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Details: July 8, 2008 Informational Hearing

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING
COMMITTEE RECORDS

2007-08
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Public Health, Senior Issues, Long Term Care and Privacy

(SC-PHSILTCP)

(FORM UPDATED: 07/02/2010)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**
- Record of Comm. Proceedings ... **RCP**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

- Appointments ... **Appt**
- Clearinghouse Rules ... **CRule**
- Hearing Records ... bills and resolutions
  (**ab** = Assembly Bill)
  (**ar** = Assm. Resolution) (**ajr** = Assm. Joint Resolution)
  (**sb** = Senate Bill)
  (**sr** = Sen. Resolution) (**sjr** = Sen. Joint Resolution)
- Miscellaneous ... **Misc**

Senate

Misc.

INFORMATIONAL HEARING

Committee on Public Health, Senior Issues, Long Term Care and Privacy

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The committee will hold an informational hearing on the following items at the time specified below:

Tuesday, July 8, 2008
1:15 PM
330 Southwest
State Capitol

Pt.01

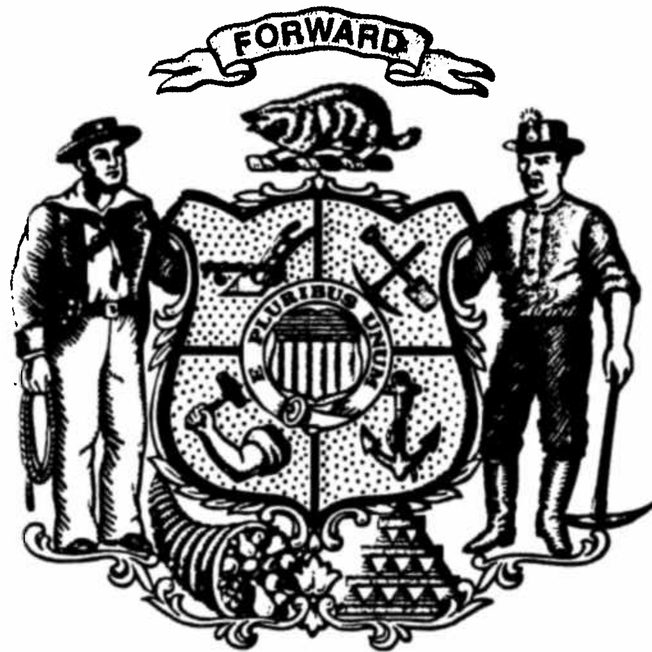
The first topic of the Informational Hearing will be an update from the Department of Health & Family Services on the operation of the Manor Care nursing homes since the change in ownership to a private equity group, The Carlyle Group.

Pt.02

The second topic will include testimony from Commissioner Sean Dilweg of the Office of the Commissioner of Insurance regarding long term care insurance and related senior issues.

Testimony will include invited speakers

Senator Tim Carpenter
Chair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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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DATE: **May 5, 2008**

TO: **Insurers Selling Life Insurance or Annuities and Insurance Producers Doing Business in Wisconsin**

FROM: **Sean Dilweg, Commissioner of Insurance**

SUBJECT: **Improper Use of Certain Designations / Titles Targeting Senior Purchasers**

The use of senior or retirement specific designations and titles by insurance producers in the marketing and sales of individual life insurance and annuities directed to seniors has increased nationwide. The use of titles, with words such as "certified," "accredited," "retirement planner," "senior advisor" or "senior consultant," implies special training or education for selling specialized products to seniors. However, this may not be true. The use of certain designations may mislead seniors who are considering purchasing life insurance or an annuity from an agent or company into thinking that special courses or exams were passed and signify expertise in seniors' financial matters, when, in fact, no such expertise exists. Some designations may have little or no educational requirements.

This bulletin applies to the marketing and sales of all life insurance and annuities, and requires the proper use of designations by producers.

Section Ins. 2.16, Wis. Adm. Code, **Advertisements of and deceptive practices in life insurance and annuities**, provides for the regulation of the advertising of life insurance products and annuities. Insurance companies are responsible for all advertising for their products whether the advertisement is prepared by the company or the producer. The inclusion of designations in an advertisement is considered part of the advertising of the product.

Any producer who advertises himself or herself as holding special status due to training or advanced education must be able to provide documentation of expertise, such as a course syllabus and proof of successful completion of the course of study or training. No producer should hold himself or herself out through the use of designations or credentials as possessing special knowledge or expertise relating to retirement or the senior market, unless such designation or credential is supported by a documented program of study.

