to select specific information from 12 fields of data contained in the Producer Database. User selects entities and chooses fields (maximum of 4 fields may be selected per report.)
- **Company Appointment Report (CAR)**– a listing of active Appointments, Terminations or Appointment/Termination History for a specific company (must be an affiliated company) in a specific state.
- **Company Appointment Reconciliation Report (CARR)** – provides a listing of active Appointments in a specific state with the ability to complete electronic "not-for-cause" terminations. (You can only view and terminate agents from affiliated companies)
- **Alerts** – this product is designed to provide notification to users indicating a specific change has been made to data stored in the producer database.

Accessing Products:

To access the PDB products, you will need an Internet connection. The web address for NIPR is www.nipr.com.



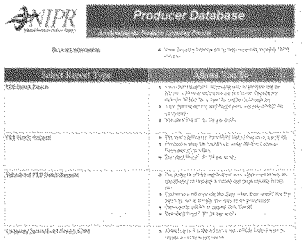
This is the main menu. From this screen you can access a variety of information about such things as the NAIC by clicking on the **NAIC** link or read current updates about NIPR in the **Latest News Releases**. Also, you can access the states websites by clicking on **Link to Departments of Insurance States**. This will allow you to access state specific information with a click of the mouse. Under the heading **Products & Services** you will find much more information about our products. To access PDB, simply *click* on **Log in to PDB** in the column left of the homepage.



NOTE: Be sure to check the disclaimers for the day. They are located under the "NOTICE" heading.

Enter, in the first box, your customer number. Your personal identification number (password) goes in the second box. These will be provided to you when you set up an account with NIPR. Keep them safeguarded, as you are responsible for their usage. Now *click* on **Submit** to login.

This screen will allow you to select your report type. We will discuss the following reports in more detail:



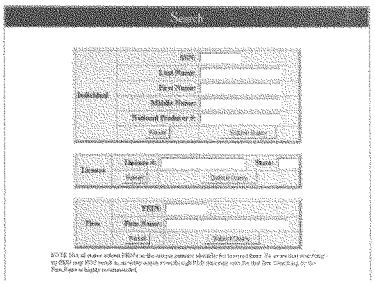
- Detail Report
- Batch Request
- Company Specialized Report
- Company Appointment Report
- Company Batch Request
- Company Appointment Reconciliation Report
- Industry Alerts

PDB Detail Report

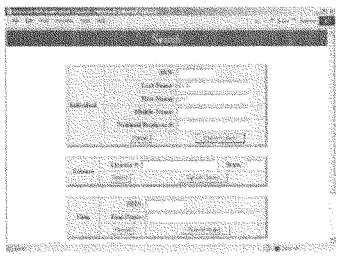
The Detail Report will provide information about agents/producers, agencies or companies. *Click* on **Detail Report** and you will come to the search screen. You can search for an individual by entering any of the following:

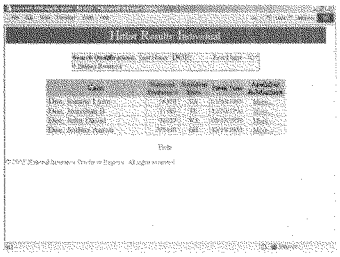
- Social Security Number and the exact spelling of the individuals last name
- The individuals last name and first name
- The individuals license number in a specific state
- National Producer Number (NPN)

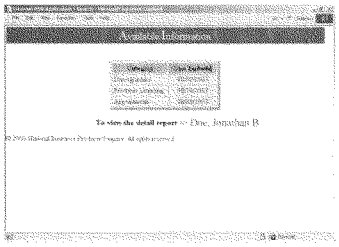
There is also a "wildcard" search method. If you do not know the exact name or correct spelling, simply enter the first letter of the name (or as much as you are sure of) and enter an asterisk (*). You can search for a Firm by entering the FEIN (Federal Employer Identification Number) or the name of the firm. It is suggested that you use the "wildcard" search for Firms as not all states supply the FEIN as a unique identifier for firms.



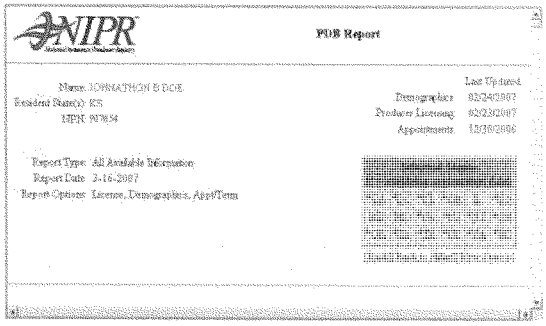
For example purposes, we will be using "John Doe". We entered the last name "Doe" and the first name as "Jo*". This was done because the PDB entry could be under "John" or "Jonathan", depending on how the states supply the information. After entering the information *click* on **Submit Query** to start search process. The system will search and provide a listing of entries matching the information entered.



