S. HRG. 110–771

WHAT SENIORS DON'T KNOW BEFORE THEY ENROLL—AGGRESSIVE SALES OF MA PLANS IN MISSOURI

FIELD HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

ST. LOUIS, MO

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REGARDING THE MEDICARE ADVANTAGE PROGRAM

MONDAY, JUNE 30, 2008

U.S. SENATE
SPECIAL COMMITTEE ON AGING
St. Louis, MO

The committee met, pursuant to notice, at 9:04 a.m., at the St. Louis Senior Center, 5602 Arsenal, Hon. Claire McCaskill, presiding.

Present. Senator McCaskill.

OPENING STATEMENT OF SENATOR CLAIRE McCASKILL

Senator MCCASKILL. Good morning. I want to welcome everyone here. I appreciate everyone being here. This is a special hearing of the Senate Special Committee on Aging. I am honored to be a member of that committee in Washington, and I want to thank Chairman Kohl, Senator Kohl from Wisconsin, and Ranking Member Gordon Smith from Oregon who have agreed to allow this committee hearing to take place in St. Louis.

In visiting with Chairman Kohl, he is very aware of the challenges that seniors face right now in terms of health care decisions. He is very aware of how confusing it is and how difficult it is to make the right decisions and how susceptible many seniors are to unfortunate sales tactics that may be implemented. So he was enthusiastic about the idea of having a hearing here in St. Louis where we could get testimony from people, not just people that may be dealing with this issue nationally, but people here in Missouri that can talk about the challenges that Missourians are facing as they are confronted with the issues of health care decisions, particularly around the Medicare Advantage program.

I want to make one brief introduction. I told my mother what we were doing this morning, and she said, well, I think I need to go as an exhibit. [Laughter.]

My mother, who will turn 80 in August, is here with me. Say hi to everybody. [Applause.]

I will give a brief opening statement and then I will introduce the panel and we will take testimony from all of you. We will have a period of time where we, hopefully, can ask some questions and make sure that we leave this hearing with a clear understanding of the good news and whatever bad news there may be about these programs and the implementation of these programs.

I want to discuss Medicare Advantage plans here in Missouri. I understand these plans may be helpful under the right conditions. I am very worried, however, that after more than a year of congres-

sional scrutiny, I am still hearing from constituents, almost on a daily basis, who feel they have been victims of predatory and sometimes illegal sales and marketing techniques.

Our investigations have also revealed these concerns apply to the relatively new Medicare Advantage product, special needs plans. These plans are designed for low income or seriously ill seniors who may lose much needed assistance from Medicaid to cover copays when placed in one of these Medicare Advantage plans. It is important to ensure vulnerable seniors are not pressured into inappropriate plans due to high sales agent commissions and company profits.

Medicare Advantage was created to improve access, choice, and services for seniors. They have been touted as the solution for rural citizens, those with special needs, and as a way to increase choice and efficiently bundle services for low income seniors eligible for both Medicare and Medicaid.

In February, however, the GAO—and GAO is the Federal auditing agency that looks into all the Government programs and provides objective information to Government about those programs—released findings that under many different scenarios Medicare Advantage actually costs seniors more money out of pocket and limits the services they would have received with regular Medicare.

In addition, GAO issued another report just last week stating that Medicare Advantage plans had under-reported profits to CMS by $1.14 billion on top of the $35 billion the plans and studies made in 2005, while 80 percent of the beneficiaries were enrolled in plans for which expenses for medical care were lower than projected. In other words, what these companies are paying out in expenses are lower than we anticipated, and the money they are making is higher than we anticipated.

Further, there exists today an alphabet soup of choices for seniors, be it MA, PDP, PPO, HMO, SNP, PFFS, or MSA. Be assured the senior is given multitudes of options for each separate plan. So if the goal of these plans was to offer more choices, we should say that we have certainly succeeded. However, some would say this is a confusing array of choices. It has been to the detriment of seniors in this country.

In Missouri alone, there are over four dozen Medicare Advantage plans and special needs plans. All this choice is expensive. Congress' expert advisory panel on Medicare payment policy, which is the Medicare Payment Advisory Commission, known as MedPAC, and the Congressional Budget Office, CBO, have determined that on average the Federal Government is paying these private plans 12 percent more than it costs to treat comparable beneficiaries through traditional Medicare, with some plans receiving up to 19 percent more.

The commission has also warned us that unless we rein in these expenses, the Medicare Hospital Insurance Trust Fund will become insolvent much more quickly than currently projected.

Furthermore, Medicare's actuary has recently testified that seniors who choose to remain on traditional Medicare are subsidizing these Medicare Advantage plans by $48 per couple each year, adding up to $700 million coming from taxpayers to help finance the overpayments to these Medicare Advantage programs.

Last week, the Senate minority blocked legislation to prevent a large cut in physician Medicare reimbursement that would also have prohibited some predatory sales tactics under Medicare Advantage. I am particularly concerned about the individuals who are at greatest risk, frail elders and people with complex or serious chronic needs who are supposed to be served by the special needs plans. These are some of the fastest growing plans contributing to an 11 percent growth in overall Medicare Advantage enrollment in the last 6 months. Their growth is surely fueled in part by the 19 percent premium they receive for these plans. In other words, these plans make even more money for the companies than the regular Medicare Advantage plans. So there is an incentive for these companies to, in fact, market the special needs plans. They are more profitable for the companies.

I look forward to hearing from our witnesses about these issues. It is my intention to continue efforts in Washington to address and resolve them, including putting pressure on Congress and this administration to assure that seniors are not being swindled and that the American taxpayer is not either.

Today I want to get a "boots on the ground" look at how the Medicare Advantage plans have impacted my State.

With that, I welcome the testimony from today's witnesses and their information as to how we can best move forward from here to protect seniors with good quality health care that is not so confusing to seniors that it makes them sick.

Let me introduce the panel. First, I will begin on my right and I will introduce all of the panel, and then each of you will be given 5 minutes to testify. Then we will have time for questions and answers that will all go on the record.

Gloria Maples is here. She is a senior from Troy, MO. She is a courageous woman, caring for others so much she is here to share her story to prevent others from suffering the same problems that she has encountered.

Next is Kathryn Coleman. She is the Associate Regional Administrator for the Division of Medicare Health Plans Operations for CMS in Kansas City. She has spent years working for better health for senior citizens in Missouri and 13 States across the Midwest.

Rona McNally is the Project Manager for the Missouri SNP. She is a caring woman who has fought for years to provide advocacy and accurate education for Missouri's senior citizens.

Carol Beahan is the Director of the CLAIM Program. She has 20 years of experience working with older adults and providing them with things like home health, senior centers, and Medicare education.

Mary Kempker is the Consumer Affairs Director for the Missouri Department of Insurance Institutions and Professional Registration. Beyond her 14 years as a consumer advocate, she is an active member of multiple boards dealing directly with senior health issues.

Wes Shoemyer is the Senator from the northeast corner of our State. He is a farmer. He is a tireless advocate for the people in his district, and he has introduced legislation in the Missouri legislature dealing with some of the problems that he has learned about. He came to this issue the same way I did, seniors calling

him on the phone as their elected representative saying, help, I am confused. Something is wrong. I accidentally got the wrong plan. I do not know how to get out. I am not sure what plan to be in. This is the kind of calls that all elected officials are getting on a constant basis from the people we represent because of the confusing choices that are out there right now. He is here to testify about his perspective on this important problem.

Robb Cohen is Chief Government Affairs Officer for XLHealth. He has over 20 years of health care experience, including health care consulting and investment banking, and he frequently lectures on health care policy and management topics.

We will begin the testimony this morning with Ms. Maples from Troy, MO. Thank you so much for being here.

STATEMENT OF GLORIA MAPLES, TROY, MISSOURI

Ms. MAPLES. I went on Medicare May 1, 2006. I have Part A and B. Physicians Mutual is my supplement and Advantra RX Premier is my prescription D plan. I pay $5 for generics, $25 for non-generics. I have had no copays for doctor, hospital, blood work, and for specialists.

In October 2006, I had unexpected three-way bypass surgery and was in the hospital for 7 days. I ended up with four specialists and paid no money out of pocket.

On January 13, 2007, a lady came to my house from GHP. She showed me what I was paying for Physicians Mutual and prescription D a year and what GHP Advantra Option II would cost a year with copays to doctors and specialists. It sounded good. So I signed up for it.

Later in January, when I got my card and literature, I decided it was not a good deal when I started reading a $175 copayment per day for 5 days for phase 1 through 5 per stay because if you go in 2 weeks or a month later, the hospital days start over again, a $250 copayment for out patient facility, 20 percent coinsurance for outpatient procedures, and much more. I decided, since I already had a serious surgery, this was not the plan for me.

I called GHP on January 29, 2007 and told Christine I wanted to cancel GHP Advantra Option II that was to start February 1. She put it in the computer and said, OK, it is canceled. Then I called Advantra RX Premier, my prescription plan, and talked to Robert and told him not to cancel me February 1. He put that in the computer and said, OK, it is not canceled.

February 22 I found out I was still with GHP. Fourteen phone calls later between Advantra RX and GHP, I sent a copy of all paperwork around April 16th to the Department of Insurance.

Finally, on May 20, 2008, I received a letter from GHP stating I will be disenrolled as of May 31, 2008.

On May 29, Deb Mitchell from GHP called Medicare and we had a three-way call with Tea Smith. She took my Medicare information and re-enrolled me with Advantra RX Premier, telling me it would take effect June 1. Six phone calls in June to Advantra RX, three phone calls from them, two faxes, that I sent them stating they did not get, I have no health insurance or prescription plan for the month of June, going into July and have to pay out of pock-

et for my prescriptions and one I did not get, as it would have been $120 out of pocket.

[The prepared statement of Ms. Maples follows:]

Gloria J. Maples

I was misinformed with GHP on a few things and when I got my Health card and literature, I called on Jan 29 & cancelled as it was suppose to start Feb 1. Christina said ok it's cancelled, same day I called Advavtra RX Primier and told them do not cancell me out. Robert said OK it's taken care of.
Feb 21 late in the day received call from DR. saying I am no longer in Medicare.
Feb 22 Called GHP Nancy said it showed that I was not cancelled on Jan 29 and that I had to sign a paper to be disenrolled. She faxed it to me, I faxed it back.
Feb 28 Gladys Gill from GHP telling me I have to re enroll with Advantra Rx Primier then they will let Medicare know.
Feb 28 called Advantra RX Primier, talked to Brenda Tubbes for 60 minutes explaining everthing then I waited 15 minutes being transfered to enrollment dept. Cheyenne said my re enrollment would start March 1st. Did not happen!
March 8 received letter from Advantra RX Primier asking for Proof OF Special Elgibilty. I am totally confused!
March 10 my insurance man came to my house, for 3 1/2 we was on the phone with GHP and an underwriter named,Fredia She even called GHP.
Had to refax papers to them that I faxed on Feb 22.
March 14 Gladys Gill from GHP called and told me to call Advantra RX Primier and tell them I have 1 election and this will disenroll
me from GHP. This also did not happen!
5 more phone calls to Advantra RX in March.
4 phone calls to them in April
Around April 16 sent all paper work to Dept of Health Ins.
May16 received a phone call form Deb Mitchell GHP Appeal Coordinator stating that GHP approved me to be disenrolled from them going back to Feb 1st. I asked how that would work going back that far when I had 4 months of perscriptions, 8 Chiropractic visits, 2 primary visits, 1 to my cardivasculor Dr. and lab work. Plus I was paid up until May 31st and made all my co pays.
She said she did not know.
May 27 called Medicare explained everything to Laura Lee. She said my disenrollment should end Mat 31st not Feb 8th.
May 27 Called Deb Mitchell at GHP told her what Medicare said. She said ok but she had to talk to somone else and she would call me back.
May27 Mike Davis called me from GHP, He explained to me how much I was paying for Physcians Mutual & Advantra RX & how much I was paying for GHP if I do not go in hospitol for any major surgeries I told him I knew all that but I did have a major surgery and I did not pay out 1 cent and I want to go back to that. He said OK and Deb would call back to me
May 29 called Deb Mitchell at GHP told her I needed letter faxed to me stating I am disenrolled as of May 31st,she faxed that to me and called Medicare and we had a 3 way phone call talking to Tea Smith. She took my Medicare information and renrolled me with Advantra RX Primier stating it would take effect June 1st.
5 phone calls in June to Advantra RX I still am not with them, Medicare shows I

am with GHP and GHP shows I am no longer with them as of May 31st.
I have no health coverage or perscription D coverage and I had to pay out of pocket for my June perscriptions!
In closing when you call these 2 places not counting Medicare, you get someone differant and if you ask to be transferred to someone higher up they can not do that and a lot of times you will get differant answers to the same question.I have lots of paperwork on this subject

Senator MCCASKILL. Thank you very much. I think that was a pretty good illustration of how difficult it can be to undo one of these decisions once you have made it based on a salesperson convincing you that it is a good thing and then later figuring out that maybe it is not the right thing. Thank you very much for your testimony.

Ms. Coleman.

STATEMENT OF KATHRYN COLEMAN, ASSOCIATE REGIONAL ADMINISTRATOR, DIVISION OF MEDICARE HEALTH PLANS OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES, KANSAS CITY, MO

Ms. COLEMAN. Good morning, Senator McCaskill.

Senator MCCASKILL. Good morning.

Ms. COLEMAN. My name is Kathryn Coleman. I am from the Kansas City Regional Office of the Centers for Medicare and Medicaid Services (CMS). I am pleased to be here today to discuss the CMS oversight of sales and marketing on Medicare health plans, specifically Medicare Advantage (MA) programs.

