CMS Proposes Rules to Curb Marketing Abuses

BY JANE ANDERSON
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The Centers for Medicare and Medicaid Services, seeking to curtail marketing abuses within Medicare Advantage and Medicare Part D prescription drug plans, has proposed new regulations that would prohibit such tactics as door-to-door marketing and cold-calling of beneficiaries.

The proposed rules, which would incorporate into regulation several requirements that CMS already has imposed administratively, would tighten marketing standards and require independent insurance agents who sell Medicare Advantage and Part D products to be licensed by the state, the agency said.

The rules, which are subject to public comment, also seek to eliminate incentives for agents to "churn" beneficiaries, or persuade people to change plans, in order to gain enhanced commissions, said Abby Block, director of the CMS Center for Beneficiary Choices.

"There won't be the kinds of incentives there are in the market now for brokers and agents to try and convince beneficiaries to move from one plan to another," Ms. Block said at a press briefing.

CMS plans to roll out the final rule before the fall open enrollment season.

CMS Acting Administrator Kerry Weems noted that the proposed regulations "go beyond what the insurance industry recently endorsed as necessary regulatory changes to the program." He added, "I want to emphasize that this is a large and comprehensive rule."

However, the House Committee on Energy and Commerce, which has released a report on the Medicare Advantage program, said that the proposed changes in marketing requirements "will do little to address the fundamental problems with Medicare Advantage plans."

According to Rep. Bart Stupak (D-Mich.), chairman of the committee's subcommittee on oversight and investigation, the committee's report "has verified countless stories of deceptive sales practices by insurance agents who prey on the elderly and disabled to sell them expensive and inappropriate private Medicare plans." He noted in a statement that the report "shows that steps taken by CMS will not be nearly enough to protect our most vulnerable citizens from deceptive sales practices."

The committee report recommended better sales agent training, strengthened state oversight of plan sales operations, standardization of plan benefit packages, and comprehensive tracking of beneficiary complaints.

The CMS proposal received mixed reviews from Medicare Advantage stakeholders.

Karen Ignagni, president and CEO of America's Health Insurance Plans, said in a statement that the proposed regulations are "an important step to ensure beneficiaries can rely on the information being provided to make the Medicare coverage decisions that are right for them." In March, AHIP advocated for stronger federal regulation and oversight of Medicare Advantage and Part D plan marketing activities.

Robert Hayes, president of the consumer advocacy group the Medicare Rights Center, said in a statement that the proposed regulations "are inadequate to address the problems we see every day. These regulations do nothing to prevent insurance companies from using high commissions and volume-based bonuses to encourage agents to enroll people with Medicare in substandard plans that provide inadequate financial protection, abysmal customer service, and poor access to providers."

The proposed marketing standards for Medicare plans would prohibit cold-calling and expand the current prohibition on door-to-door solicitation.

Specifically, the proposed plan marketing standards would prohibit cold-calling and expand the current prohibition on door-to-door solicitation to cover other unsolicited circumstances, such as sales activities at educational events like health information fairs and community meetings, or in areas such as waiting rooms where patients primarily intend to receive health care–related services, according to CMS.

In addition, Medicare Advantage organizations that use independent agents to market would be required to use state-licensed agents and to report to states that they were using those agents.

The regulations also would require Medicare Advantage organizations to establish commission structures for sales agents and brokers that are level across all years and across all product types. Commission structures for prescription drug plans would have to be level across the sponsors' plans as well. The requirements are designed to discourage "churning," and would ensure that beneficiaries are receiving the information and counseling necessary to select the best plan based on their needs, according to CMS.

The rule also proposes new protections for beneficiaries enrolled in special needs plans (SNPs), a type of Medicare Advantage plan that provides coordinated care to individuals in certain institutions, such as nursing homes; those who are eligible for both Medicare and Medicaid; and those who have certain severe or disabling chronic conditions.

The proposed rules would require that 90% of new enrollees in SNPs be special needs individuals, would more clearly establish and clarify delivery of care standards for SNPs, and would protect beneficiaries enrolled in both Medicare and Medicaid from being billed for cost sharing that is not their responsibility.