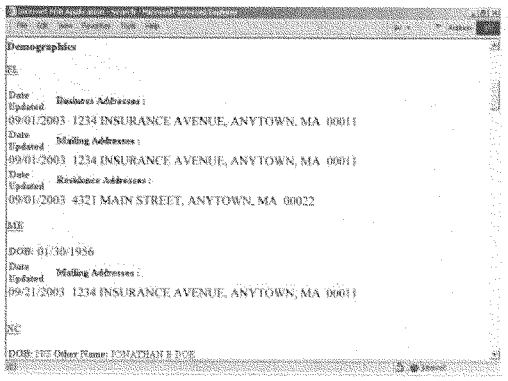




This is called the "Hitlist" screen. For our example, this "Hitlist" screen shows all individuals with the last name "Doe"' and a first name starting with "Jo". This screen will also display the National Producer Number, resident state, and date of birth to help identify the correct entry. There is also a More button. We recommend that you point and click on the "more" link. This will provide you with the categories of available information for the requested individual. The "Available Information" screen provides you a peek at the information that is available for the selected individual. For example, for our selection, "Doe, Johnathon B", we know that "Demographics and License/Appointment Summary" information is available. Up to this point, you have not been charged. Once you click on the name "Doe, Johnathon B" you *will* be charged.

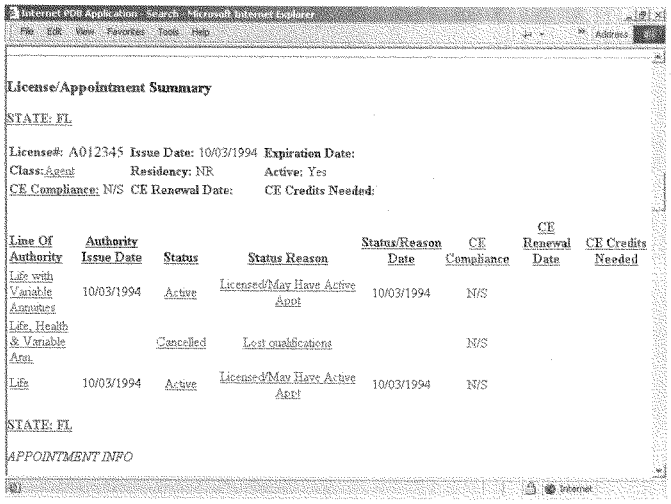


This is the first page of the "Detailed Report". Under the name is the Resident State and National Producer Number. This is a 10-digit number shown without the leading zeros. Each entity in the PDB is assigned a unique number. This can be used as an Identifier and should be captured in any spreadsheets or files on licensing. We know from the previous screen that only demographics and license/appointment information is available. This page shows us all the states that have submitted data to the PDB on this individual. They are highlighted and underlined. The "*" indicate those states which have submitted company appointment information. (This is important later on). You can click on the highlighted areas to go directly to that state or scroll down the page.



This page shows the producer's demographics by state: date of birth and address information and any other names the agent might have used for licensing (i.e. maiden name, middle name, middle initial). As you continue down the page, you will find the license/appointment summary.

The license/appointment summary provides the state of licensure, license numbers, issue date, expiration date, class, resident status, and whether the license is active.



License/Appointment Summary

STATE: FL

License#: A012345 **Issue Date:** 10/03/1994 **Expiration Date:**
Class: Agent **Residency:** NR **Active:** Yes
CE Compliance: N/S **CE Renewal Date:** **CE Credits Needed:**

Line Of Authority	Authority Issue Date	Status	Status Reason	Status/Reason Date	CE Compliance	CE Renewal Date	CE Credits Needed
Life with Variable Annuities	10/03/1994	Active	Licensed/May Have Active Appt	10/03/1994	N/S		
Life, Health & Variable Ann.		Cancelled	Lost qualifications		N/S		
Life	10/03/1994	Active	Licensed/May Have Active Appt	10/03/1994	N/S		

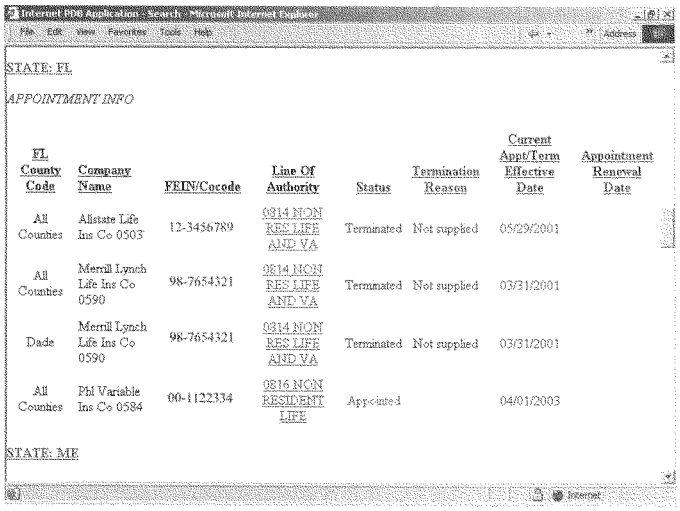
STATE: FL

APPOINTMENT INFO

You will also find additional licensing information as follows:

- Line of authority
- Authority issue date
- Status
- CE information will be part of the database in the future

This is individual appointment information. Shown are the name of the company, FEIN or NAIC CoCode of the appointing company, line of authority and status, dates and renewal.