If producers misrepresent their level of expertise in marketing and sales activities, they will be subject to penalties under state law. An insurer who allows its producers to use misleading designations will also be subject to penalty under state law.

The following is a partial list of the recognized programs of study which have had courses approved for continuing education credit in Wisconsin.

Recognized Programs of Study:

Chartered Financial Consultant
Chartered Life Underwriter
Life Underwriter Training Council Fellow
Certified Employee Benefit Specialist
Registered Health Underwriter
Certified Financial Planner
Fellow of the Life Management Institute
Registered Employee Benefits Counselor
Health Insurance Associate
Certification in Long Term Care
Fraternal Insurance Counselor

Contact Information:

Mike Honeck – Chief of the Health and Life Insurance Section
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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, *Governor*
Sean Dilweg, *Commissioner*

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PRESS RELEASE

FOR IMMEDIATE RELEASE
May 5, 2008

For more Information contact:

Mikaela Reck
Public Information Officer
(608)267-9336 or
mikaela.reck@wisconsin.gov

SENIORS BEWARE - CONSUMER ALERT
QUESTION CREDENTIALS OF "SENIOR SPECIALISTS"
BEWARE OF "FREE LUNCH" SEMINARS

Madison, WI — Many seniors have worked hard to accumulate a lifetime of savings. Since older adults are the fastest growing segment of investors, they have become the focus of many financial services firms' marketing and sales activities.

Unfortunately, it can be difficult to identify legitimate offers and products that are suitable for a person's financial needs.

State and federal regulators are increasingly concerned about abusive sales practices that target seniors and may result in fraud. Wisconsin is one of several states which by law requires intermediary agents to make a determination of the suitability of a purchase or replacement of an individual life insurance product or annuity before making a recommendation to a prospective buyer.

Follow these suggestions to become a more informed consumer:

- **Question the credentials of "experts."** Individuals often boast designations and credentials using terms such as "certified," "accredited," "retirement planner," "senior advisor" or "senior consultant" to convince people they have special expertise to help seniors choose investment strategies. This may not be true. While some organizations require members to complete a difficult study program and pass extensive exams to earn designations, other organizations have much less stringent requirements that can be completed in a three- or four-day course. In the worst cases, some senior "expert" designations are earned simply by paying a monetary fee. Ask about the person's qualifications and training, and check them out for yourself. Find out how the person earned the credential, and whether the credential actually requires learning more about older adults' financial needs and/or more about the product being sold.

- **Beware of the "Free Lunch" Seminar**. According to a report from FINRA (Financial Industry Regulatory Authority), four out of five investors 69 years and older received at least one invitation to a free lunch investment seminar in the past three years and three out of five received six or more. There is often a catch to a "free" seminar, even those advertised as unbiased and educational. Federal regulators examined 110 firms that offer free lunch seminars and found that every seminar was a sales presentation. While certain information provided at seminars may be

-more-

useful, a seminar may end up being a sales presentation for life insurance, annuities, other insurance products, or investments. Such seminars often use enticements, including free meals and door prizes, or claims of "urgency" or "limited space," in order to encourage you to attend. You should be aware that if you give contact information on a registration form, that information will be used to solicit you for future sales and marketing efforts.

- **Does this product make sense for you?** Always be sure you understand what is being sold. Do not hesitate to ask questions. Financial products can be complicated even for the most informed consumer. You should be able to explain this product in your own words to someone (other than the salesperson) in a way that makes sense to both of you. The product must be right for you, your lifestyle, your financial goals, and your tolerance for risk. It's rare that one product will meet the financial needs and goals of everyone attending a seminar. Be cautious about any promises that one product can meet all your financial needs. If the presenter doesn't know your personal financial situation, he/she can't know if the product is right for you.

- **Never make a final decision at a seminar.** A *Boston Globe* article reported that "more than a third of 'free lunch' seminars aimed at seniors focused on unsuitable or fraudulent investments." If you attend a seminar, you may be exposed to high pressure tactics, frightening stories about individuals who don't have enough money to live on in retirement, and promises of amazing financial returns. Consider obtaining a second opinion from an accountant or other professional who will not benefit financially from the sale.

- **Report scams.** If you feel that you may have been pressured into purchasing a product that is not right for you or if you feel that you may have been misled during a sales presentation about the product you purchased or if you simply don't understand the product, do not hesitate to contact your state or federal regulator for assistance. Regulatory agencies are available to assist you. Financial scams happen to all kinds of consumers, including seniors. Do not let fear or uncertainty keep you from contacting the proper regulatory agencies.