Building on the lessons learned and information gathered during 2006 and 2007, CMS has continued to strengthen its oversight of MA organizations this year. Examples of our recent compliance and oversight improvements include posting surveys of corrective actions taken against MA organizations on our Web site, establishing higher star ratings for plan performance, embarking on an extensive secret shopping program of plan marketing events that has led to compliance actions, and more accurate sales presentations, requiring private fee-for-service plans to call new enrollees to verify their desire to join the plan, and most recently proposing an extensive set of new regulations related to marketing and beneficiary protection.

Fundamentally, before a plan sponsor is allowed to be participating in Medicare Advantage, it must submit an application and secure CMS approval. CMS performs a comprehensive review of each application to determine whether the sponsor meets program requirements. Participation one year is no guarantee that the plan would be permitted to participate in future years. Every year plans also must submit formulary and benefit information for CMS review prior to being accepted for the following contract year. For each 10 sponsors, CMS has established a single point of contact known as an account manager for all communications with the plan, and the account managers work with the plans quickly to resolve any problems, including compliance issues.

CMS also collects and analyzes performance data submitted by plans' internal systems and beneficiaries on an ongoing basis. We have established baseline measures for performance data and have been tracking results. Plans not meeting these baseline measures are contacted by CMS and compliance actions are typically initiated. Actions range from warning letters all the way through civil monetary penalties and/or pulled 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, of course, the foremost concern.

Oversight efforts are not limited to CMS' efforts alone. We have strengthened our relationship with State regulators that oversee the market conduct of health insurers, including MA organizations.

But clearly, we have more work to do. Specifically, CMS has worked cooperatively with the National Association of Insurance Commissioners and the State's Department of Insurance in Missouri to develop model compliance and enforcement of a memorandum of understanding (MOU). This MOU enables us and the State's Department of Insurance to freely share compliance and enforcement information to better oversee the operations and market conduct of the companies we try to regulate and to facilitate the sharing of specific information about marketing agent conduct. Missouri, of course, was very involved with the drafting of the MOU and was the first State to sign it in April of 2007.

CMS recently issued a proposed regulation as a continuation of our efforts to enhance compliance and oversight of the MA program. The proposed rule would incorporate into regulation a number of requirements that CMS previously applied through operational guidance and it also would introduce several new Medicare Advantage plan requirements. The new proposed prohibitions on door-to-door marketing and cold-calling, as well as new proposed requirements pertaining to broker-agent commissions, are even more stringent than what the insurance industry recently endorsed as necessary for the program.

The proposed rule would also make a number of changes to the requirements for special needs plans, a type of Medicare Advantage plan that provides coordinated care to individuals in certain institutions such as nursing homes, and those who are eligible for both the Medicare and Medicaid programs and/or have certain severe or disabling chronic conditions. These plans are required to adhere to the same marketing guidelines and other general Medicare Advantage program requirements.

Among other things, the proposed rule would add the following additional requirements. Plans would be required to have documented arrangements with States to facilitate the coordination of Medicare and Medicaid benefits. Plans would be required to verify a beneficiary's special needs plan's eligibility prior to enrollment, and plans would be required to include in the contract with providers language specifying that the beneficiary is not liable for costs that are the responsibility of the State under Medicaid. Finally, plans would be required to have models of care specifying delivery of care standards specific to the types of special needs individuals enrolled in the plan.

In addition, to discourage churning of beneficiaries from plan to plan each year in a manner that earns agents and brokers the highest commissions, the proposed regulation would establish commission structures for sales agents and brokers that are level across all years and across all Medicare Advantage plan products. These requirements are designed to ensure that beneficiaries are receiving the information and counseling necessary to select the best plan based on their needs.

In addition to the regulation, we also will be using several mechanisms to ensure that Medicare Advantage organizations conduct marketing activities that are compliant with existing regulations

and guidelines. We have been very clear that organizations are responsible for the actions of sales agents and brokers whether they are employed or contracted. They must ensure that they are properly trained in both Medicare's 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 their health-related or non-health-related services or benefits. Employees, brokers, and independent agents must first ask the beneficiary's permission before providing assistance in their residence prior to conducting any sales presentation or accepting an enrollment form in person.

We continue to make significant progress in overseeing Medicare Advantage organizations and Part D plan sponsors. With ongoing effort and vigilance, I am confident we will continue to see high levels of plan compliance with program requirements, along with significant improvements where necessary.

Thank you for the opportunity to be here this morning, and I look forward to the questions.

[The prepared statement of Ms. Coleman follows:]

STATEMENT OF

KATHRYN COLEMAN,

ASSOCIATE REGIONAL ADMINISTRATOR

DIVISION OF MEDICARE HEALTH PLANS OPERATIONS

KANSAS CITY REGIONAL OFFICE

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICARE ADVANTAGE IN MISSOURI

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

June 30, 2008

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
Kathryn Coleman,
Associate Regional Administrator
Division of Medicare Health Plans Operations
Kansas City Regional Office
Centers for Medicare & Medicaid Services
Before the
Senate Special Committee on Aging
On
Medicare Advantage in Missouri
June 30, 2008

Good morning, Senator McCaskill. I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) oversight of sales and marketing by Medicare health plans – specifically, Medicare Advantage (MA) organizations.

Building on lessons learned and information gathered during 2006 and 2007, CMS has continued to strengthen its oversight of MA organizations this year. Examples of our recent compliance and oversight improvements include: posting summaries of corrective actions taken against MA organizations on the CMS web site; establishing five-star ratings for plan performance; embarking on an extensive secret shopping program of plan marketing events that has led to compliance actions and more accurate sales presentations; requiring private-fee-for-service plans to call new enrollees to verify their desire to join the plan; and most recently, proposing an extensive set of new regulations related to marketing and beneficiary protections.

Fundamentally, before a plan sponsor is allowed to even participate in the MA program, it must submit an application and secure CMS approval. CMS performs a comprehensive review of each application to determine whether the sponsor meets program

requirements. Participation one year is no guarantee that the plan will be permitted to participate in future years. Every year, 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. Account Managers work with plans to quickly resolve any problems, including compliance issues.

CMS also collects and analyzes performance data submitted by plans, internal systems, and beneficiaries on an ongoing basis. We have established baseline measures for the performance data and have been tracking results over time. Plans not meeting the baseline measures are contacted by CMS and compliance actions are typically 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.

Oversight efforts are not limited to CMS's efforts alone. CMS has strengthened relationships with State regulators that oversee the market conduct of health insurers, including MA organizations. 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. Missouri was very involved with the drafting of the MOU and signed it on April 16, 2007.

As noted, CMS recently issued a proposed regulation – Revisions to the Medicare Advantage and Prescription Drug Benefit Programs – as a continuation of efforts to enhance compliance and oversight of the MA program over the past months. The proposed rule would incorporate into regulation a number of requirements that CMS previously applied through operational guidance. It also would introduce several new MA plan requirements. The new proposed prohibitions on door-to-door marketing and cold-calling as well as new proposed requirements pertaining to broker/agent commissions are even more stringent than what the insurance industry recently endorsed as necessary regulatory improvements to the program.

The proposed rule would make a number of changes to requirements for Special Needs Plans (SNPs), a type of MA plan that provides coordinated care to individuals in certain institutions such as nursing homes, and those who are eligible for both the Medicare and Medicaid programs and/or have certain severe or disabling chronic conditions. These plans are required to adhere to the same marketing guidelines and other general MA program requirements. Among other things, the proposed rule would add the following additional requirements: plans would be required to have documented arrangements with States to facilitate coordination of Medicare and Medicaid benefits; plans would be required to verify beneficiaries' SNP eligibility prior to enrollment; plans would be

required to include in contracts with providers language specifying that the beneficiary is not liable for costs that are the responsibility of the State under Medicaid; and, finally, plans would be required to have models of care specifying delivery of care standards specific to the types of special needs individuals enrolled in the plan.

Similarly, to discourage "churning" of beneficiaries from plan-to-plan each year in a manner that earns agents and brokers the highest commissions, the proposed regulation would establish commission structures for sales agents and brokers that are level across all years and across all MA plan product types (for example, HMOs, PPOs, and private fee-for-service plans). These requirements are designed to ensure that beneficiaries are receiving the information and counseling necessary to select the best plan based on their needs.

In addition to the proposed regulation, CMS is using several mechanisms to ensure that MA organizations conduct marketing activities that are compliant with existing regulations and marketing guidelines. We have been very clear that 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. 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. 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 now would be happy to answer any questions you may have.

Senator MCCASKILL. Thank you. Thank you for your public service.

Ms. McNally.

STATEMENT OF RONA McNALLY, PROJECT MANAGER, THE MISSOURI SMP

Ms. MCNALLY. Good morning, Senator McCaskill. I thank you for the opportunity to share my experiences regarding Medicare Advantage marketing issues.

I am Rona McNally, Project Manager for the Missouri SMP. We are a statewide program empowering seniors to prevent Medicare and Medicaid error, fraud, and abuse. We are funded by the U.S. Department of Health and Human Services, Administration on Aging. We partner with the Missouri Alliance of Area Agencies on Aging to provide education and advocacy for Missouri's seniors.

The implementation of Medicare Part D coincided with the statewide availability of Medicare Advantage, increasing the task of insuring that all people with Medicare understand the choices that are available to them. This increased beneficiaries' vulnerability to very aggressive sales tactics.

Prior to the approved date that marketing activities could begin, aggressive sales practices were already apparent. Insurance agents were requesting opportunities to present educational seminars at senior centers and volunteer for programs stating that they are representatives of Medicare or mandated by Medicare to do outreach and education. When these efforts failed, agents attended presentations given by area agency on aging staff in order to provide information regarding the plans they represent.

Free meals are one of the tactics used by sales people. Seminars are often offered at local restaurants in order to educate seniors about Medicare benefits. I attended one such meeting. The representatives provided information about investments, insurance plans, and told about the helpful resources they could offer. However, the information and resources were not available at the meeting. In order to receive any information, an agent would need to visit their home.

We have noticed that the calls are often the same regardless of the area of the State they come from. Common calls include a senior receives a call from a person claiming to be with Medicare, stating that someone needs to come to their home to discuss their benefits. Many seniors report the caller to be very insistent and at times rude or threatening. One person made a call to an insurance company with the intention of purchasing a prescription plan but eventually discovered they have enrolled in a Medicare Advantage plan or been convinced that a free Medicare Advantage plan would be better for them. This is frequently discovered when a person visits their physician's office only to find that the physician will not accept the plan's payment.

Agents come to the door unexpectedly and state he or she is with Medicare and need to speak to the resident about their Medicare benefits. Most report they believe the plan to be a supplement to Medicare, a Medicare prescription plan, or a specific plan to pay for vision, dental, and hearing services only.

Agents who visit senior housing apartments and complexes often go door to door or host bingo games with prizes. Residents are then switched to a Medicare Advantage plan.

People receiving both Medicare and Medicaid benefits, known as dual-eligibles, are prime targets for sales representatives as they are able to change plans one time per month all year long. Agents will change these individuals from plan to plan, called churning. It happens so many times, that most often the individual is unable to inform us of which plan that he or she is currently enrolled in. At one point, an agent had churned an individual so many times that the agent himself called our office for help. Plan information is shared through databases, and the client had been switched from plan to plan so many times that the databases were not matching information and the pharmacy database was showing that the client had no drug coverage. It took us 4 days to unravel the situation providing her access to prescription coverage.

A lady from a senior housing complex in our town received a call one day at approximately 11 a.m. from someone stating he needed to come to her home to discuss her Medicare and Medicaid benefits with her at two that afternoon. She called my office with questions and concerns, and I agreed to come to her apartment to be with her during her visit. A young man came to her door, sat down in her living room, and proceeded to inform her that he had a plan for her that would provide her with vision, dental, and hearing coverage at no cost to her.

The resident questioned him as to how his company could afford to provide those benefits to her at no cost. He replied that the Government pays them well to provide the benefits, and besides, he would enroll her in this policy build a trusting relationship with her and then sell her a life insurance policy.

I asked the agent to leave material behind for her to discuss with her son and stated that she had questions she needed answers to before making this commitment, such as whether her doctor may accept this plan. The agent wanted us to get the phone right away and he would call for her. When he finally left her apartment, she stated that she did not know what she would have done if she had been alone. She felt so pressured.

These circumstances often come between people with Medicare and their access to health care. For example, we assisted one lady who relies on weekly injections to be able to walk. She has not been able to receive the injections for about four weeks because her physician would not accept the Medicare Advantage plan she had enrolled in. However, the agent that sold her the plan assured her that all providers accept the plan.

I thank you for this opportunity to share with you the experiences and concerns that have been expressed to us. I welcome the opportunity to answer any questions you may have.

[The prepared statement of Ms. McNally follows:]

Good morning Senator McCaskill. I thank you for the opportunity to share my experiences regarding Medicare Advantage marketing issues.

I am Rona McNally, Project Manager for the Missouri SMP, a statewide program empowering seniors to prevent Medicare and Medicaid error, fraud, and abuse, funded by the U.S. Department of Health and Human Services Administration on Aging. We partner with the Missouri Alliance of Area Agencies on Aging to provide education and advocacy for Missouri seniors.

The implementation of Medicare Part D coincided with the statewide availability of Medicare Advantage, increasing the monumental task of ensuring that all people with Medicare understand the choices that are available to them. This increased beneficiaries' vulnerability to very aggressive sales tactics.

Prior to the approved date that marketing activities could begin, aggressive sales practices were already apparent. Insurance agents were requesting opportunities to present educational seminars at senior centers, pay for lunches, and volunteer for programs, stating that they are representatives of Medicare or mandated by Medicare to do outreach and education. When these efforts failed, agents attended presentations given by area agency on aging staff in order to provide information regarding the plans they represent.

Free meals are one of the tactics used by salespeople. Seminars are offered at local restaurants in order to educate seniors about new Medicare benefits. I attended one such meeting. The representatives provided information about investments, insurance plans, and told about the helpful resources they could offer. However, the information and resources were not available at the meeting. In order to receive any information, an agent would need to visit them at their home.