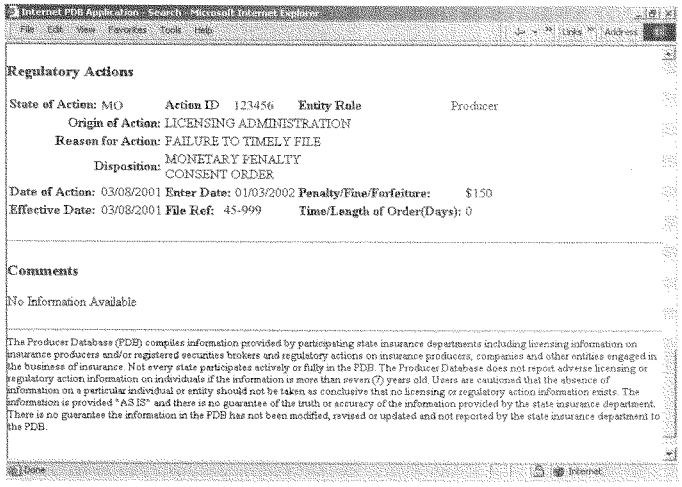
STATE: FL

APPOINTMENT INFO

FL County Code	Company Name	FEIN/Cocode	Line Of Authority	Status	Termination Reason	Current Appt/Term Effective Date	Appointment Renewal Date
All Counties	Allstate Life Ins Co 0503	12-3456789	0814 NON RES LIFE AND VA	Terminated	Not supplied	05/29/2001	
All Counties	Merrill Lynch Life Ins Co 0590	98-7654321	0814 NON RES LIFE AND VA	Terminated	Not supplied	03/31/2001	
Dade	Merrill Lynch Life Ins Co 0590	98-7654321	0814 NON RES LIFE AND VA	Terminated	Not supplied	03/31/2001	
All Counties	Phl Variable Ins Co 0584	00-1122334	0816 NON RESIDENT LIFE	Appointed		04/01/2003	

STATE: ME

At the bottom of the report, it will list any Regulatory Actions (RIRS), if taken. We will also indicate when no information is available for a particular item.



Regulatory Actions

State of Action: MO **Action ID** 123456 **Entity Role** Producer
Origin of Action: LICENSING ADMINISTRATION
Reason for Action: FAILURE TO TIMELY FILE
Disposition: MONETARY PENALTY
CONSENT ORDER
Date of Action: 03/08/2001 **Enter Date:** 01/03/2002 **Penalty/Fine/Forfeiture:** $150
Effective Date: 03/08/2001 **File Ref:** 45-999 **Time/Length of Order(Days):** 0

Comments

No Information Available

The Producer Database (PDB) compiles information provided by participating state insurance departments including licensing information on insurance producers and/or registered securities brokers and regulatory actions on insurance producers, companies and other entities engaged in the business of insurance. Not every state participates actively or fully in the PDB. The Producer Database does not report adverse licensing or regulatory action information on individuals if the information is more than seven (7) years old. Users are cautioned that the absence of information on a particular individual or entity should not be taken as conclusive that no licensing or regulatory action information exists. The information is provided "AS IS" and there is no guarantee of the truth or accuracy of the information provided by the state insurance department. There is no guarantee the information in the PDB has not been modified, revised or updated and not reported by the state insurance department to the PDB.

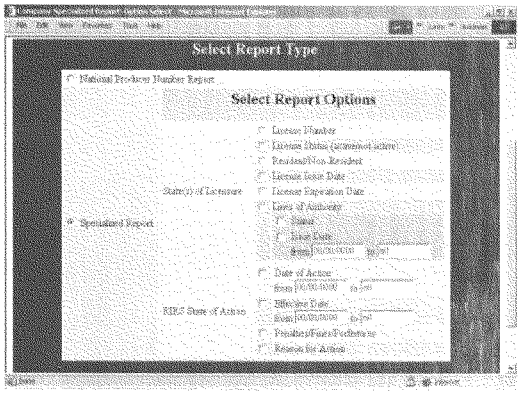
This concludes the demonstration for detailed lookups. If additional information is required, please contact the specific state departments of insurance.

PDB Detail Batch Report

If you have a large number of producers to enter, you can enter them in a **BATCH** request. This batch request will return the same information as the detailed report. You will select **Batch Report** from the "Select Report Type" screen as mentioned on page 2. Producers can be entered by hand or by uploading a comma-delimited (CSV) file. Depending on the amount of information gathered, this report could take some time to generate. Once all of the information is gathered, you will be given the option of purchasing the report. After the report is purchased, you will have the option of viewing the information or downloading the information in XML. For more information on the batch request, please call us at (816) 783-8467.

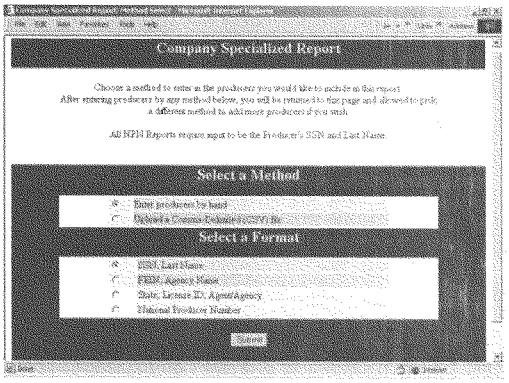
Company Specialized Report (CSR)

The Company Specialized Report allows you to create a report specific to your needs by selecting from the various fields in the PDB. You may select up to 4 fields per report. You may also select information from specific states. Names of individuals may be typed in or submitted in a comma-delimited file. No charges will be incurred until the report is purchased. Click on the **Company Specialized Report**. From this screen, we display the pricing and ask you to make a selection to create a new report or you could view an existing report. Reports will stay available for 7 days before they are deleted. By clicking on **Create a New Specialized Report** you will see the option selection screen. As indicated, you may select up to 4 options and limit the search by entering dates. You will also notice we have a special area for RIRS actions, this was included to accommodate our customers interested only in RIRS. Once you have entered your selections, *click* the **Submit** button at the bottom of the page.