Important Contacts

In all cases, before you disclose any personal or financial information, call the Office of the Commissioner of Insurance at (800) 236-8517 or the Department of Financial Institutions Division of Securities at (608) 266-1064 to verify that the person is licensed to sell insurance products or securities products, and that there have been no complaints or enforcement actions against the person. If a company hosted the seminar, contact the Better Business Bureau (or check their website at www.bbbonline.com) to learn about any complaints. To check for complaints against securities brokers, visit the Web sites of the NASAA (North American Securities Administrators Association) at www.nasaa.org, or FINRA (Financial Industry Regulatory Authority) at www.finra.org.

Created by the Legislature in 1871, Wisconsin's Office of the Commissioner of Insurance (OCI) was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

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Testimony of Sean Dilweg
Wisconsin Insurance Commissioner

Before the
United States Ways and Means Subcommittee on Health

Regarding:
Medicare Advantage Private Fee-For-Service Plans

May 22, 2007
2:00 p.m.
Longworth House Office Building
Room 1100

Testimony of Sean Dilweg
Wisconsin Insurance Commissioner

Good morning Chairman Stark, Ranking Member Camp, and members of the Subcommittee. My name is Sean Dilweg and I am Commissioner of the Wisconsin Office of the Commissioner of Insurance. Thank you for inviting me here to share with you some observations on Medicare Advantage Private Fee-for-Service Plans as Insurance Commissioner of my home state of Wisconsin. I also currently serve as chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators from 50 states, the District of Columbia, and five U.S. territories, and although I am not testifying in my NAIC capacity today, I would like to supplement some of my views with the collective views and experiences of the nation's insurance commissioners on today's topic.

Marketing Complaints:

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

In this role insurance departments receive the whole spectrum of consumer complaints about private Medicare programs, including Medicare Advantage and Medicare Part D. In many instances, the consumer complaints are routine, and to be expected for these large and complex programs. However, I would like to share with you an issue that has become of growing concern to me and other state insurance regulators, which is abuse in the marketing and sales of Medicare Advantage plans.

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

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

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

37 out of 43 state insurance departments have reported receiving complaints about inappropriate or confusing marketing practices leading Medicare beneficiaries to enroll in a Medicare Advantage plan without adequately understanding their choice to remain in traditional Medicare or without adequate understanding of the consequences of their decision. Beneficiaries believed they were signing up for a Medicare Part D stand-alone drug plan or a Medigap plan to supplement their traditional Medicare, but instead they were enrolled into a Medicare Advantage plan. Too often we find that the beneficiary did not know that he or she made this choice, or that he or she was not made aware of the implications of this decision, such as the fact that they would be giving up traditional Medicare, their Medigap policy, and also potentially restricting their access to doctors and other providers. We have heard instances when a beneficiary continues to send in their Medicare supplement premium for several months after they've signed up for a Medicare Advantage plan. In the most troubling of these cases, unscrupulous agents have enrolled beneficiaries with dementia into an inappropriate plan.

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

31 out of 43 state insurance departments have also reported cross-selling, where insurance agents and brokers use Medicare Part D as a pre-text to get in the door with a senior, a situation that is not prohibited by the Medicare marketing guidelines.[1] Once inside, agents instead sell the senior an unrelated and sometimes unsuitable insurance product -- including Medicare Advantage plans, annuities, life

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

insurance policies, funeral policies, and other types of products. These other products are often much more lucrative to the agent than a Medicare Part D plan.[2] In Wisconsin, one insurer paid agents a commission of $50 for a Part D sale, whereas the commission for a Medicare Advantage sale was $250. With these types of financial incentives, inappropriate steering of beneficiaries to Medicare Advantage is difficult to avoid.

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

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

These marketing concerns compound the difficulty consumers already face with these confusing programs, but are inherently acceptable under the Medicare Modernization Act of 2003 (MMA), and are exacerbated by troublesome and aggressive marketing tactics.

Limited State Regulatory Authority:

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

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

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

Since MMA, state regulators have lost all of their regulatory authority over Medicare Advantage plans, except for licensure and solvency. Prior to MMA states shared some regulatory oversight over Medicare Advantage plans, but the MMA scaled back on the ability of state insurance regulators to set or regulate marketing and sales standards for Medicare Advantage plans, and instead limited state regulation of Medicare Advantage plans to licensing and solvency. The MMA also established the same limited boundaries of state regulation for Medicare Part D plans.