We have noticed that the calls are often the same, regardless of the area of the state they come from. Common calls include:

- Seniors receive a call from a person claiming to be with Medicare stating that someone needs to come to their home to discuss their benefits. Many seniors report the caller to be very insistent and, at times, rude or threatening.
- Placing a call to an insurance company with the intention of purchasing a prescription drug plan, but eventually discovering that they have enrolled in a Medicare Advantage plan, or being convinced that a "free" Medicare Advantage plan would be better for them. This is frequently discovered when a person visits their physician's office, only to find that the physician won't accept the plan's payment.
- Agents came to the door unexpectedly and state he or she is with Medicare and need to speak to the resident about their Medicare benefits. Most report that they believed the plan to be a supplement to Medicare, a Medicare prescription plan or a specific plan to pay for vision, dental and hearing services only.
- Agents have visited senior housing apartments and complexes, often going door-to-door or hosting bingo games with prizes. Residents are then switched to a Medicare Advantage plan.

People receiving both Medicare and Medicaid benefits, known as dual eligibles, are prime targets for sales representatives, as they are able to change plans one time per month all year long. Agents will change these individuals from plan to plan, called "churning." It happens so many times that most often an individual is unable to inform us of which plan he or she is currently enrolled in. At one point, an agent had "churned" an individual so many times that the agent himself called our office for help. Plan information is shared through databases, and the client had been switched from plan to plan so many times that the databases were not matching information and the pharmacy database was showing that the client had no drug coverage. It took us four days to unravel the situation and provide her access to prescription coverage.

A lady from the senior housing complex in our town received a call one day at approximately 11:00 a.m. from someone stating that he needed to come by her home to discuss her Medicare and Medicaid benefits with her at 2:00 that afternoon. She called my office with questions and concerns and I agreed to come to her apartment to be with her during the visit. A young man came to her door, sat down in her living room and proceeded to inform her that he had a plan for her that would provide her with vision, dental, and hearing coverage at no cost to her. The resident questioned him as to how his company could afford to provide those benefits to her at no cost. He replied that the government pays them very well to provide the benefits, and besides, he would enroll her in this policy, build a trusting relationship with her, and then sell her a life insurance policy. I asked the agent to leave materials behind for her to discuss with her son and stated that she had questions she needed answers to before making this commitment, such as whether her doctor would accept this plan. The agent wanted us to get the phone right away and he would call for her. When he finally left her apartment, she stated that she did not know what she would have done if she had been alone, she felt so pressured.

These circumstances often come between people with Medicare and their access to healthcare. For example, we assisted one lady who relies on weekly knee injections to be able to walk. She had not been able to receive the injections for about four weeks because her physician would not accept the Medicare Advantage plan she had enrolled in, however the agent that sold her the plan assured her that all providers accept the plan.

I thank you for this opportunity to share with you the experiences and concerns that have been expressed to us. I welcome the opportunity to answer any questions you may have.

Senator MCCASKILL. Thank you so much.
Ms. Beahan.

STATEMENT OF CAROL BEAHAN, DIRECTOR, CLAIM PROGRAM

Ms. BEAHAN. On behalf of the CLAIM Program, it is my pleasure to testify before this——

Senator MCCASKILL. You probably need to hold that a little closer.

Ms. BEAHAN. Get closer?

Senator MCCASKILL. That is better.

Ms. BEAHAN [continuing]. Testify before the Senate Special Committee on Aging. My name is Carol Beahan and I have the privilege and honor to serve as the Director of CLAIM, the State health insurance assistance program for Missouri.

The Centers for Medicare and Medicaid Services provide our funding through a contract with the Missouri Department of Insurance Financial Institutions and Professional Registration. We collaborate with community partners and community hospitals, community action agencies, area agencies on aging, and faith-based organizations to train volunteer staff about Medicare. We do not only teach them about Medicare Part A, B, C, and D, but also about supplemental insurance, Missouri Health, net Missouri's Medicaid Program. Every day our volunteers provide objective guidance as they assist people to make informed decisions regarding their Medicare benefits.

Medicare Advantage plans challenged our training and counseling due to the complexity of the plans. During December 2007 and through May 2008, we have documented over 1,400 inquiries regarding the plans. CLAIM identifies two primary concerns regarding Medicare Advantage plans. Improper sales tactics by agents and brokers; lack of education to agents, providers, and consumers regarding enrollment, benefits, and plan mobility. I would like to address both of these issues.

CLAIM concurs with prior statements made by our colleagues. One of our volunteers, regularly attends Medicare Advantage plan luncheons and public events and indicates the sales pitch often lacks detail. Specific information about cost sharing or benefit coordination with providers is often glossed over.

Several of our community partners are located in public housing facilities. They have explained to us that agents visit a resident and use the opportunity to get referrals for other clients within the building. Although not illegal, it has resulted in many residents changing their plans without totally understanding what they have done. Important health plan changes are being made on the fact that their friend told them about the nice lady or gentleman who just visited them. Older adults are often trusting and can be easily misled.

The individual ability of an agent to sell his product can be very effective. For example, we determined that one of our recent callers purchased the same plan she was already enrolled in because the new agent made the benefits sound so much better than the benefits they had.

In Missouri, we do have 47 Medicare Advantage plans and 12 special needs plans available. Although not all the plans are avail-

able in all portions of the State, it still makes choices overwhelming even for the savviest consumer. The following are just a few examples of the concerns.

Lack of provider education can ultimately cost the consumer. When inadvertently referring a patient to a follow-up test to an out-of-network provider, who is responsible for that error? The doctor and provider of the test or the consumer? The consumer is responsible for the bill.

Medicare Advantage plans in nursing home facilities. We are aware of situations where a person in a nursing home had been told to drop their Medicare Advantage plan. This is not the best advice. The person may or may not able to purchase a supplemental policy or they may not be eligible for Medicaid, leaving them with Medicare only. The Medicare Advantage plan is responsible for skilled nursing care just as much as traditional Medicare.

Each Medicare Advantage plan is set out to service specific areas by designated ZIP codes. Education must be provided to ensure clients understand what areas of the State are included in the network. Hardships are incurred by clients who move to new ZIP codes and learn their plan no longer works for them as they are out of network, out of the service area, or providers do not accept the payment from the plan.

Traditionally Medicare benefits do not cover all medical expenses. There are deductibles and coinsurance to consider. Enrollment in a Medicare Advantage plan needs special attention to details in order to determine the best alternative for their individual cost sharing. Decisions for dual-eligibles, some of our most vulnerable clients, become even more difficult. It is especially important for Medicare Advantage plan agents to thoroughly understand the ramifications of their plans with respect to the client's needs. This does not always occur.

These problems are symptoms of lack of education by agents, providers, and consumers. The stories could fill volumes. One thing that is clear. These plans may be great for the marketplace, but improvements should serve the public. It is obvious the older an individual becomes, the more difficult it becomes for them to understand the multitude of choices presented. Due to the number of plan sales and marketing practice requiring closer scrutiny and authority and enforcement by the Missouri Department of Insurance, agents must be fully educated before they are allowed to sell plans. A company offering Medicare Advantage plans must also commit to educating providers and consumers.

I appreciate the opportunity to speak before you today, and I shared with you some real-life situations about Medicare Advantage plans and how they are impacting Missourians. The employees and the volunteers at CLAIM will continue to assist people with Medicare so they can make informed decisions regarding their benefits.

Thank you and I welcome the questions.

[The prepared statement of Ms. Beahan follows:]

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Senate Special Committee on Aging
June 30, 2008
St. Louis, Missouri

Testimony submitted by Carol Beahan

On behalf of the CLAIM Program it is with pleasure I testify before the Senate Special Committee on Aging. My name is Carol Beahan and I have the privilege and honor to serve as the Director of CLAIM, the state health insurance assistance program for Missouri. The Centers for Medicare & Medicaid Services provide our funding through a contract with the Missouri Department of Insurance, Financial Institutions and Professional Registration. We collaborate with local community partners including hospitals, community action agencies, area agencies on aging and faith-based organizations to train volunteers and staff about Medicare. We not only teach them about Medicare Part A, B, C and D, but also about supplemental insurance and Mo Health Net (Medicaid). Every day our volunteers provide objective guidance as they assist people to make informed decisions regarding their Medicare benefits.

Medicare Advantage Plans challenge our training and counseling due to their complexity. During December 2007 through May 2008 we have documented over 1,400 inquiries regarding the plans. CLAIM identifies two primary concerns regarding Medicare Advantage Plans:

1. Improper sales practices by agents/brokers
2. Lack of education to agents, providers and consumers regarding enrollment, benefits, and plan mobility

I will address both of these issues.

Improper sales practices by agents/brokers

CLAIM concurs with the prior statements made by our colleagues. One of our volunteers regularly attends Medicare Advantage Plan luncheons and public events and indicates the sales pitch often lacks details. Specific information about cost sharing or benefit coordination with providers is often glossed over.

A public housing story . . . Several of our community partners are located in public housing facilities. They have explained to us that agents visit a resident and use the opportunity to get referral for other clients within the building. Although not illegal, this results in many residents changing their plans without totally understanding what they have done. Important health plan changes are made based on the fact that their friend told them about the nice lady or gentleman who just visited them. Older adults are often trusting and can be easily misled.

The sales pitch… The individual ability of an agent to sell his product can be very effective. For example, we determined that one of our recent callers purchased the same plan she was already enrolled in because the new agent made the benefits sound so much better than the benefits she was already receiving.

Lack of education to agents, providers and consumers regarding enrollment, benefits and plan mobility

In Missouri there are 47 Medicare Advantage Plans and 12 Special Needs Plans available. Although not all plans are available in all portions of the state, it still makes choices overwhelming even for the savviest consumer. Following are just a few examples of concern.

Lack of provider education can ultimately cost the consumer. When inadvertently referring a patient for follow-up tests to an out-of-network provider, who is responsible for the error? The doctor, the provider of the test or the consumer? The consumer is responsible for the bill.

Medicare Advantage Plans and nursing home facilities... We are aware of situations where a person in a nursing home has been told to drop their Medicare Advantage Plan. This is not the best advice. The person may or may not be able to purchase a supplemental policy or they may not be eligible for Medicaid, leaving them with Medicare only. The Medicare Advantage Plan is responsible for skilled nursing care just as much as traditional Medicare.

Each Medicare Advantage Plan is set up to serve specific areas designated by zip codes. Education must be provided to ensure clients understand what areas of the state are included in their network. Hardships are incurred by clients who move to a new zip code and learn their plan no longer works for them as they are out of network, out of the service area or providers do not accept payment from that plan.

Traditionally, Medicare benefits do not cover all medical expenses and there are premiums, deductibles and co-insurance to consider. Enrollment in a Medicare Advantage Plan heeds special attention to details in order to determine the best alternative for an individual's cost sharing. Decisions for dual eligibles, some of our most vulnerable clients, become even more difficult. It is especially important for Medicare Advantage Plan agents to thoroughly understand the ramifications of their plans with respect to the client's needs. This does not always occur.

These problems are all symptoms of lack of education by agents, providers and consumers. The stories could fill volumes.

One thing is clear, these plans may be great for the market place but improvements could be made to better serve the public. It is obvious that the older an individual becomes, the more difficult it becomes for them to understand the multitude of choices presented. Due to the number of plans, sales and marketing practices require closer scrutiny and authority for enforcement by the Missouri Department of Insurance. Agents must be fully educated before they are allowed to sell plans. Subsequently, the companies offering Medicare Advantage Plans must also commit to educating providers and consumers.

I sincerely appreciate the opportunity to speak before you today. I share with you real-life situations about Medicare Advantage Plans and how they are impacting Missourians. The employees and volunteers of CLAIM will continue to assist people with Medicare so they can make informed decisions regarding their benefits.

Senator MCCASKILL. Thank you, Ms. Beahan.
Senator Shoemyer.

STATEMENT OF HON. WES SHOEMYER, STATE SENATOR FROM MISSOURI

Mr. SHOEMYER. Thank you, Senator McCaskill. Thanks for holding this. Of course, I thank Senator Kohl for putting this out. I thank the St. Louis Senior Center for allowing all of us to be here.

I am Senator Wes Shoemyer, and I serve 13 counties in northeast Missouri, a very rural area. I think my being here this morning tells us how widespread this problem is. In fact, in rural Missouri, what I have really found—we hear Medicare supplement policies, and what many folks do not understand is that these are replacement policies. In an era of HMO's and PPO's and fee-for-service, the folks in my area, especially in the rural parts of Missouri, are under a fee-for-service scheme. When they buy this policy, certainly benefits are put before them that are available, but they only find that those benefits are available 300 miles away or 200 miles away. I think when you are a senior and your access to transportation and your access to mobility—this is very disheartening to those folks who have been sold a policy that they thought was going to really cover their health care and only go to their local doctor and be turned away.

I want to thank the folks from CLAIM and RSVP, Heartland RSVP, from Kirksville in my area. They have been very diligent in working with the folks to get them back on the red, white, and blue card.

Much of my testimony also goes into being very confusing aspects that folks have. So I do not want to go through all of it, except I wanted to highlight—maybe the most abused is dual-eligibles with Medicaid. These applicants are the ones, in fact, that they are very targeted.

I do want to tell you what we did in Missouri. Obviously, we cannot, as the Federal Government can do——and I got to tell you, Senator, with $1.4 billion, we could get a lot of health care I believe. So I really appreciate that.

But we can only regulate how business is conducted, and I think that we heard that there are some rules being written. But what my legislation—what I thought really needed to be done was require a two business day waiting period between the presentation of the plan to an applicant and to sign the paperwork enrolling them in a plan. Let us give a little cooling off period so the pressure that is put on people immediately—they have a chance to think. As they always say, go sleep on it.