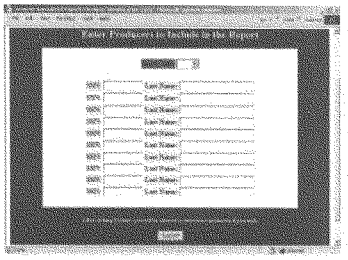
This screen gives you two options for entering the data. You can either enter the information by hand, or you can upload a comma-delimitated (CSV) file. Also, on this screen, you need to select how you will enter the data. Your options are as follows:

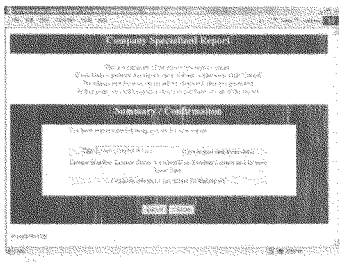
- SSN, Last Name
- FEIN, Agency Name
- State, License ID, Agent/Agency
- National Producer Number



For this example, we will chose to enter the data by hand, and to use SSN and Last Name.

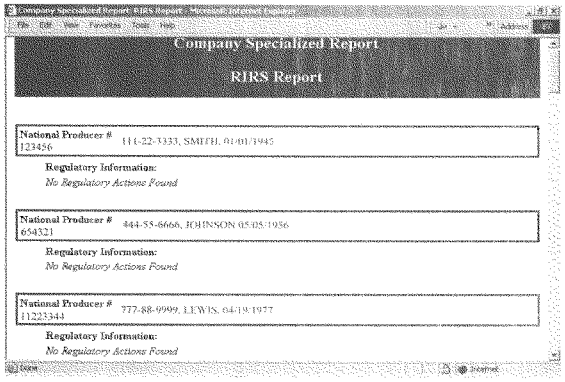
You may enter up to 10 producers on each page. Once you have entered 10 producers, *click* **Submit**, and you will have the option to enter 10 more. When all of your data has been entered, *click* **Done.** This will take you to a screen that will summarize your request and give you the ability to Title your report. By *clicking* on **Submit** it will begin generating your report. Depending on the amount of information gathered, this report could take some time. You can view the status of the report by selecting that option on the first Company Specialized Report screen. Once all of the information is all the information is compiled, you will be given the option of purchasing the report for $50.





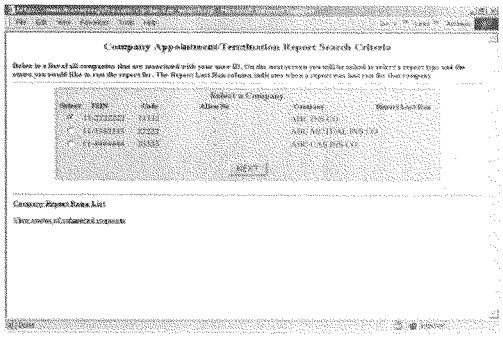
Browse allows the user to view the report on a page by page basis in their web browser. Download allows the user to download the Company Specialized Report to their local workstation. The report is Comma-Delimited (CSV). This feature enables the user to manipulate the information in any fashion they please after the report has been downloaded. Download XML will also allow the user to download and manipulate the data in the XML format.

If you chose to browse the report online, it will look like this:

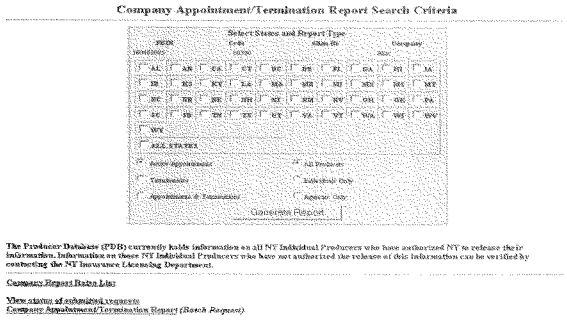


Company Appointment/Termination Report (CAR)

This is the fifth listing from the report selection screen and provides a listing of active appointments, terminations or appointment/termination history for a specific company in a specific state. To use this report simply *click* on **Company Appointment/Termination Report**. Only data from your affiliated companies can be viewed. If more than one company is listed select the company desired and *click* **NEXT**.



Choose the type of report desired, and select the state. You may enter one state, multiple states or all states that the company is licensed in (there is a $50 charge per state). You may also select to receive information on individuals only. Finally *click* **Generate Report**. Since this is a batch report, it may take a little time to complete. You can check the status of submitted reports by *clicking* the **View status of submitted requests** button.

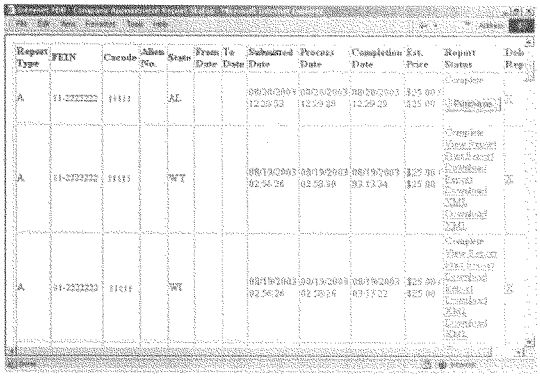


View Report - enables the user to view the Company Appointment Report in a page-by page format.