This means that, unlike Medicare Supplement insurance or other types of state-regulated health insurance, the state insurance commissioner has very limited authority over the actual insurance company. In Medicare Advantage and Medicare Part D a state insurance department has no say in whether a marketing strategy or practice (such as permitting cross-selling or cold-calls) or advertisement is appropriate for this often-vulnerable population. We have limited ability to monitor companies in the marketplace and limited ability to take corrective action against a company for misconduct.

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

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

State Efforts:

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

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

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

Even once the MOU is fully operational, state regulators are still very limited in their ability to prevent marketing and sales abuses. The preemption of state authority over the operations of Medicare Advantage plans - except licensure and solvency - means that consumers must go to CMS for assistance, regardless of the fact that state regulators have a closer connection to their citizens, more dedicated resources, and greater expertise in dealing with insurance consumer complaints than CMS. Despite these limitations, states continue to assist consumers to the best of their ability.

Financial Incentives:

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

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

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

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

Legislative Suggestions:

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

Medigap as a model for improved plan regulation:

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

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

problems, rather than having to call CMS who seems to have neither the manpower nor the expertise to deal with many of these types of complaints.

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

Medigap as a model for simplification:

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

Although Wisconsin is a relatively small, rural state, we have 92 Medicare Advantage plans 50 of which are Private Fee For Service Plans with premiums, in addition to the Medicare Part B premium, ranging from $-0- to $211 per month, and over 50 Medicare Part D prescription drug plans offered by 22 companies. Each plan has different benefit options, cost share, and formularies. Many of the problems I discussed earlier have occurred because these programs are simply too confusing for people to understand. Medigap plans were simplified so that beneficiaries are able to compare plans and costs, and thereby make educated buying decisions. Under the Medigap model, beneficiaries have many choices of coverage. I have heard from our Medicare-eligible seniors that they or their children, some of whom are attorneys or PhD's, are unable to figure out all the various options under Medicare Advantage and Part D so that they can make a good decision for their coverage. Yet, with simplified and consistent benefits and benefit plan designs amongst the plans, beneficiaries are able to truly compare plans when making their buying decisions.

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

plans, yet with many choices of coverage. The standardized benefits were set by CMS, in conjunction with the NAIC through a unique delegation from Congress. Given the opportunity by federal law, the NAIC worked with CMS, industry representatives, consumer advocates, and other interested parties to establish a Model regulation that includes benefit, benefit design and regulatory standards for all Medigap plans.

Medigap as a model for improved consumer protections:

In 2006, a major Medicare Advantage company offered several Private Fee-For-Service plans in Wisconsin. One of those plans, as an example, provided Medicare Part A and Part B coverage along with prescription drug coverage at no additional premium to the enrollee. The plan had a $180 per day hospital co-pay for the first 3 days of a hospital stay. After the third day the plan picked up all hospital charges. That same plan in 2007 now charges $39 per month additional premium and has changed its hospital cost-share to a $550 deductible for any hospital stay whether it is for one day or 30 days. The company informed its enrollees through the CMS approved plan amendment document. The plan document did not significantly highlight these reductions in coverage and increased premium in any way. In addition, to my knowledge, the company did not hold informational meetings with its beneficiaries to go over the changes to their plan during the open enrollment period. For many beneficiaries, the way they found out about the changes is when they got their premium payment coupons and if they went to the hospital.

That is one of the major problems with the Medicare Advantage plans. They can change the cost-share provisions and the premium annually so that the stability in coverage expected by the beneficiary is really not there. People are used to stability and consistency in their health insurance plans from year-to-year. Medicare Advantage does not provide that stability. This could not happen under the Medigap regulatory model, as Medigap plans are guaranteed renewable which means plans cannot unilaterally change coverage from year-to-year except to adjust to original Medicare's changes of its deductibles and co-payments Although premiums might differ slightly, the benefits for an individual beneficiary would not change. Plans could decide to offer a different set of benefits or plans for new enrollees, but they would not be able to disrupt the coverage they are already providing to insureds. I urge you to consider these types of key consumer protections.

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

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

Summary:

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

Thank you again for this opportunity to testify today.

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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Date?

Medicare Advantage

- Medicare Part C (Medicare Advantage) provides coverage for hospital stays and outpatient care, including doctors visits and is provided by private insurance plans.

- Since January 1, 2006 my department has received almost 700 complaints from consumers about marketing and sales involving Medicare Advantage (MA) plans.

- Since these cases involve Medicare Advantage plans, the hands of state regulators are often tied as states are largely preempted from regulating MA plans. The marketing guidelines are established by CMS, and thus, a large regulatory gap exists in the regulation.