Then we will require the agent to provide each client with a statement, approved by our department, that advises the applicant to check with their doctor or other health care providers to make sure that they will accept the plan. Make this very clear and very bold.

They also require the agent to have the applicant to sign a disclosure statement that they were given information stating that Medicare Advantage plans are not Medigap or supplemental plans. Make it very clear that this is a replacement policy.

We heard this legislation in committee. Obviously, there was no one testifying in opposition. It did not move any further than the committee hearing in the State. Obviously, there are some pretty powerful interests that do not want to see this type of regulation for protection of little people go forth.

Senator Engler offered a similar bill. We did get that amended on House bill 1283, which was the Insure Missouri bill. However, that bill died in the Senate.

So I think the real reason I came was to see the number of folks here in the city. I drove across a lot of vast area. I have really got a lot to do when I get home. I have got to plant some beans. That means that is how important it is all across the State, and that is why I appreciate so much you traveling here and taking this testimony. I look forward to any questions. Thank you.

[The prepared statement of Mr. Shoemyer follows:]

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18TH DISTRICT – COUNTIES OF:
ADAIR, AUDRAIN, CLARK, KNOX,
LEWIS, MARION, MONROE, PIKE,
PUTNAM, RALLS, SCHUYLER,
SCOTLAND & SHELBY

MISSOURI SENATE

WES SHOEMYER

18TH DISTRICT

June 27, 2008

United States Senate Special Committee on Aging
Washington, DC 20610-6400

Members of the Committee:

Good morning.

I am Missouri State Senator Wes Shoemyer from the Missouri 18th Senatorial District which encompasses 13 counties in northeast Missouri.

Last summer, my office started receiving calls from elderly folks who had listened to the advertisements on television or to salesmen either on the phone or at their door and had purchased health insurance coverage that they subsequently found out they couldn't use. This is how I learned about Medicare Advantage Plans.

My constituents were going to the doctor and being told that the Doctor did not take the Medicare Advantage Plan and that they would have to pay out of pocket for their office visit.

Medicare Advantage Plans, as you know, are HMO programs. In my district, there are very few HMO's. Honestly, there are very few health care providers.

When we started looking at the problem, we were somewhat overwhelmed at the decisions that have to be made relating to health care after the age 65.

At age 65 you are eligible for Medicare. Traditionally,
Medicare – Part A is hospital inpatient costs – w/deductible
Medicare – Part B is medical expenses (doctors) – w/deductible
Medicare – Part D is pharmacy

When the deductibles became too high another entity was created call the Medigap plans. These supplemental policies cover the cost of the deductibles and provide other services. In Missouri, you have a choice which plan and services fit your needs best. There are 10 plans, A through J. Next, you have to find an insurance company that offers that plan at the best price.

That's a lot of decisions. Along comes someone who says we have this really great option and that's were the problem started. We heard many scenarios:

My constituents did not realize they had signed up for the plan. They didn't sign anything and never agreed to change from their supplement & Part D plan to an Advantage Plan.

Constituent thought it was a supplemental plan. They didn't understand and were not informed that the Advantage Plan was everything.

The area where we saw the most abuse was dual elligibles (MEDICAID). Applications were filled out incorrectly by the agent stating that the constituent does not have MEDICAID when, in fact the agent was told that the person was on MEDICAID. The agent did not know how MEDICAID worked with MEDICARE and therefore could not inform the constituent that with the Advantage Plan they would have to pay more out of pocket because MEDICAID does not pay as a secondary payer.

In this era of privatization, the federal government allowed insurance companies to begin selling Medicare Advantage Plan. These plans include Medicare Parts A and B and your supplemental coverage. Some of the Medicare Advantage Plans also cover pharmacy, or Part D. During the enrollment period, the airwaves are inundated with commercials for Medicare Advantage Plans. Nice looking actors tell their story and say they found salvation by switching over to (whatever) Medicare Advantage Plan. The entire decision making dilemma was taken care of by this plan and with one simple monthly payment.

However, if the plan is not offered in your area, the costs are too high.

The fact that these plans are allowed to be called "Medicare" is very misleading. Medicare is a government sponsored program, with government safeguards open to those who qualify and available everywhere. Medicare Advantage is not.

The Heartland RSVP Program, our CLAIM office in Kirksville, has been very successful working with CMS and the MO Department of Insurance in getting the constituent back on traditional Medicare "Red, White and Blue" Card.

I wanted to see if there was anything that the state could do. In addition to writing about this in my weekly newspaper column, I talked with Heartland RSVP and learned the ins and outs of the problem. My office contacted the Missouri Department of Insurance and was told that all the state could regulate was agent behavior. With the help and approval of the Department, SB 773 was drafted. This bill would have:

- → required a 2 business day waiting period between the Presentation of the plan to an applicant and signing the paperwork enrolling them in the plan.
- → required the agent to provide each client with a statement, approved by the department, that advised the applicant to check with their doctor and other health care providers to make sure that they will accept this plan.
- → required the agent to have the applicant sign a disclosure saying that they were given information stating that Medicare Advantage Plans are not Medigap or supplemental plans.

As you have probably guessed, the legislation was heard on February 12th, by the Senate Committee on Small Business, Insurance and Industrial Relations. There was no testimony against the bill; however, the committee did not take further action on the bill. Senator Engler, who had offered a similar bill, did get the language amended to HB1283, the Insure Missouri Bill, however that bill died in the Senate.

In the intervening months, I have read that CMS is cracking down on this behavior, but I feel it is very important for the federal government and the State of Missouri to insure that our elderly citizens are not sold a "pig in a poke" so to speak.

Respectfully submitted,

Senator Wes Shoemyer
Missouri Senate

Senator MCCASKILL. Thank you, Senator. We really appreciate you. I know this is a busy time for farmers, and you are glad to get out of the city and get back to the honest work that you do and get those beans in the ground. I am glad to hear you can plant. You are not close enough to the river to have any problem. It should be a good year for you then. Those commodity prices are pretty darned good right now.

Ms. Kempker.

STATEMENT OF MARY KEMPKER

Ms. KEMPKER. Good morning. I appreciate the opportunity to testify and to participate and hopefully strengthening the consumer protections, especially for our most vulnerable population. The comments I am about to give are those of my own personal observations through my employment and not that of my employer.

In my capacity as Director of Consumer Affairs, I actively participate in investigating complaints on Medicare Advantage solicitation abuses. I also participate on the NAIC Senior Issues Task Force, and I am a member of Missouri SHIP or CLAIM Advisory Board.

While CMS retains the jurisdiction over the actual product, the marketing of the product, and the training and certification of the agents, the States are allowed to pursue solicitation abuses, and through those investigations, I find that the following concerns still exist and are still occurring. agent solicitation abuses, insurance company oversight, Federal waiver issues, and oversight over the marketing centers.

Agent complaints brought to light the following abuses through our investigations.

Agents representing themselves as Medicare. You are going to see a common theme between the three agencies here.

Agents sponsoring a bingo event. As one agent was calling "bingo," the other agent was literally having the seniors sign applications while they were playing bingo.

Agents churning dual-eligibles on a monthly basis. The churning monthly caused disruptions in coverage and the individuals were unable to secure health care and/or prescriptions.

Agents asking consumers to just sign the form to prove to my boss that we met today. However, the signature on the form enrolled the unsuspecting senior in the Medicare Advantage plan that they did not want.

Agents are unaware that Missouri's HealthNet, or our Medicaid program, does not cover copayments, leaving many financially vulnerable individuals with even greater out- of-pocket expenses.

Agents fail to provide consumers information on the fee-for-service networks which do not have a standard network but rely on doctors to accept or participate in the plan. By failing to disclose the network requirements on a special needs, a private fee-for-service plan, one elderly disabled senior went 1½ months without his 18 prescriptions.

While States can pursue Unfair Trade Act violations against the agents and take action to suspend or revoke their license, our hands are tied in actually taking actions and pursuing violations against the insurance companies on these products. CMS retains

the authority, again, over approving the benefit plan and the product, the marketing of materials, the training and the certification of the agents. While investigating complaints on agents, we at Consumer Affairs will request the marketing materials and the training materials from the company. However, we lack the authority to police the content of those programs.

Another issue for me is the Federal waiver grant by CMS. The Federal waiver allows a plan to operate within the State without a certificate of authority from the Department of Insurance. It allows this for 3 years, but CMS encourages the plans to pursue a COFA by the end of those 3 years. By foregoing the State COFA process, CMS further restricts the State's ability to apply the appropriate regulatory pressures necessary. The States lack the COFA to revoke if concerns are not resolved and/or financial solvency secured. Missouri's experience is that those companies with Federal waivers generate the most complaints within our division.

Finally, companies and/or insurance agencies hire call marketing centers to initiate contacts with the seniors and to set up the appointments. I do have two examples from call centers that I would like to play for you, and I would like for you to be cognizant of the following. They identify themselves as from Medicare Advantage. They never identify the company or the product that they are soliciting. They make it appear that they mailed out the red, white and blue book, the Medicare and you book. They intrigue the senior by saying, there are changes to your Medicare. You are entitled to these new programs at no additional cost, and it will actually save you money on Medicare.

One senior requested that the information be mailed to her because she is not comfortable with individuals entering her home. But the caller succeeded in setting the appointment anyway.

Finally, the product being solicited on these policies as a special needs plan for duals or for those with special health care or specific medical conditions.

On one call, the caller keeps questioning the consumer on her health conditions until he finds anything that may qualify her for an SNP plan. Then he rejoices by setting up the appointment whether it is appropriate or not. So if you bear with me, I will play these for you.

Senator MCCASKILL. Thank you.

Ms. KEMPKER. Senator McCaskill, while she is doing that, I can go ahead with the remainder of my speech for the sake of time.

Senator MCCASKILL. Sure.

Ms. KEMPKER. During the 2008 session, the legislation that the Senator mentioned was introduced for the abuses by the agents by encouraging or by requiring the agent to contact their provider to make sure that they participate in the program, to contact their local SHIP program for general and unbiased information and answers to their questions, and again to require two business days before the application becomes effective.

CMS indicated the requirements, however, are more stringent than MMA. So even if the legislation were to pass, the States would still lack the authority to enforce that particular legislation.

The NAIC, in collaboration with CMS, insurance companies, and advocacy groups, is working on a white paper that addresses the

abuses nationally, and they are providing suggestions for strengthening consumer protections. It is anticipated that the white paper will be adopted at the September NAIC meeting in D.C. This white paper provides more extensive suggestions to remedy the abuses, more extensive solutions to remedy the abuses than what are currently being proposed in the legislation.

Here is an example of the phone calls. I want you again to keep in mind the abusive areas that I mentioned.

Senator MCCASKILL. Sure.

[Audio recording played.]

Ms. KEMPKER. That call is from the fall of 2007, the other from February 2008. The insurance company presented before the department and agreed to address the problems, but as you can tell, the 2008 call pretty well mirrors still the 2007 call. While CMS requires the call center script to be filed and adhered to, the oversight appears to be lacking as far as onsite visits or audits to ensure compliance with those call scripts.

In addition to the abuses I mentioned prior to playing, what certifications are they talking about? There are so many abuses ladened in these that I think the oversight of the call center is lacking.

Anyway, I applaud your efforts in pursuing this issue.

I will be glad to answer any questions.

[The prepared statement of Ms. Kempker follows:]

Hello, I am Mary Kempker, Consumer Affairs Director for the Missouri Department of Insurance, Financial Institutions and Professional Regulation. I appreciate the opportunity to testify on the Medicare Advantage solicitation abuses and participate in ensuring consumer protections are strengthened to protect our most vulnerable population.

In my capacity as Director of Consumer Affairs, I actively participate with investigations involving Medicare Advantage solicitation abuses, participate on the National Association of Insurance Commissioners Senior Issues Task Force and am a member of Missouri's SHIP Advisory Board.

Investigating Medicare Advantage abuses involves interviewing the elderly, subpoenaing the agent to appear before us and, if necessary, subpoenaing the company to appear before Consumer Affairs. While the Centers for Medicare and Medicaid Services (CMS) retain jurisdiction over the actual product, marketing of the product and the training and certification of the agents, the states are allowed to pursue agent solicitation abuses.

Through investigating solicitation abuses, Consumer Affairs identified three areas of concern: agent solicitation; insurance company responsibilities and call or marketing centers.

Agent complaints brought to light the following abuses:

1. Agents representing themselves from Medicare or Medicare Advantage
2. Agents sponsoring a bingo event at a senior center and as one agent called bingo, the other agent was asking seniors to sign forms or set up appointments as they played bingo
3. Agents churning the dual eligible. Since CMS guidelines allow dual eligibles to switch plans on a monthly basis, agents take advantage of dual eligible seniors. The seniors, however, find themselves unable to purchase prescriptions or procure medical care because of the time required to process the changes in CMS' and the insurance company's systems.
4. Agents asking consumers to sign a form just as proof to their boss that they met. However, signature on the form enrolled the unsuspecting senior into a MA plan.
5. All of the agents appearing before us didn't know that Missouri's Medicaid program did not cover copayments leaving these financially vulnerable individuals with even greater out of pocket expenses and facing the choice of purchasing their prescriptions or food.
6. Agents fail to provide information on PFFS participating providers. PFFS plans do not have a standard network. The insured receives the benefit provided in the policy if the provider "agrees to accept the plan". The provider's agreement can change on a daily basis. Because the network requirements were not disclosed, one elderly, disabled consumer went 1 ½ months without his 18 prescriptions.

While the states can pursue Unfair Trade Act violations against the agents and can take action to suspend or revoke the license, our hands are tied when pursuing violations against the insurance company on Medicare Advantage plans. CMS retains authority over approving the benefit plans filed by the company, the marketing materials, the training and certification of agents, and investigating any claim or provider complaint from the senior. While investigating complaints against the agents, Consumer Affairs will request marketing materials from the company to ensure appropriate training. However, the states do not have the authority to police the content of the training, the continued training and certification, premium billing, policy content nor claim adjudication issues.