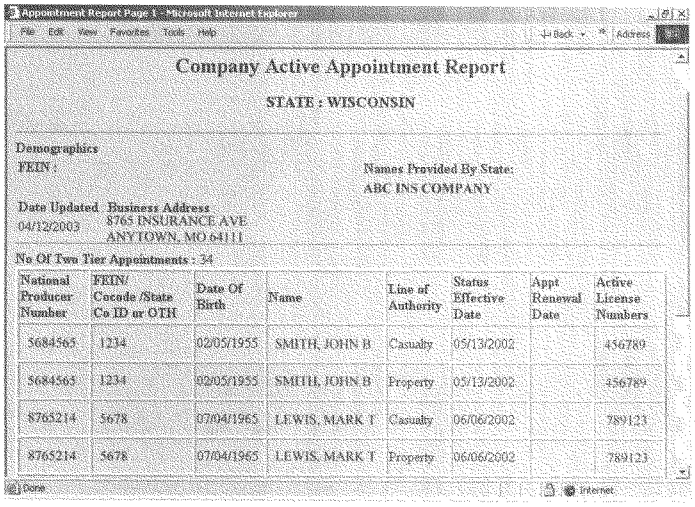
Print Report - allows the user to print the report in sections. This is especially useful for printing large reports.

Download Report - permits the user to download the Company Appointment Report to their local workstation in a colon-delimited format.

Download XML - permits the user to download the Company Appointment Report to their local workstation in the XML format.



Here is a sample of a completed report:



Company Active Appointment Report

STATE : WISCONSIN

Demographics
FEIN :

Names Provided By State:
ABC INS COMPANY

Date Updated: 04/12/2003
Business Address: 8765 INSURANCE AVE, ANYTOWN, MO 64111

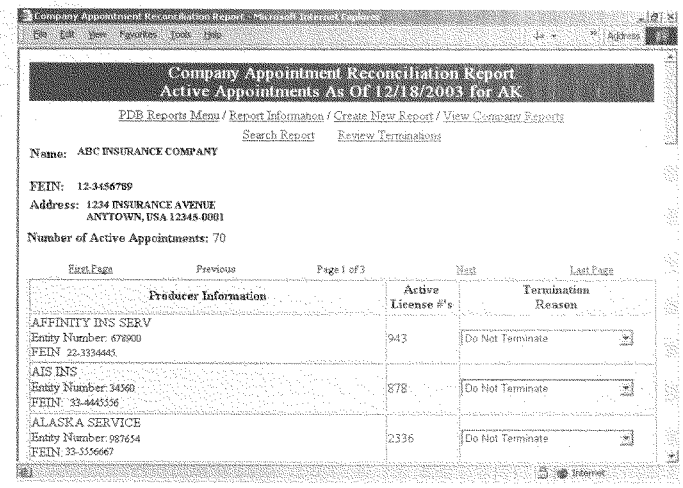
No Of Two Tier Appointments : 34

National Producer Number	FEIN/ Cocode /State Co ID or OTH	Date Of Birth	Name	Line of Authority	Status Effective Date	Appt Renewal Date	Active License Numbers
5684565	1234	02/05/1955	SMITH, JOHN B	Casualty	05/13/2002		456789
5684565	1234	02/05/1955	SMITH, JOHN B	Property	05/13/2002		456789
8765214	5678	07/04/1965	LEWIS, MARK T	Casualty	06/06/2002		789123
8765214	5678	07/04/1965	LEWIS, MARK T	Property	06/06/2002		789123

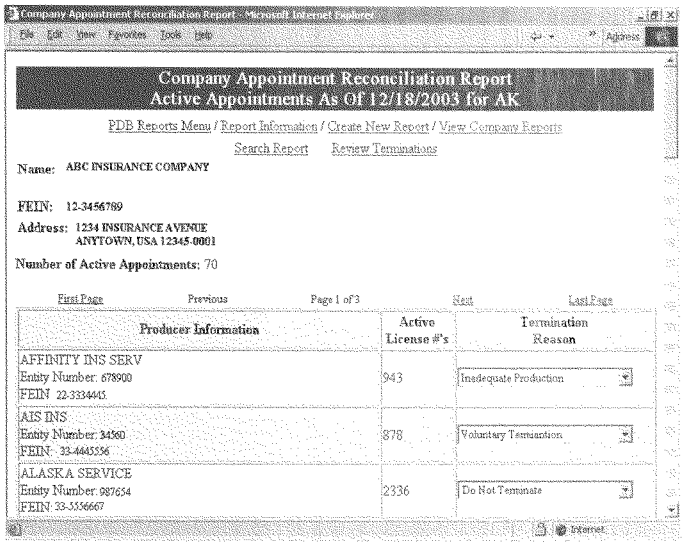
The report give you the National Producer Number, last 4 digits of the SSN for individuals or entire FEIN for business entities, date of birth, name, line of authority (if applicable), effective date of the appointment, renewal date and the active license number.

Company Appointment Reconcilliation Report (CARR)

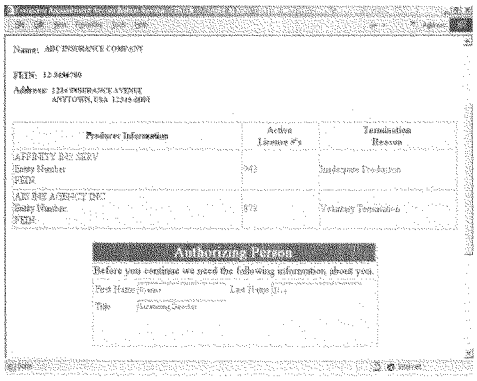
The Company Appointment Reconciliation Report (CARR) is designed to facilitate the appointment renewal process for Regulators and for the Insurance industry. As an NIPR customer you can use the CARR to create a listing of your active appointments for a specific company in a specific state. This report is similar to the Company Appointment Report, however, the CARR has the added functionality of completing "Not for Cause" terminations directly from the report. This allows you to reconcile your company's agent listing against the Producer Database. The terminations are generated electronically through the NIPR Gateway and sent to the appropriate state insurance department for processing. The report will be generated exactly like the Company Appointment/Termination Report. Once the report has been purchased, you will want to click View.