CMS is accepting comments on the proposal until July 15. ■

POLICY & PRACTICE

AHIP Proposes Reform Plan

The United States could reduce total health care spending by $145 billion in the next 7 years while improving the quality of patient care by implementing five proposals, according to a plan from industry group America's Health Insurance Plans. The AHIP plan endorsed a combination of measures, including better disease management and care coordination, prevention, a move to electronic transactions, a transition to a value-based payment system, and new technology, to improve the U.S. health care system and save money. The group also called for replacing the current medical liability system with a dispute resolution process consisting of an objective, independent administrative process. AHIP President and CEO Karen Ignagni said that most pieces of her group's proposal are in use now by health insurance companies. "Plans have made measurable progress, but the nation needs a coordinated approach across the public and private sectors to maximize the impact of these strategies," Ms. Ignagni said in a statement.

ACP Provides Framework

The American College of Physicians has reiterated its 2002 message that all Americans should have access to affordable health insurance coverage. In an update to its 6-year-old position paper, ACP reviewed the key reforms recommended and said they remain, with some revisions, a viable approach to making coverage available universally. The paper emphasized ACP's belief that reforms to expand coverage should be done in concert with changes in health care financing and delivery to improve outcomes and efficiency of care. "Expanding health insurance coverage to all Americans is a moral imperative," said Dr. Jeffrey Harris, ACP president. The paper recommended expanding Medicaid coverage, creating tax credits, and adding options for small employers. It also asked for federal government support for states to expand coverage and organize care around a patient-centered medical home.

Consumer Reports to Grade Hospitals

Consumer Reports has begun grading hospitals, and plans to eventually add ratings for other health care providers. The ratings, which include nearly 3,000 hospitals, are available at www.consumerreportshealth.org. The online tool allows consumers to compare hospitals based on their treatment approaches for nine chronic conditions. The comparison includes the time spent in the hospital and average out-of-pocket costs for each condition. The effort is the first project of the newly launched Consumer Reports Health Ratings Center.

Florida Expands Coverage Options

Florida Gov. Charlie Crist, a Republican, has signed legislation that will allow the state to negotiate with health insurers to develop affordable health coverage for the 3.8 million uninsured Floridians aged 19-64 years. The legislation focuses on primary and preventive care to discourage unnecessary emergency department visits. Private insurers have indicated that the plan will allow them to create benefits packages for about $150 a month or less. All benefit plans will include, at the very least, coverage for preventive services, screenings, office visits, outpatient and inpatient surgery, urgent care, prescription drugs, durable medical equipment, and diabetic supplies, according to the governor's office. Approved insurance companies also would have to offer consumers a plan that includes catastrophic and hospital coverage. In addition, the new law creates a centralized clearinghouse where small businesses can choose from a variety of health care plans for their employees.

CMS Outlines Hospice Rights

The Centers for Medicare and Medicaid Services has finalized regulations that give Medicare beneficiaries with terminal illnesses the right to determine how they receive end-of-life care. The provisions, contained in an overhaul of regulations governing the hospice industry, include explicit language on patient rights that had not existed under the previous regulations, CMS said. According to the new rule, patients who choose hospice, or palliative care, over curative treatment are entitled to such things as participation in their treatment plan, the right to effective pain management, the right to refuse treatment, and the right to choose their own physician. CMS noted that although many hospice patients already are active in their own treatment plans, this regulation is the first to set out a detailed list of patient rights. "End-of-life care has changed markedly in the past 25 years and it is time to update our regulations to reflect advances in medicine and hospice industry practices as well as patient rights," said CMS Acting Administrator Kerry Weems in a statement.

Mass. Uninsured Rate Cut

In the first year after Massachusetts implemented its health insurance coverage expansion and reforms, the uninsured rate among adults in the state dropped by almost half, from 13% to just over 7%, according to an Urban Institute study published online in Health Affairs. The study also showed that access to care for low-income Massachusetts adults has increased, and the share of adults with high out-of-pocket health care costs and problems paying medical bills has dropped. In addition, the study's author found no evidence that the expansion of publicly subsidized coverage has "crowded out" employer-sponsored coverage. The reforms, enacted in April 2006, included an expansion of Medicaid, state subsidies for low-income residents to purchase health insurance, and a new purchasing arrangement for private health insurance. Under the reforms, most uninsured individuals must purchase insurance or pay a penalty to the state.

—Jane Anderson