Another issue is the Federal Waiver granted by CMS to those companies lacking a certificate of authority to do business in the states in which their products are marketed. The Federal waiver allowed the company rights to conduct business without the Certificate of Authority for three years but required the companies to pursue a Certificate of Authority before the end of the three years. By forgoing the state's Certificate of Authority process, CMS further restricted the states ability to apply any appropriate regulatory pressure on the company. The states lacked a certificate of authority to revoke if concerns were not resolved and/or financial solvency secured. Missouri's experience is that the plans with Federal Waivers generate the most complaints.

And finally, companies and/or insurance agencies hire call or marketing centers to initiate contact with the consumer and set up appointments. I have two examples here today from call centers. The first call you will hear is from fall 2007.

Listen to call.

What's wrong with the call?

1. They identify themselves as from Medicare.
2. The caller appears to suggest he/she mailed out the "red, white, and blue" book.
3. The caller intrigues the consumer by stating it involves "changes to their Medicare benefits."
4. The caller never identifies the company or the product.
5. The caller indicates it will only take 15 minutes.
6. And finally, the product being solicited is a PFFS SNP for duals or those with specific medical conditions.

Missouri called the insurance company using this call center to appear before us and after hearing the call, the company agreed to ensure the CMS script would be adhered to. Here's a call from February 2008 from a call center of this same insurance company.

Listen to the call.

Notice any changes?

The only change I noticed was that the caller stated they were calling from Medicare Advantage instead of Medicare. Other than this, the caller

1. Indicates it's an entitlement program.
2. Fails to identify the company or the product.
3. Again states it will only take 15 minutes.
4. Keeps questioning the consumer on her health conditions until he finds anything that may qualify her for a SNP plan. It sounds like the member may have sleep apnea, not COPD, the required diagnosis for a SNP.
5. The caller rejoices at setting the appointment, whether appropriate or not.

While CMS requires the call center scripts to be filed and adhered to, oversight through site visits and on-site audits to ensure compliance appear to be lacking.

During the 2008 legislative session, legislation was introduced to thwart the abuses by requiring the agent encourage the consumer to contact their provider to ensure participation, contact their SHIP program for general unbiased information and require 48 hours before the application became effective. CMS indicted the requirements were more strict than MMA so, even if the legislation were to pass, the states still lacked the authority to enforce.

The National Association of Insurance Commissioners, in collaboration with CMS, advocacy groups, states, and insurance companies, is producing a white paper identifying the issues nationally and providing suggestions for strengthening consumer protection.

I will be glad to answer any questions.

Senator MCCASKILL. Mr. Cohen.

STATEMENT OF ROBB COHEN, CHIEF GOVERNMENT AFFAIRS OFFICER, XLHEALTH

Mr. COHEN. Senator McCaskill, thank you for inviting me to testify regarding Medicare Advantage sales and marketing oversight. I am Robb Cohen from XLHealth. We are headquartered in Maryland and operate chronic special needs plans in the Southeast and South Central United States. These are areas of high prevalence of chronic disease. We serve 64,000 members, of which 3,500 are in Missouri, including in 113 of 114 counties, offering a valuable choice with added and disease-tailored benefits to chronically ill seniors who have historically had limited Medicare options. Our sole business is as a chronic special needs plan. Our company was founded as a disease management organization focused on diabetes, CHF, COPD, and ESRD. Our goal is to offer a beneficial Medicare product option to Medicare beneficiaries with one or more of the qualifying conditions and to deliver improved quality and satisfaction at a reduced cost through a targeted care model and benefit design.

My testimony will focus on issues related to and efforts to improve beneficiary education and marketing. We believe each beneficiary should make a well informed choice and it is our responsibility to do everything possible to ensure that occurs. We believe our care model and benefit design offer value for disease-qualified beneficiaries and that over time our care model will result in beneficiaries experiencing better quality and outcomes. Special needs plans, because they care for Medicare's most needy beneficiaries, must be required to be special. An important component of beneficiary education is our work with the area agencies on aging, state health insurance plan counselors, and other members of the aging services network. We want to inform educators, as well beneficiaries, to make appropriate Medicare coverage choices.

We acknowledge that there have been problems with Medicare Advantage sales and marketing, including with Care Improvement Plus. Also, we agree with proposed increases in regulation and oversight so that seniors are able to make well reasoned Medicare choices. We have experienced growing pains, including beneficiary complaints. Our goal is to address every single complaint in a manner that resolves the complaint and use the knowledge gained to fix root causes and eliminate future complaints.

Our efforts to address marketing issues include a pre-enrollment verification call, mandatory agent testing, and thorough investigation of all member complaints with agent discipline where warranted. Beginning in November 2007, we have required completion of a recorded pre-verification call with each applicant. The verification call asks the applicant questions, including whether the applicant understands they are enrolling in Medicare Advantage and that they are leaving Medicare fee-for-service or any other Medicare Advantage or Part D plan. As a result, disenrollments have been reduced.

We instituted mandatory testing for all the agents in 2007, and we support proposed regulations to require agents to pass a written test. We employ sales managers in each market, including Mis-

souri, to manage the broker network. Our compliance department investigates all network complaints, including ones that allege agent misconduct. We have improved our complaint management process, including growing our compliance staff from 3 employees in early 2007 to over 20 today. We believe our number of complaints is within CMS' expected industry benchmarks and we strive to process complaints within CMS expected timeframes. In addition, we do not tolerate unacceptable broker practices and implement various levels of discipline, including suspensions and terminations.

We believe there is much work that can be done by Care Improvement Plus and State and Federal regulatory authorities to improve how we market our health plan. We support proposed changes in regulation of Medicare Advantage marketing, including regulation of broker commissions, appointment of agents through State insurance departments, and creation of a national registry of agents who have been disciplined so that all Medicare companies can benefit from each other's efforts to eliminate agents with confirmed violations.

Finally, while we are highly respectful of the need to reduce and respond to complaints, we are pleased about the following statistics from member surveys conducted in 2008 by an independent research firm. These are just a couple of statistics from the survey. Ninety-four percent of members were satisfied with the plan. Ninety-six percent of members were satisfied with the enrollment process, and 91 percent of members said their health status was the same or better since joining the plan, with 30 percent saying they had gotten better, and 97 percent of those saying XLHealth Support contributed to their improvement.

In summary, every complaint is one too many. We want to improve beneficiary education and agent oversight to eliminate complaints. To the extent there are complaints, we want to protect beneficiaries and handle complaints appropriately. As a new company that has grown tremendously, we believe that we have improved significantly in the past 18 months and we constantly strive to be responsive to all member comments and concerns.

Thank you, and I would be pleased to answer any questions.

[The prepared statement of Mr. Cohen follows:]

Senate Committee On Aging
June 30, 2008 Hearing

Testimony of
Robb Cohen
Chief Government Affairs Officer, XLHealth / Care Improvement Plus

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

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

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

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

Beneficiary education

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

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

Medicare marketing issues

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

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

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

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

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

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

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

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

Marketing oversight

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

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

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

Conclusion

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

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

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

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

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

Senator MCCASKILL. Thank you, Mr. Cohen. I sincerely appreciate you being here. It is brave in many ways, Mr. Cohen, because all of the witnesses and all of the testimony is about the frustration and the problems with these plans. So I do not want you to leave this hearing not realizing that we appreciate you being here, and it does say a lot about your company that you were willing to come to this hearing and willing to take questions and willing to withstand some of the criticisms. That does make me believe that you want to do the right thing or you would not be here. So I am very appreciative of that.

I would like to go through a number of questions I have for many of you. I think one of the things I would like to start with is the notion that these are called Medicare Advantage programs.

Ms. Coleman, has CMS taken a position over whether or not it is appropriate that we call these private insurance companies—that we allow them to be called "Medicare"?

Ms. COLEMAN. They are required to refer to themselves as something other than Medicare or Medicare Advantage. They are not required to describe themselves as not being from Medicare. So when the caller referred—the comment that they were from Medicare, that was not appropriate. They are not in compliance with our rules.

Senator MCCASKILL. If we know that the word "Medicare" is the green light, I mean there is not a person in this room who does not get that, that when you use the word "Medicare," that sends a signal to seniors that this is the Government. Well, this is not the Government. They have nothing to do with the Government. This is entirely a private—now, if they called and said, this is Acme Insurance Company and I think I have got a better product to sell to you, it seems to me—I mean, you heard them refer to themselves on that call as a Medicare training specialist.

Obviously, this is going on in every—I should not say in every call—but they are getting in the door with these seniors by using the word "Medicare." Why should we not pass a law that says you cannot call yourself Medicare if you are not Medicare? [Applause.]

Ms. COLEMAN. As a daughter of a Medicare beneficiary, I try to view my job as a career civil servant through her eyes, and I could not agree more with you personally how confusing the program can be to seniors. It is unfortunate that you hear calls like that. I find it terribly sad. I guess we can make all the rules in the world, and there is always going to be someone out there who tries to get right up to the edge.

But those calls that Mary shared were clear violations of our rules, and if that information was forwarded to my office in Kansas City, we would follow up immediately with the plan. It always helps to have the agent/broker information, names. We will follow up with the plan to ensure that they are aware of what happened and that that was a clear violation of our rules.

Senator MCCASKILL. Mr. Cohen, would your company have any problem if we changed the laws in Washington and quit allowing any of these insurance companies to be called Medicare Advantage programs?

Mr. COHEN. I am not sure actually I have an answer to that question for you sitting here today. I would be happy to get back to you.

Senator MCCASKILL. Well, obviously common sense——you would have to acknowledge that it is a huge advantage—pardon the expression—to able to call this the Medicare program.

Mr. COHEN. Yes. I would agree that using the word "Medicare" is something that alerts the beneficiary. It is a word they are very used to.

Senator MCCASKILL. Well, that goes on the list for changes that need to occur. We should not call these things Medicare. They are not Medicare, and that is what causes the confusion, I think, for a lot of seniors.

Let us talk a little bit about compliance. Let me start with you, Mr. Cohen. What kind of compliance actions have been taken against your company and in how many States?

Mr. COHEN. I am actually here today with our compliance officer, Tom Mapp, who came with us today. I am not the compliance officer.

As I mentioned, we have had complaints. We have complaints come into our office through a number of channels, through CMS system, as well as direct beneficiary complaints. They are all followed up on through our compliance office. So we certainly do—we have had complaints in each our markets. I think all Medicare insurance companies have complaints.

The question is to what extent do you follow up with them and process them and, as I said, not just process them on an individual basis, but look at them to get at the root cause to stop future complaints to improve the process.

Senator MCCASKILL. I can explain the root cause. It is money. The problem is money because people make more money the more insurance policies they sell. So they are motivated to cross the line slightly or completely in order to close the sale because they do not make the money if they do not close the sale.

How many of your agents have been fired for engaging in unfair marketing techniques?

Mr. COHEN. I would not be surprised if we know a very specific answer to that question. About 80.

Senator MCCASKILL. So 80 agents have been fired? How many agents do you have?

Mr. COHEN. About 3,000, a little more than 3,000. So I guess about 3 percent have been terminated.

Senator MCCASKILL. OK.

How many civil monetary penalties has your company been assessed? How many CMP's by CMS? Have you ever been assessed a fine?

Mr. COHEN. We have never been, no. We are a relatively new company. We started in 2007. We have certainly had audits by CMS, routine audits, nothing special for us, if you will, and those audits have gone well.

Senator MCCASKILL. But you have a corrective action plan as a result of those audits. Do you not have corrective action plans that have been imposed upon your company as a result of the audits?

Is there not a corrective action plan, in fact, that you went through in Missouri?

Mr. COHEN. I think that the corrective action plan that we have had is fairly standard. It is just a standard term as part of the audit process. I do not think we have had——

Senator MCCASKILL. Well, it is standard to the extent that a lot of the insurance companies who go through it have corrective action plans, but it means there is something you have got to fix.

Mr. COHEN. Absolutely, and we have submitted to CMS and had those approved. Yes, that is correct.

Senator MCCASKILL. OK.

Now, let me ask you, Ms. Coleman, are you aware of any CMP's that have been imposed, civil monetary penalties that have been imposed, on companies in your region?

Ms. COLEMAN. I am not aware of any CMP in particular. I do not believe that there are any—well, let me think. There are national plans which may have members in our region, but I am not aware of any that are smaller, localized plans. But I would have to get back to you to confirm that.

Senator MCCASKILL. Do you have the ability to go in? Let us assume that you take this call back and you figure out who that agent was. Do you have the ability to take money out of that agent's pocket?

Ms. COLEMAN. No.

Senator MCCASKILL. Do you have the ability at the Missouri Division of Insurance to take money out of that agent's pocket?

Ms. KEMPKER. No, we do not.

Senator MCCASKILL. OK. That has got to be fixed. So the only person who can be penalized for an agent going out and lying to these people and saying that they are Medicare training specialists when they are really insurance salesmen—the only people who can be penalized there are the people that have stock in that insurance company, the insurance company itself?

Mr. COHEN. Senator McCaskill, I would like to note that if a beneficiary is misled or enrolls in a plan and later finds out that it is not what they had expected, they can disenroll from that plan. We do not question the individual. We do not go back and say, are you sure you did not understand?

Senator MCCASKILL. No, no. I mean the agent. I mean the person who—what I have learned the hard way is the way you stop that behavior is the person who engages in the bad behavior has to pay a price. What is happening in these instances is you have got agents—and we were able, I should tell you, Mr. Cohen, even you though you did not provide it, to get your sales incentive payments. We Googled it. You did not provide it for us after we asked, but we were able to Google it and get the money that your agents are paid for selling the policy and we have that information.