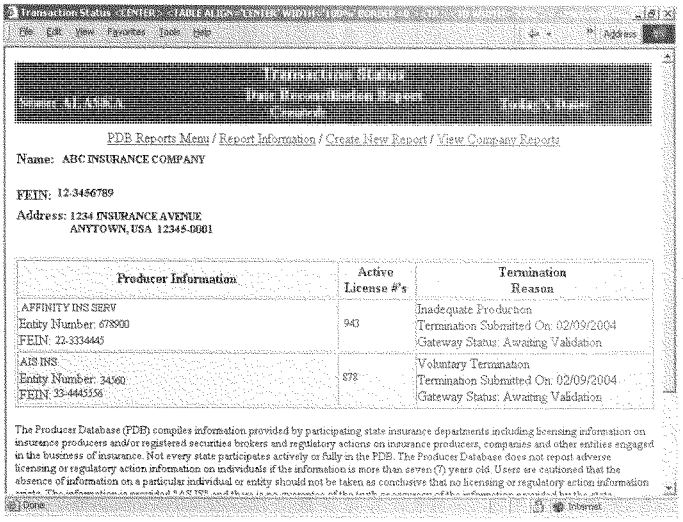


In the third column titled "Termination Reason" the report will default to "Do Not Terminate". If you wish to terminate a specific appointment, you will need to select a termination reason from the dropdown box. These reasons will vary from state to state, depending on that states valid termination reasons.



After selecting which appointments you want to terminate, you will click **Review Terminations** at the top of the page. It will summarize your terminations and ask for an authorizing persons name and title. Once you have reviewed the terminations, you will need to click **Submit**. This will create the termination transactions that will be sent through the NIPR Gateway to the respective insurance department. These transactions will be billed at your current appointment / termination transaction rate. You can view the status of your transactions by selecting **View Terminations** from the report selection screen.





This screen will be updated as we receive information on the transactions from the state insurance departments. You will want to check it daily until all of your termiantions have been processed.

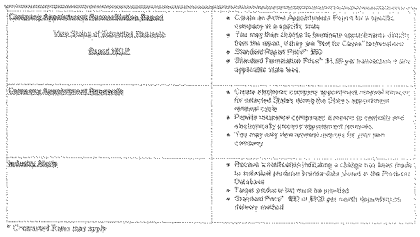
Alerts

In the complex world of producer licensing, the receipt of timely information is crucial. The Alerts product is designed to provide notification to users indicating a change has been made to data stored in the Producer Database (PDB). The initial offering of Alerts will provide notification for 2 fields:

Resident State License Status Change

License Expiration Date Change

Additional fields are scheduled to be added throughout the year. These Alerts are informational only, and it is highly recommended that the Alerts be investigated before any action is taken because of the Alert. Subscribers will have multiple options for selecting producers to track. Alert information can be accessed by receiving email notifications (Push Method) or the customer can log in and access the information at their convenience (Pull Method).

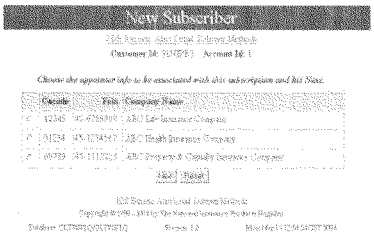


ALERTS Pricing

Push Method	Pull Method
$50.00	$100.00

ALERT charges are monthly per company.

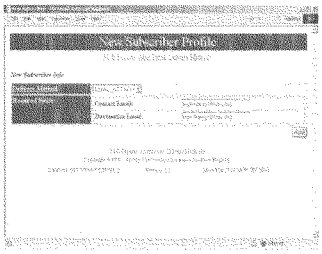
Step 1 – Associate Company



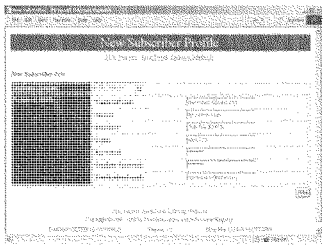
After logging into PDB, you will select **Industry Alerts** from the Select Report Type Screen. The first time you access Alerts, you will need to associate a company with your password. This will allow you add target individuals from company appointments (this is explained in Step 4). Select the desired company, and click **Submit**. This step will only apply to insurance companies.You can only associate one company per password. If you are an insurance company customer and there are not any companies to associate with your Customer ID, please contact NIPR Marketing at (816) 783-8467 or marketing@nipr.com. If you are non-insurance company customer (Agency, MGA, TPA, etc.) you will need to click the button for **Continue without Appointer Info.**

Step 2 – Select a Delivery Method

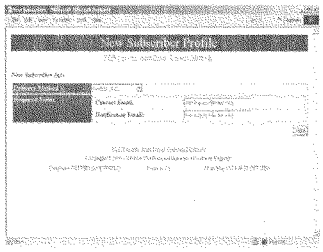
You will need to select a delivery method from the Subscriber Profile page. You will have three options on receiving Alerts:



Email_Attach – This will generate an email to a user specified email address. The Alert will be a file attachment to the email. When selecting this option, you will simply need to enter a contact email and a destination email address. The destination email address is where NIPR will send your Alert.



FTP_Push – This will allow NIPR to send the Alert file to a user specified location. You will need to provide NIPR with the following information: Contact email, Server, Directory, Login, Password, and Notification email. You will need to work with your IT Department to gather this information. The notification email is where NIPR will send notification that we have sent the file to your server.



Web_SSL – With this option, NIPR will place the Alert file on our server to be picked up at the users convenience. You will need to enter a contact email and a notification email. The notification email is where NIPR will send notification that you have an Alert file to be picked up. This email will contain a link to the location of your files. You may be prompted to login prior to viewing the reports. The files will remain on our server for 14 days. You will be able to view the file multiple times during this time.

Email_Attach and FTP_Push will receive "Push Method" pricing, while Web_SSL is considered the "Pull Method" Once you have selected the delivery method and entered the required information you will need to click the ADD button.

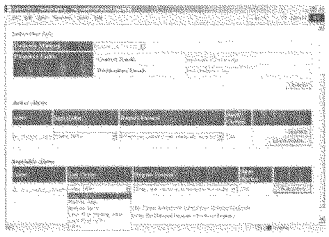
Step 3 – Subscribe to specific Alerts

On the Subscriber Profile page, under the heading of Active Alerts, you will have the option of selecting the type of change you wish to receive Alerts on. The initial offering will contain the following two Alerts:

Lic_Change_Date – You will receive notification** when the Expiration Date of a producers license has changed. This is useful in determining if a producer has renewed their license.

Lic_Res_Status_Change – You will receive notification** when the Status of the producers resident license has changed, i.e. ACTIVE status to INACTIVE, or INACTIVE to ACTIVE.

**Through your selected delivery method



Next to the Alert you wish to subscribe to, you will need to select a Sort Order. The Sort Order only indicates the order that the records appear on the report. For each report, there is a set of defined columns (NPN, STATE, FIRST, MIDDLE, LAST, DOB, LIC_NAME, BEFORE, AFTER). These columns will not change when changing the sorting preference. The number of records in the report also does not change. Changing the Sort Order only affects the order that the records appear on the report.

You will also need to select a Report Format. The Alert report can be received in the following formats:

- Plain Text, Comma Delimited, with Header
- Plain Text, Tab Delimited, with Header
- Plain Text, Position Aligned, no Header
- Plain Text, Space Aligned, with Header
- HTML Data Table, with Header
- XML

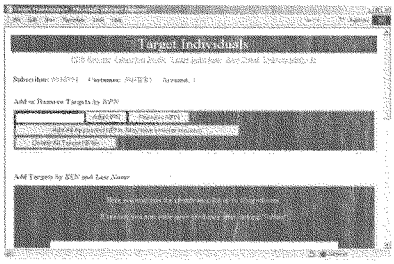
The Plain Text versions can easily be viewed using common spreadsheet software (i.e. Microsoft Excel). The HTML version will allow you to view the data in your Internet browser. The XML format will allow users greater functionality for reading, filtering, and manipulating data, however programming would need to be done on the users end. If you are unsure which method is best for you, please contact your IT Department for assistance.

Once you have selected your Sort Order and your Report Format, click Subscribe. You will need to do this for each Alert you are subscribing to.

Step 4 – Adding Target Individuals

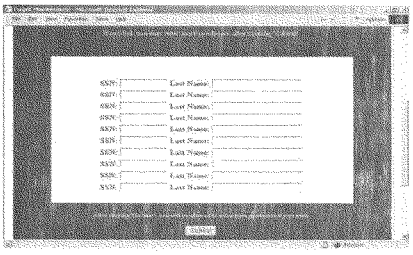
Target individuals are the producers that you are interested in receiving Alerts on. The National Producer Number (NPN) will be the unique identifier used for the Alerts application. It is recommended that you incorporate the NPN into your company database to assist in identifying producers. You can add target individuals one at a time, by entering their NPN number and selecting **Add NPN**. You can also remove individuals by entering their NPN and selecting **Remove NPN**.

If you associated a company with your password, you may select **Add All Appointed NPN's**. This will create a list of target individuals from that company's active appointments in the PDB. This option will only add NPN's from the one company associated with your password. If you wish to receive Alerts for other affiliated companies, you will need to add additional accounts under your customer id. Please contact NIPR Marketing regarding this option- (816)783-8468 or niprinquiry@naic.org.



You can also add target individuals by entering SSN and Last Name. In the boxes provided, simply enter the information and select submit. You may enter 10 targets at a time using this method. After selecting **Submit**, you will have the option to enter 10 more. Repeat this process until you have entered all targets.

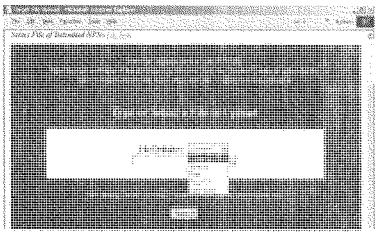
Please Note: NPN will be the unique identifier for Alerts. The SSN will not be returned as an identifier on your Alerts.

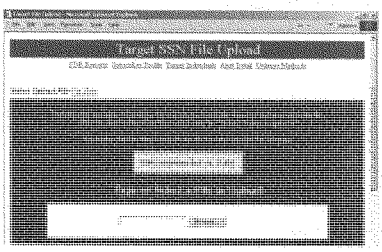


Another option is to upload a file of producers. If you are not familiar with delimited files, you will want to work with your IT Department to ensure the file is in the correct format. Files should have a ".txt" or ".dat" extension. If you need further assistance on the file format, select File Help, after selecting the Upload method.