So the agent wants to sell the policy because they make money if they sell the policy. If they get the person to sign the card, they get the money. If we had the ability to say, you find the person who made that call. You find the agent that went out to that house and said they were a Medicare training specialist. I assume that would be something that would be wrong. You cannot say you are a Medi-

care training specialist when you are an insurance salesman. Can you?

Ms. COLEMAN. No, you cannot.

Senator MCCASKILL. So if that agent himself or herself was fined and had to pay the money out of their own pocket, it seems to me the word would travel pretty quickly. If you cross the line, it is not going to come out of the company's pocket, it is going to come out of your pocket. Has there been any attempt to try to do that that you are aware of?

Ms. COLEMAN. Not that I am aware of, but I do know through information sharing what we are now doing with the departments of insurance, one thing that we can do regionally is to share information about brokers like that or agents, so other States can be aware this is happening in Missouri and this person may end up in Iowa or Kansas or Nebraska. So we are trying to be very proactive. We are just getting off the ground. To be quite honest with you, we have a lot more work to do, but we are very pleased with the relationships we do have with the State departments of insurance. I think the more we can share and work together, there will be pressure put on companies like Mr. Cohen's to have agents that are trained and licensed and working appropriately.

I am sure they do not look forward to having calls like that come to their health centers, and I am certain they take action to pursue people like that, I would hope, and address things so that they do not violate our rules.

Senator MCCASKILL. Well, obviously, it is going to be very difficult for us to catch people who do this because most of the time it happens in someone's living room when the only person there is the senior and the salesperson. The senior is going to say XYZ happened, and the salesperson could say, oh, no, XYZ did not. I explained it fully. They are just confused. So it is a he said/she said in terms of the conduct of the agent. But in the instances where we catch agents doing it, it seems to me we ought to have an ability to go after not just their companies, but the agents themselves.

Would that take a legislative change on the State level for you to be able to do that, Ms. Kempker?

Ms. KEMPKER. Part of the problem is we have the authority to suspend or revoke the license. As far as redacting commissions, that would be through the insurance companies, and because it is a Medicare Advantage product, we have no authority over the commissions. It would be at the Federal level. They would have to impose some type of legislation to either allow the States to do that or enforce it on the Federal level through the companies.

I will tell you that the call center calls——those individuals are not agents. They are literally a marketing company and they pay these individuals a certain dollar amount for every appointment that they set. So not only do you have the very rogue agents pushing the products for the high dollar commission, you have the individuals in the call center who are not agents who are making those statements. The oversight should be by the company or the insurance agency that hires them, and that appears to me to be lacking or nonexistent.

Senator MCCASKILL. So what is happening is, to get the agents in the door, they are hiring just a bunch of people in cubicles with

headsets that are making these phone calls based on generated data lists of people who potentially—let us talk a little bit about the special needs program.

I think this is interesting because it is my understanding—and somebody correct me if I am wrong—that there are two instances where special needs comes into play. One is somebody who is dually eligible. Right? So somebody who is Medicaid, they can also get a special needs, or if they have a chronic illness by virtue of calling her where he got the woman to say that she had a breathing problem that allowed the special needs to kick in.

What is the reasoning behind allowing the Medicaid people to be sold a new policy every month? What is the reasoning behind that? Does anybody know? Ms. Coleman, do you know what the reasoning is?

Ms. COLEMAN. We did not want any of those individuals to lapse in coverage. We wanted to make sure that they had coverage throughout the year at every day of the month.

Senator MCCASKILL. Well, I think that sounds as a good reason, but I think we can see what the problem is. Mr. Cohen, I am correct, am I not, that your agents would get an extra bonus on top of their commission for getting a special needs plan signed up? It is my understanding they make another $150 on top of the regular commission if it is a special needs program.

Mr. COHEN. I do not know the details of that. I do know that we only offer—our company only offers special needs plans. So I would be a little confused that we could offer something as a bonus for doing something when we do not do anything else.

Senator MCCASKILL. I am thinking it is somebody who is already on the program who you sign up for another one. Is that right?

I have got here, we are pleased to announce the launch of our 2008 sales bonus program. Beginning March 1, 2008, effective through December 1, 2008, in addition to the commission you currently receive from your FMO selling entity, we are pleased to announce the following bonus program paid directly to you through your FMO selling entity. This comes off the Internet from your company, Care Improvement Plus, specialized care for Medicare beneficiaries.

Members enrolled in the green or blue counties are eligible for bonus incentives beginning March 1, 2008. Members enrolled in yellow or red counties have revised commissions beginning April 1, 2008. We will be paying a $150 bonus for each new Care Improvement Plus member who meets the following criteria. has an effective date of March 1 through December 1, resides at the time of enrollment in one of the green counties in the attached map. Please note the 90-day charge-back policy still applies. $112.50 bonus for each new Care Improvement Plus member.

So basically if you get somebody involved in one of these programs and your agent sells them another program in a month, they are going to get a $150 bonus during this period of time.

Mr. COHEN. From what you have read, yes, there is a bonus that sounds like it is county-related. It does not sound like it is taking an existing person and selling them something different. It sounds like it is taking someone who is not in any of our plans and enroll-

ing them into one of our plans, from what you have said. But yes, you are correct that there is a bonus there.

Senator MCCASKILL. So if somebody is already in one of these plans and your agent manages to put them in a different plan, even though they are already in a special needs plan, they get to change every month, as you know. The people in special needs that are dually eligible can change plans every month. So if your agent calls upon someone who has company A's special needs program and you sell them your policy, CIP special needs program, even though they are both special needs programs, your agent is going to get 150 bucks for selling that policy, extra besides their commission, based on this document.

Mr. COHEN. Yes. It sounds like we are paying bonuses related to members that join our plan whether they came from Medicare fee-for-service or another special needs plan or no matter where they came from.

Senator MCCASKILL. I am assuming it is fairly easy to find the people who are on Medicaid. I assume you can find the people who are on Medicaid in terms of approaching them for sale?

Mr. COHEN. I do not know.

Senator MCCASKILL. OK.

Do you have agents from other States—brokers from other States that are working in Missouri selling your plans, Mr. Cohen?

Mr. COHEN. I am fairly certain we have a requirement that to be able to sell a plan, you need to be licensed in the State in which you sell. So, yes, I have heard that complaint in the industry. We as a company have a specific requirement that you must specifically be licensed in the State in which you sell. I do not know that we have had that in effect since we started January 1, 2007, but we heard that issue in the industry and we instituted that.

Senator MCCASKILL. Well, one of the disappointments that I was hearing I will share now for the record. We had an insurance agent who contacted us that wanted to come testify, and he shared with us his frustrations about these programs and the way they are being marketed. Without telling you where he is from or his name, he says that there are a lot of unhappy seniors in his area who had been given the hard sell on Care Improvement Plus in his town. They were working two senior low income subsidiary building towers in the city. Insurance brokers, one as far away as Oklahoma, were going door to door in these buildings, selling these policies to seniors who were not told they were being taken out of Medicare. He had to personally help one elderly lady disenroll after she signed up last November and was unable to pay her bills.

Another elderly woman was taken out of her Part B after specifically asking not to be removed from it due to its subsidies on drug costs. After being signed up for the CIP policy, she then got a bill from her pharmacy for $131 for drugs. She had previously paid a $2 copay.

Unfortunately, for this agent, afterward he called someone else in the company and said that he was going to testify. He began getting e-mails and contacts that he thought was going to hurt his career, and he then called us back and said he was going to decline to participate because of that.

Is it illegal for agents from Oklahoma to be working in Missouri, Ms. Kempker?

Mr. KEMPKER. Missouri has a law that any solicitation of insurance—insurance products—that all agents have to be licensed. So it is a Missouri requirement, and both agents on the calls were from Oklahoma City.

Senator MCCASKILL. OK. What were the dates of those calls?

Mr. KEMPKER. One was, I think, August or September last year, and the other one we received February this year. As far as the actual dates, I do not know. We were surprised that we were able to obtain the actual recordings, much less anything else.

Senator MCCASKILL. Ms. Coleman, I know that you all have done the secret shopping program, and Senator Kohl asked me to convey to you—and I know this is probably somewhere above you in the bureaucracy, but if you would convey—we were frustrated. Senator Kohl had asked for the results of that secret shopping program. Evidently there were some write-ups about it I understand maybe in the New York Times or somewhere, but yet our committee has not been allowed to access the results of the secret shopping program. There have been a number of written requests to CMS about that.

For the record, I wanted to reiterate Chairman Kohl's frustration that that information is still not forthcoming to our committee and we are anxious to look at the secret shopping program to determine what you all learned as you sent people out to these various companies to see what kind of information they were being given in terms of the marketing practices. If you would convey that, we would appreciate that.

Ms. COLEMAN. Sure. I could certainly follow up with my folks on that.

I can tell you that we did take some corrective actions after the secret shopping concluded last summer. Several plans were sent warning letters following our attendance at their events, and we did request corrective action from two plans that we found in serious violation of our rules. We actually issued an intermediate sanction against one plan, and it required them to suspend their marketing and enrollment until they could demonstrate that they had actively and adequately corrected their problems.

Senator MCCASKILL. Ms. Maples, could you tell me how much time did you put into trying to get your situation straightened out? Did you do it all on your own?

Ms. MAPLES. No, I did not do it. At first, I did it on my own, and a lot of it you have to do on your own. But I had an excellent, excellent insurance man with Physicians Mutual. He was at the house one day for 3½ hours, and we was on the phone with GHP all that time just talking to different people.

A lot of these—you talk to one person. They will tell you one thing. You hang up and call right back and talk to somebody else. They will tell you something completely different. I am having the same problem with Advantra RX Premier right now too.

Senator MCCASKILL. That is Medicare D?

Ms. MAPLES. Yes, Part D. I mean, every time you call, you are talking to somebody different. I called the enrollment department

at Part D, and they say, well, we do not do anything. We are just hired to enroll. We do not even know what is in your file.

Then I get a phone call the other night asking me why I got off of Advantra RX, and this is like at 8:30 at night. I said, I am trying to get back on the Advantra RX. Well, we are just making a survey to better ourselves. I said, well, I got lots I could tell you. I do not think you have got enough time to listen to it all. You know?

I said, I would rather talk to somebody higher up than you. Well, he started asking me the questions like what plan was I on, this and that. Then I finally got him to let me talk to his supervisor. So I explained everything for about 10 minutes it took me, and then she started saying, are you white, black, Hispanic, Indian, blah, blah, blah, and I answered that. She said, are you on Medicare A, A/B, and all this and that? I told her what I was on. She said, OK, thank you. I said, wait a minute. Can you help me with my problem or tell me who to talk to? No, ma'am, I cannot.

Senator MCCASKILL. Well, you know what that was.

Ms. MAPLES. A survey.

Senator MCCASKILL. What these companies do is they do surveys to validate that they are terrific.

Ms. MAPLES. Exactly.

Senator MCCASKILL. The person who called you had nothing to do with that company.

Ms. MAPLES. Exactly.

Senator MCCASKILL. The person who called you is somebody who was hired by the company to call people and find out what it was that——

Ms. MAPLES. Exactly.

Senator MCCASKILL. They are trying to help their marketing and, in fairness to them, make sure they do a better job, if they can, in terms of customer service. But the person you talked to had nothing to do with the company. They were just hired to survey you and ask you questions about it.

Ms. MAPLES. Yes. To me, though, the supervisor should have said, sorry, you know, I cannot help you.

You would not believe how many times I have had to explain this over and over and over. I mean, my paperwork shows it right here. Actually this has been going on going back to January 29, and then I started again on May 29, when GHP finally disenrolled me, that I wanted to be disenrolled from. Like I said, as of now, I have no health insurance and no prescription.

Senator MCCASKILL. Are you paying now out of pocket?

Ms. MAPLES. I have had to pay for June out of pocket, and I am on a diabetic pill also called Actos and it was going to cost me $120 and I did not get it refilled.

Senator MCCASKILL. Tell me about when the sale occurred, was it in your house?

Ms. MAPLES. Yes.

Senator MCCASKILL. How did they get there? Did they call you to make an appointment?

Ms. MAPLES. Right. They called me to make an appointment, and then I decided—I even tried calling and canceling. I was working. I have 5 acres. So I was working out in my yard because it was a nice day, even though it was January. Oh, this will not take long.

I drove all the way out here. I need to talk to you. It is very important. I said, well, I really like being outside. She just insisted. So she went inside, and like I said, she made everything sound so good, but I sure did not know about all the 20 percent off of this and that and 5 days in the hospital and——

Senator MCCASKILL. Ms. Maples, were you sure at the point in time that you signed on the dotted line—did you understand that this was a private insurance company, that you were no longer going to have Medicare coverage?

Ms. MAPLES. No. I signed it all and then she said something to me right before she left. She said, now, when you get your card, do not show your red, white and blue card. Only show that card. Do not show any other card. She said that is for prescription and everything. But she did not tell me that I would not be—yes, off of Medicare.

Senator MCCASKILL. So you did not understand, at the point in time she left, that by signing up with this private insurance company, you were no longer going to have any Medicare coverage at all.

Ms. MAPLES. Exactly.

Senator MCCASKILL. OK.

Ms. Beahan, I am curious, and maybe somebody else on the panel can explain this to me. What would be the motivation that a nursing home would want someone to drop their Medicare Advantage program? Why would that be to the benefit of the nursing home to convince their residents to no longer have MA programs?

Ms. BEAHAN. It may be that nursing home does not accept that plan, so they believe that if they drop that Medicare plan, they will be back on original Medicare. But that person may not be able to purchase a Medicare policy because they may have lost their guaranteed issue for a Medigap policy or they may not be eligible for Medicaid or they may only be in there for skilled care and it will be a short period of time. So they may not understand how the Medicare Advantage plan actually works for them or maybe the benefits are not as equal as the traditional fee-for-service.

Senator MCCASKILL. Generally speaking, Mr. Cohen, do your agents match—this goes to Senator Shoemyer's point. Senator Shoemyer talked about one of the reasons that these programs were touted by this administration—this administration wants everything private. This administration wants everything to be private, including Social Security. So Medicare Part D was their big plan to take pharmaceutical private. Medicare Advantage is their plan to begin the process of getting everyone off any Government insurance and getting them all on private. This is their "your are going to be private" program for this administration in terms of getting people to private coverage as opposed to Medicare coverage.

You know, I guess what I am trying to get at is are you all matching what services are available in the county with what you are selling. In other words, when an agent comes into Kirksville, which Senator Shoemyer represents, and she is going to sell a special needs policy. Does she, before she sells that policy, know what doctors in that community take your policy? Does she know whether or not there is dental available? Does she know whether or not

there is vision available in that community? Is that information that your agents know when they make the sale?

Mr. COHEN. We are a chronic special needs plan, not a dual-eligible special needs plan. So the issues are a little different, but for the most part, yes, we try to structure our benefits in a way to offer benefits that the beneficiary—the added benefits that the beneficiary—would not otherwise have. So that is the work we try and do on benefit design and benefits that are targeted toward the diseases that we cover. So in terms of on the benefit side, the answer should be yes.

On the doctor side, we are a little unique in that we are what is called a regional PPO. So we do have a network. But yet we allow beneficiaries at any time to go out of the network so beneficiaries should not have to travel. We are potentially subject to the issue that has come up with private fee-for-service where a doctor could turn down the plan, but we work very hard to go educate physicians that we will pay them the same way as Medicare. We do not have any network requirements. So beneficiaries are allowed to go to any doctor at any time.

Senator MCCASKILL. Does it cost them more to go to someone out of network?

Mr. COHEN. No.

Senator MCCASKILL. Well, then why do you have a network?

Mr. COHEN. We have a network to assure access and because it is a CMS requirement to be what is called——special needs plans by definition under Medicare law have to be what is called a CCP, a coordinated care plan. So there is no such thing as a special needs plan that does not have a defined network. There is no such thing as a private fee-for-service special needs plan. That is not possible under the law. So we have to have a network and we do.

Senator MCCASKILL. All right. So you have a network, but anybody who has your plan can go to any doctor.

Mr. COHEN. Yes. In our case, yes.

Senator MCCASKILL. They do not pay any extra.

Mr. COHEN. That is absolutely correct.

Senator MCCASKILL. So if somebody buys your plan in Kirksville and they go down to their local doctor to get diabetes treatment because they have been getting all their diabetes medication and strips and everything from one doctor—they go to that doctor and that doctor says, I do not take your plan, then all that person has to do is say, well, yes. They will pay you the same as they will pay any other doctor in the network.

Mr. COHEN. That is correct, though it is not just the beneficiary that would do that. If we heard from the beneficiary that they were having difficulty with their doctor, we would work very hard to do outreach to that physician and to educate them to what you just described, that we are not there to be intrusive. As a special needs plan for the chronically ill, our goal is to provide an added level of care coordination and not in any manner to interfere with patient-doctor relationships. So we will pay the Medicare fee schedule with no negative impact on the beneficiary.

Senator MCCASKILL. Senator Shoemyer, in your legislation—or are you aware, Ms. Coleman, at the Federal level? Has there been any attempt to, in fact, require these plans to include in whatever

they give to the person they are selling the plan to the list of doctors that they can see in their area?

Mr. SHOEMYER. Well, I think that would be something that would be very helpful. Obviously, that was one of the things that we were asking to give time to ask a trusted family member to give time to——

Senator MCCASKILL. Check.

Mr. SHOEMYER [continuing]. Check with their doctor to ensure that if they do buy it, that they are covered. You know, there is just a whole host of these, especially with Medicaid in Missouri and the secondary payor issue that comes out of that, that I think are things that people just need to be informed. That is why in the legislation we pursued in Missouri that is all that we can do in regards to selling these insurance policies, is regulate the way that agents' behavior is acted on in Missouri.

Senator MCCASKILL. Ms. Coleman, has there been any effort to require the sales people to match up—I know that when I look at what plan I have taken in the past, I get a booklet that shows me all the doctors that are available under that health care plan. Is there any requirement anywhere that that be done on these plans?

Ms. COLEMAN. I do not believe there is a requirement that they specifically give them the list of doctors, but we do review all Medicare Advantage applications for network adequacy in the areas in which they are marketing and enrolling individuals, and we do ask the agents to tell the beneficiary—I believe it is in our rules, but I have to confirm—that the plan does limit their access if they do have a network that is closed. They do need to inform the beneficiary at the time of the application of that fact.

Senator MCCASKILL. Do you know whether CMS agents have done super shopper programs in Missouri? Secret shopper, not super shopper. Super secret shoppers. [Laughter.]

Ms. COLEMAN. I know there was limited secret shopping in Missouri during the initial phase last year, but we do have plans to resume and expand our secret shopping in the fall through the next benefit year.

Senator MCCASKILL. Do you all actually monitor the marketing materials? Do you get the marketing materials into your office and look at them?

Ms. COLEMAN. Yes, we do. We actually do quite an extensive monitoring of marketing submissions from the plans. It is done electronically, and the work is actually done for certain plans right in the regional office in Kansas City.

Senator MCCASKILL. What do you think is the best way that we can get a handle on these marketing techniques, you know, the lunches and the bingo games and the door-to-door? I know somewhere in these materials is a quote from someone going door to door, that somebody in one of these facilities—I do not know who gave us this—but came into the woman's room and said, the Lord told me to come in here because you had an oxygen sign on the door. Did you give us that material, Ms. Kempker?

Ms. KEMPKER. Yes, I did.

Ms. MCNALLY. That came from me.

Senator MCCASKILL. That came from you? This was in a senior center?

Ms. KEMPKER. Subsidized housing.

Senator MCCASKILL. Subsidized housing, which of course is a prime target because in subsidized housing, they are more likely to be Medicaid.

Ms. KEMPKER. Correct.

Senator MCCASKILL. So there is a chance that if you have a subsidized housing senior facility, that every person in that building is eligible every single month to be sold.

Ms. KEMPKER. Correct.

Senator MCCASKILL. In fact, one agent could hang out there, get to be friends with everyone, and just sell a different company—one broker could sell a different company's program every month to every senior and make a really good living.

Ms. KEMPKER. You have described it. Yes, that is exactly what he is doing.

Senator MCCASKILL. So are there brokers that are staying there and selling different policies to different people different months? Like let us say if Mrs. Jones—and the same person sells Mrs. Jones one company's policy one month and another company's policy two months later.

Ms. KEMPKER. I have reports of that occurring. Hopefully, what we hope to do is to encourage—I think it is very important for Medicare beneficiaries. We have got to understand what this is and what is going on. Once it happens to you—for example, the lady who had been churned so many times she was unable to get her medicines—it is not going to happen to you again.

Senator MCCASKILL. Is there a way that we can——we know where all the low income senior housing is in the State. Correct?

Ms. KEMPKER. Correct.

Senator MCCASKILL. Are we doing something on a proactive basis to inform these low income senior housing facilities about the dangers of the marketing of these programs?

Ms. MCNALLY. We are making every effort to. It seems like one of the problems or frustrations that I personally have is that as we come up with ways to educate seniors or things to tell them, some new salesman comes up with a pretty good idea that sounds very appealing to them that we have not thought of yet. So they come up with a different way of approaching.

We have developed the book that you have in your hand. Actually we did not develop that. The Alabama project developed that. We just reprinted it with the SHIP's permission, Ms. Beahan's program and ours. There is a questionnaire that we hope someone will fill out before they actually agree to purchase one of those plans and consider all of the questions that are important in that decision.

Senator MCCASKILL. Well, this is a terrific booklet. I mean, this is terrific. If someone goes through these questions and answers on these last two pages, they are going to be protected because they are going to find out the information that they need to know before they have happen to them what happened to Ms. Maples.

It seems to me, Senator Shoemyer, that it would be a really good idea to get the Division of Aging, State of Missouri, to actually begin a program in every nursing home and every low income senior center with the help of these organizations to make sure that

these booklets are available everywhere and that the people who are distributing them are the people at the facilities they trust as opposed to someone who comes in that they do not know because that is part of the problem. I am sure Mr. Cohen's company would not do this, but there might be a company that would now put out a marketing piece that looks exactly like this, protect your Medicare by buying a Medicare Advantage program, even though it is not really Medicare. It is an insurance policy.

It seems to me that if we have learned anything today, what we have learned is that while these programs—and let me take just a couple of minutes on the record to say if there are good things about these programs, some of these policies are the right product for the right person at the right time. There is nothing about this hearing that should imply that all of these companies are evil or that all these products are bad.

But what it is, it is a dangerous marketing environment, Mr. Cohen. You have people that are worried about their health from the time they get up in the morning until the time they lay their head down at night. They are worried about their finances from the time they open their eyes in the morning until the time they lay their head down at night. Those are the two primary concerns that the elderly of this State and every State in our country have. To not be more aggressive in terms of going after agents that are taking advantage of those two realities is something that we cannot rest until we get this fixed.

I think that there has been a tendency, I think, Ms. Coleman—and I will take this up and I know Senator Kohl will take this up with the highest levels of your organization. I think there is a tendency to give companies too many bites at the apple in terms of bad behavior. It is a little bit like raising kids. When you tell your kids if you do that again, something is going to happen to you, and then you tell them again, you know, if you do that again, something is going to happen to you, you know what is going to happen? They are going to do it again because nothing happened to them.

I do not think that the civil monetary penalties——and I would ask for the record and we will follow up with the people in Washington. We need for the record all the CMP's that have been imposed because now we know they made $37 billion in profit in 2005. Now, that is before the marketing and the techniques over the last 2 or 3 years. These companies are wildly profitable, and they have a desire to continue to be wildly profitable.

I think the only way we are going to get companies' attention for bad marketing techniques is to hit them hard when they do it. I mean the agents. I mean the call centers, every place we can. If we start doing that, the word will spread like wildfire, and these companies will be very, very careful because it would cost them dearly.

Unless and until we do that, I think the seniors of this country are going to continue to be in jeopardy of being misled and spending money they do not need to spend and missing out on benefits that they are entitled to that they are not going to get.

So I will take back the information we have learned today.

I want to thank each of you individually for your help here today. I want to particularly thank the Senior Center, and I know that

the head of the Senior Center is here. Where is she? Will you raise your hand? There she is. Thank you so much for your help. Let us give her a round of applause and all of her staff. [Applause.]

They worked hard to get this ready today, this facility.

I want to thank everyone who attended this hearing, and if you want a copy of this booklet, which is not from an insurance company—this is from people that are trying to make sure you are making the right decision—just let us know if you are here attending the hearing, and we will make sure you get a copy of it. I want to thank all the witnesses for being here today.

I particularly want to thank my staff that is here from Washington, D.C. and the staff from the Special Committee on Aging from the Senate that is here from Washington, D.C. to help us with this hearing today.

The hearing is adjourned. Thank you. [Applause.]

[Whereupon, at 10:46 a.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR CLAIRE MCCASKILL

I would like to welcome everyone to today's hearing. I particularly want to thank our witnesses for taking time out of their busy schedules to be with us here today.

I want to discuss Medicare Advantage (MA) plans in Missouri. I understand that these plans may be helpful under the right conditions. I am concerned, however, that after more than a year of congressional scrutiny, I am still hearing from constituents who have been victims of predatory and, sometimes, illegal sales and marketing tactics. Our investigations have also revealed these concerns apply to the relatively new Medicare Advantage product Special Needs Plans. These plans are designed for low income or seriously ill seniors who may lose much needed assistance from Medicaid to cover co-pays when placed in a Medicare Advantage plan. It is important to assure vulnerable seniors are not pressured into an inappropriate plan due to high sales agent commissions and company profits.

Medicare Advantage was created to improve access, choice and services for seniors. They have been touted as the solution for rural citizens, those with special needs, and as a way to increase choice and efficiently bundle services for low-income senior's eligible for both Medicare and Medicaid.

In February, however, the GAO released findings that under many different scenarios MA actually cost seniors more money out of pocket and limits the services they would have received with regular Medicare. In addition a report GAO issued just last week stated that Medicare Advantage plans underreported profit to CMS by $1.14 billion (on top of the $35 billion the plans in the study made in 2005) while 80% of beneficiaries were enrolled in plans for which expenses for medical care were lower than projected.

Further there exists today an "alphabet soup" of choices for seniors, be it a MA—PDP, PPO, HMO, SNP, PFFS, or MSA. Be assured the senior is given multitudes of options for each separate plan. So if the goal of these plans was to offer more choice, we would say they have succeeded, however some would say this confusing array of choices has been to the detriment of the senior. In Missouri alone there are over four dozen MA and Special Needs Plans.

All this choice is expensive; Congress's expert advisory panel on Medicare payment policy, The Medicare Payment Advisory Commission (MedPAC), and the Congressional Budget Office (CBO) have determined that on average the Federal Government is paying these private plans 12 percent more than it costs to treat comparable beneficiaries through traditional Medicare, with some plans receiving up to 19 percent more. The commission has also warned us that unless we reign in these expenses the Medicare Hospital Insurance Trust Fund will become insolvent much more quickly than currently projected. Furthermore, Medicare's actuary has recently testified that seniors who choose to remain on traditional Medicare are subsidizing these Medicare Advantage plans by $48 per couple each year, adding up to $700 million, to help finance the overpayments to these MA programs.

Last week, the Senate minority blocked legislation to prevent a large cut in Physician Medicare reimbursement that also would have prohibited some predatory sales tactics under Medicare Advantage. I am particularly concerned about the individuals who are at greatest risk, frail elders and people with complex or serious chronic needs who are served by Special Needs Plans. These are some of the fastest growing plans contributing to the 11% growth in overall MA enrollment in the last 6 months. Their growth is surely fueled in part by the 19% premium they receive.