There are two methods for this, Upload [NPN] File and Upload [SSN,LastName] File.

By selecting Upload [NPN] File, you must select the delimiter of the file you have created (Comma, Space, Tab, Pipe, New Line). Then enter the location of the file in the box provided, or click Browse and locate the file on your hard drive.



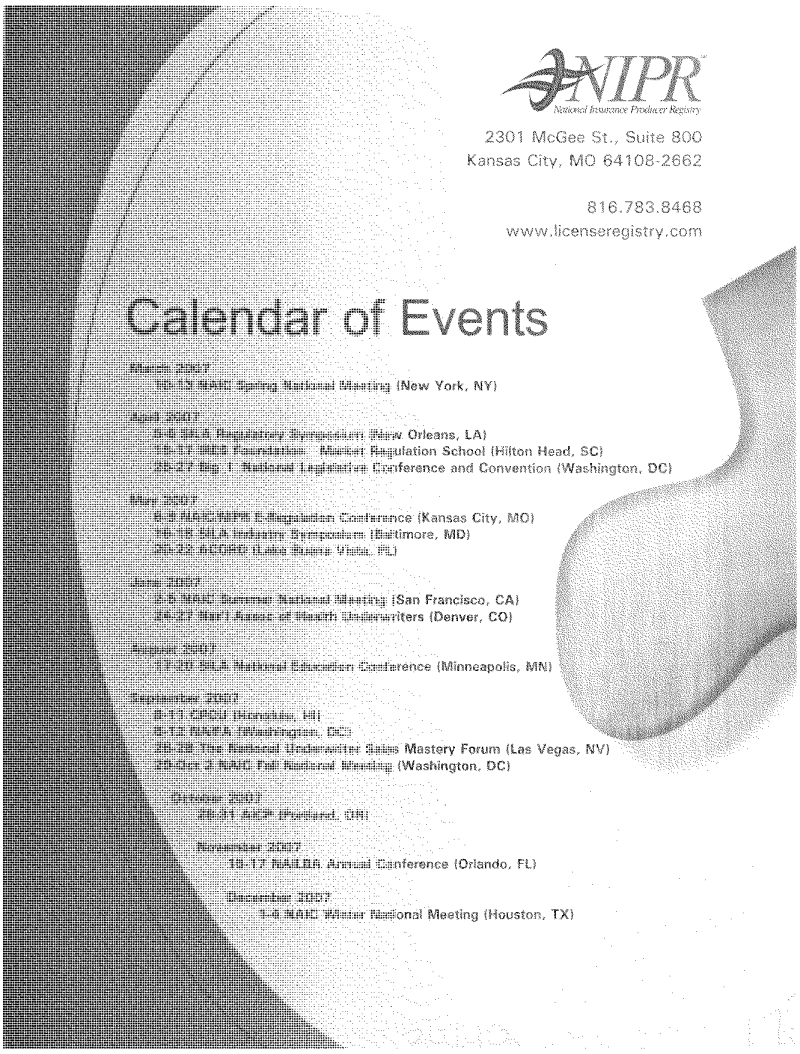


If you choose Upload [SSN,LastName] the file must be comma-delimited. You will then enter the location of the file in the box provided, or click Browse and locate the file on your hard drive.

Please Note: NPN will be the unique identifier for Alerts. The SSN will not be returned as an identifier on your Alerts.

You have now completed your set up for Alerts. You will begin receiving your Alert notices by the requested delivery method as changes are made to the PDB. If you have any questions, please contact NIPR Marketing at (816) 783-8467 or marketing@nipr.com.

We hope these instructions help explain NIPR Products. If you have any questions, please feel free to call us at **816-783-8467** or email at **marketing@nipr.com**. We value you as a customer and appreciate your business. All NIPR products are designed to be an aid to completing the licensing puzzle for regulators and the insurance industry. We welcome your comments to improve our products and our service to you - our customer. If we can be of further service, please do not hesitate to contact us. Thank you.



NIPR
National Insurance Producer Registry
2301 McGee St., Suite 800
Kansas City, MO 64108-2662

816.783.8468
www.licenseregistry.com

Calendar of Events

March 2007
16-19 NAIC Spring National Meeting (New York, NY)

April 2007
8-9 SILA Regulatory Symposium (New Orleans, LA)
15-17 SRO Foundation - Market Regulation School (Hilton Head, SC)
25-27 Big 'I' National Legislative Conference and Convention (Washington, DC)

May 2007
6-9 NAIC/NIPR E-Regulation Conference (Kansas City, MO)
16-18 SILA Industry Symposium (Baltimore, MD)
20-23 ACORD (Lake Buena Vista, FL)

June 2007
3-6 NAIC Summer National Meeting (San Francisco, CA)
24-27 Nat'l Assoc of Health Underwriters (Denver, CO)

August 2007
17-20 SILA National Education Conference (Minneapolis, MN)

September 2007
8-11 CPCU (Honolulu, HI)
9-12 NAPFA (Washington, DC)
30-Oct 3 NAIC Fall National Meeting (Washington, DC)

October 2007
28-31 AICP (Portland, OR)

November 2007
15-17 NAILBA Annual Conference (Orlando, FL)

December 2007
1-4 NAIC Winter National Meeting (Houston, TX)