I look forward to hearing from our witnesses about these issues. It is my intention to continue efforts in Washington to address and resolve them, including putting pressure on Congress and the Administration to assure that seniors aren't getting swindled and that the American taxpayer isn't either.

Today I want to get a "boots on the ground" look at how the MA plans have impacted my state. And with that I welcome the testimony from today's witnesses and how I can move forward from here.

Centers for Medicare and Medicaid Services
Enforcement Actions Against Medicare Advantage Organizations and Prescription Drug Sponsors
January 2006-May 2008

Organization Name	Contract Number (H=MA-PD; S=PDP)	Date Action Taken	Basis for Action	Action Taken	Status
Health Net	PDP (S5678)	January-08	Several Contract Violations	Suspension of enrollment and marketing	Sanction Lifted March 2008
SDM HealthCare	MA-PD (H4009)	December-07	Several Contract Violations	Suspension of enrollment and marketing	Under Sanction
Chesapeake	PFFS (H7845)	November-08	Marketing Violations	Suspension of enrollment and marketing	Sanction Lifted Nov 2007
Coventry	PFFS (H0846)	September-07	Marketing Violations	$264,000 CMP	Resolved - Settlement $190,000
Humana	MA-PD (H1804), RPPO (R5826), PDP (S588)4	September-07	Marketing Violations	$75,000 CMP	Resolved Paid in full
SunCoast	MA-PD (H5942)	August-07	Insolvency	Immediate Termination	Termination
AHC	MA PD (H1034)	July-07	Multiple Contract Violations	Immediate Termination	Termination
AHC	MA PD (H1034)	April-07	Multiple Contract Violations	Proposed Non-renewal	Termination
Torchmark-First United American	PDP (S5580)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$15,000 CMP	Resolved Paid in full
Florida Health	MA-PD (H1035)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$10,000 CMP	Resolved Paid in full
Freedom Health	MA-PD (H5427)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$5,000 CMP	Resolved Paid in full
Vista Health	MA-PD (H1076 H5850)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$11,050 CMP	Resolved Paid in full
HealthNet	PDP (S5678)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$10,000 CMP	Resolved Paid in full
HealthNet	MA-PD (H0755)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$15,000 CMP	Resolved Paid in full
SunCoast	MA-PD (H5942)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$2,100 CMP	Resolved Paid in full
Wellpoint	PDP (S5596 S5726)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$20,000 CMP	Resolved Paid in full
United HealthCare	PDP (S5805 S5820 S5921)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$75,000 CMP	Resolved Paid in full

Centers for Medicare and Medicaid Services
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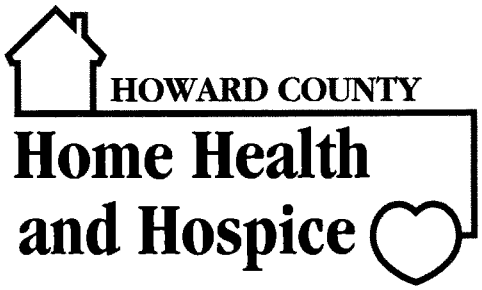
January 2006-May 2008

Organization Name	Contract Number (H=MA-PD; S=PDP)	Date Action Taken	Basis for Action	Action Taken	Status
United HealthCare	MA-PD (H0151, H0316, H0319, H0401, H0620, H0624, H0710, H1080, H1108, H1111, H1303, H1509, H1717, H2001, H2003, H2111, H2228, H2406, H2408, H2624, H2802, H2803, H3209, H3379, H3456, H3659, H3812, H3912, H3921, H4102, H4406, H4456, H4522, H4604, H5008, H5253, H5417, H5440, H5500, H5507, H5516, H5527, H5532, H9011) RPPO (R3175, R5287)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$130,000 CMP	Resolved Paid in full
Humana	MA-PD (H0307, H1036, H1406, H1407, H1804, H2649, H4510), RPPO R5826	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$120,000 CMP	Resolved Paid in full
Elder Health	PDP (S1566 S5822)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$4,000 CMP	Resolved Paid in full
Elder Health	MA-PD (H2108 H3949 H4528)	March-07	Failure to Issue 2006 ANOCs in a Timely Manner	$15,000 CMP	Resolved Paid in full
Universal	MA-PD (H5820)	February-07	Financial Solvency Concerns	Suspension of enrollment and marketing	Sanction Lifted Feb 2008
Doctor Care, Inc.	MA-PD (H5411)	December-06	Financial Solvency Concerns	Immediate Termination	Termination
Doctor Care, Inc.	MA-PD (H5411)	October-06	Financial Solvency Concerns	Suspension of enrollment and marketing	Termination



June 30, 2008

Senator Claire McCaskill

Dear Senator McCaskill;

Our Agency has had increasing amounts of negative experiences with MA Medicare companies and it alarms me that these practices continue without apparent repercussions that result in actual change in practice.

Patient Situations

Case A - Elderly sisters, who were both receiving home health services from our Agency, had a door-to-door salesman persuade them to sign up with MA Medicare's Anthem Blue Cross Smart Value Plus plan. During the course of his sales pitch, one sister kept protesting, listing their many health problems, their very long and complex medication list, etc. She reported that his response to each thing that she listed in concern was that "this is the perfect plan for you".

Repercussions: There were no premiums for this plan but the sisters didn't understand the fact that their coverage was markedly less than with their prior plan. Their home health coverage required them to pay 15% of their home health services and they had no charges with their previous plan. Even worse, one sister did not have a Medicare secondary policy and her monthly medication out of pocket expense was much higher as well. Even worse, she is responsible for the remaining 15% of her home health coverage. When our Agency staff learned this and informed her of this situation, she said that we were going to have to discharge her because she didn't have the money to pay for this 15%. This wheel chair bound very sick lady needs home health services! We sent her our Sliding Scale policy and she did complete the application. Her 15% for 4-1 thru 5-31-08 is $280.66.

Agency Impact: Patient has applied for our Sliding Scale Fee program and qualifies for only being responsible for 20% of these amounts, as her income is only 125% of the 2008 Federal Poverty level. Our Agency can not afford to write off such a significant amount of reimbursement on very many patients! Since this all began her sister has died and it is uncertain where patient will now live.

Outcome: With assistance from the Center for Medicare Advocacy and the CMS Regional Office, the sister who has no secondary insurance was moved back to her previous MA Medicare program, which does not require the 15% copay.

Phone: 660-248-2100
Fax: 660-248-3347

101 Furr Street
Fayette, MO 65248
http://www.hchhh.org

Toll free phone: 866-748-2100
Toll free fax: 866-348-3347

Case B – Patient B and his wife had a door to door salesman come to their home and persuade them to sign up with Anthem Blue Cross Smart Value Plus plan. Patient B is very ill with many health problems and is a home health patient. Patient B and his wife were not aware that their coverage was so much less. Patient B does not have a Medicare Secondary policy.

Agency Impact: Patient B's 15% for his 4-1-08 60 day home health episode is $258.65. Patient and wife's ***combined*** annual income is $15,295.20 which is only **125% of the 2008 Federal poverty level**. Patient B has applied for our Sliding Scale Fee program and qualified which means he is only responsible for 20% of this amount.

Outcome: One week after notifying Patient B of the copay and his right to disenroll, he and his wife contacted their Anthem Blue Cross Smart Value Plus plan salesman who arrived at their home on 4-15-08 and called me saying that he understood our agency was not a preferred provider with Anthem Blue Cross and this was the reason patient wanted to change back to traditional Medicare. I explained this was not correct, that the agency has been a preferred provider with Blue Cross insurances for many years. The problem is this policy has a 15% home health copay and patient can't afford that. He responded that he would have them sign the documents to change back to traditional Medicare as they requested, which went into effect May 1, 2008.

MA Medicare Billing Problems

Collecting funds on a single MA Medicare claim takes more time by our staff than 100 traditional Medicare claims. Our experience has been, no matter which MA Medicare company help desk is called, their staff do not understand Medicare HIPPS codes, episodic payment, and I have even had MA Medicare companies ask me if the service I was requesting approval for was one that traditional Medicare would cover. When I explained that it was, the person replied that they cover the same thing as traditional Medicare.

Traditional Medicare pays 60% of the 60 day episode HIPPS code reimbursement for the first episode at the initial billing, also called Request for Anticipated Payment (RAP), then recoup that 60% and pay the full 100% when the final bill is sent after the end of the 60 day payment. Any subsequent episodes are paid at 50% with the RAP, recoupment of that amount then payment of the full 100% with the final bill.

MA Medicare companies either pay every episode at 60% with each RAP and 40% with each final or 50% with each RAP and 50% with each final.

Only 2 MA Medicare claims, out of approximately 50 MA Medicare claims that our Agency has were paid at the Medicare rate. Some were over the traditional Medicare amount but many were under the Medicare amount.

If we have more than one patient with a particular MA Medicare company and that company suddenly decides that they have paid incorrectly, they will reduce the payment the Agency receives on another patient. This results in a book keeping nightmare as the second patient's payment is then less than it is supposed to be.

Humana Gold Choice – typically takes repeated claim submissions and as much as 8-10 hours per claim before payment is received.

Anthem Blue Cross – claims have been submitted repeatedly and many different error codes have been received. One of the messages is that even though the policy is Anthem Blue Cross Smart Value Plus plan, they do not have a Missouri plan. So far, we still have not received payment and still continue to receive various types of reasons for denied claims. At this time, a minimum of 6-8 hours have been spent on the phone

regarding these claims without resolution. The contact person at Blue Cross plainly states that she is at a loss to explain why the claims aren't processing.

Care Improvement Plus – we didn't realize that a patient had Care Improvement Plus until after she was discharged. When I called this company, they told us to submit the claim and then appeal after receiving a denial as we did not obtain pre-authorization. We are still waiting to see if we will receive reimbursement for services.

Note - This company requires prior authorization for services which is a method insurance companies often use to limit visits so that beneficiaries are potentially harmed by receiving inadequate care and health care providers are at legal risk due to providing less care than industry standards.

To make matters more confusing, a senior citizen's regular Medicare cards aren't destroyed when they take out a MA Medicare plan. The elderly often do not realize that they are losing their traditional Medicare when they sign onto a MA Medicare plan so give their traditional Medicare card to medical personnel to show their coverage. As part of our Agency practice now, we check with our Medicare Fiscal Intermediary's web site to determine if the patient has a MA Medicare plan prior to admission however we have learned that this information is not always accurate.

In my opinion, health care providers will reach the point that they refuse to accept MA Medicare clients. Faulty reimbursement, excessive hours spent trying to collect on claims and receiving repeated denials. Please bring penalties against the MA Medicare companies for misconduct. Please make certain that they properly pay claims or some arbitration methodology is available to make them pay appropriately. Most of all, please stop their preying on the frail, ill, elderly and inadequately explaining their increased financial responsibility and promising the rainbow by insisting "this is the plan for you".

If there is any way that I can help or any further information or details that I can provide, please feel free to contact me!

Thanks,

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Medicare Prescription Plans AND Medicare Advantage Plans

Fact 1 – Medicare has added Part D Prescription medication Medicare coverage which allows you to choose which plan is best for you from a large variety of plans.

Fact 2 – Some of the Part D Prescription Medicare plans also move your regular Medicare Part A (Hospital) and Part B (Medical) insurance to this plan.

Fact 3 – Home Health services are covered under both Medicare Part A and Medicare Part B insurance.

Fact 4 – Changing your Medicare to this plan may cause you to be responsible for a portion of charges that you did not have to pay for in past, including a portion of your home health services.

What you should do:

1) If you receive a visitor or a call from a sales person wanting you to take out a plan. Do not take it out until you have had time to make certain you are fully informed.
    a. Go to www.medicare.gov and click on Medicare Health Plans 2008 Plan Data. Follow the prompts until you get to the plan you have been considering.
    b. Read thru the different sections areas of coverage and any costs to you. If there are co-pays or coinsurance amounts, consider if the reduced monthly premium offsets the increased expense you will have whenever you need health care services.
    c. Notice if Home Health section has a copay. With traditional Medicare and with some Medicare Advantage plans, you will not have a copay. Consider if the reduced monthly premium offsets the increased expense you will have whenever you need health care services.
    d. Contact CLAIM at 800-390-3330 for guidance in choosing a plan – a Missouri state health insurance assistance program that meets the needs of Missouri's Medicare population. Certified volunteer counselors assist people locally to help them work through health care issues and understand Medicare options or changes. http://www.missouriclaim.org/beneficiaries/medicare_help.asp is CLAIM's web site address.
    e. If you receive a call or a visitor trying to sell you a Medicare Advantage plan and you did not contact them to come, this is illegal. Get the name and phone number of the person who comes to your house and report them to the Centers of Medicare and Medicaid Services' Kansas City's Regional Office 816-426-5783 or email address ROkcmMO@cms.hhs.gov.
2) If you have gone with a Medicare Advantage plan by one of these door-to-door sales persons, you need to call the Medicare Advantage plan to

inform them you are switching back to traditional Medicare, then call Medicare at 1-800-633-4227 or the Department of Health and Human Services at 1-877-696-6775 to change back to traditional Medicare if you wish to do so.

a. Be sure to report this illegal practice to the Centers of Medicare and Medicaid Services' Kansas City's Regional Office 816-426-5783 or email address ROkcmMO@cms.hhs.gov.

If you have any questions, please call Serese or Logan at 660-248-2100 or toll free 866-748-2100.

Also – read the article at www.ncpssm.org/news/archive/vp_medicare_advantage titled Attack on Medicare: Private Health Plan Subsidies Windfall for Corporate America by the National Committee to Preserve Social Security and Medicare. This article very clearly articulates why these companies are using any means they can use in order to persuade people to take out Medicare Advantage plans with less coverage but more funds in the pockets of the insurance companies!

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