- States do have regulatory oversight and authority over insurance agents and brokers; however, without the ability to regulate the plans themselves, state regulators are very limited in their ability to prevent marketing and sales abuses.

- We can only act on the extraordinarily high number of complaints that result from these abuses.

- In traditional insurance, OCI can deal with inappropriate agent action by holding the insurance company responsible for the acts of its agents and thereby having it supervise and discipline its agents.

Medicare Advantage on the Federal Level

- In July 2007 Senator Kohl introduced the Accountability and Transparency in Medicare Marketing Act of 2007; S. 1883.

    - Called for the NAIC to develop standardized marketing requirements for Medicare Advantage organizations with respect to MA plans.
    - Gave the states authority to enforce the standardized marketing practices.

- CMS has a proposed rule to codify marketing guidelines including limitations on cross selling, expanded definitions of cold-calls, and provisions to assist states in their oversight of licensed producers.

- Similar guidelines are also included in H.R. 6631, the bill introduced by Rep. Dingell and Rep. Rangel to stop scheduled Medicare physician cuts.

- This bill passed the House but has not moved in the Senate due to funding cuts to the MA program proposed in the bill. The administration has indicated it will veto legislation that reduces funding to the MA program.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

Wisconsin.gov

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Long-Term Care Insurance Data Call

- In March of 2007, the New York Times published an article, "Aged, Frail and Denied Care by Their Insurers," highlighting difficulties long-term care insurance claimants had encountered in getting their long-term care insurance claims paid.

- In June, the National Association of Insurance Commissioners (NAIC) responded to a request by Senator Charles Grassley (R-IA) requesting long-term care complaint data.

- Due to the New York Times article and Congressional interest on the issues, the NAIC Senior Issues Task Force, which I chair, and the NAIC Market Regulation and Consumer Affairs Committee pursued a Long-Term Care Insurance Data Call.

- National data was collected from 23 long-term care insurance companies (80% of the market) relating to insurance policy counts, lapse statistics, premiums, complaints, claims and cost containment expenses.

- Analysis of the data submitted by the 23 companies indicates the following:

    - The individual long-term care insurance industry continues to grow, with the majority of the growth in comprehensive policies.

    - The growth in the market has been helped by a decrease in policies lapsing.

    - The number of complaints has increased, with the majority of complaints due to claims.

    - Total claim denials have increased for each type of policy, which may relate to the increase in complaints regarding claims.

        - The percentage of claims denied increased by only 0.7% since 2004.

    - Cost containment expenses have increased substantially greater than the increase in claims payments.

- As a result of the NAIC Data Call and analysis of long-term care insurance, the Senior Issues Task Force is pursuing amendments to the NAIC long-term care insurance model law relating to external independent review for claim denials.

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Annuities

- An annuity is a contract wherein the insurance company promises to make a series of payments in return for premiums paid. Annuities may be either immediate or deferred.

- Immediate annuities provide income payments shortly after you pay the premium. Deferred annuities provide income payments at a later date.

- Annuities may be fixed, variable or a combination of both.

- The number and complexity of annuity products available today is growing, and with the aging of baby-boomers there is an increased number of potential annuity consumers.

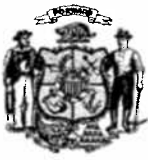
- Unsuitable sales result from selling products that do not meet the needs or are adverse to the consumers' financial situation. This can result from the complexity of the products and the lack of understanding of the products by both the agent and the consumer, and financial incentives for the agent to sell the products.

- Insurance companies need to properly supervise their distribution systems for unsuitable sales, in addition to providing adequate training and monitoring protocols to ensure their agents are recommending suitable products to consumers.

- OCI is proactively working with the industry, agents and consumers to develop standards relating to these areas.

- I am Vice Chair of the NAIC Life Committee and Chair of the NAIC Suitability in Annuity Sales Working Group. The goal is to develop a model regulation for all states to consider as they look to address unsuitable sales in their states.

- The Annuity Supervision Advisory Committee I formed last year is in the process of finalizing standards it recommends to be included in the NAIC's model regulation.



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Senior Designations

- Some agents often boast designations and credentials to convince people they have special expertise to help seniors choose investment strategies. Examples of these terms include "certified," "accredited," "retirement planner," "senior advisor" and "senior consultant."

- While some of the organizations who confer designations require members to complete in depth study programs and pass exams to earn designations, others have much less stringent requirements – in some cases simply a monetary fee.

- As Vice Chair of the NAIC Life and Annuities Committee I am aggressively pursuing the adoption of a model regulation to provide guidance to insurers and agents regarding the use of senior related certifications.

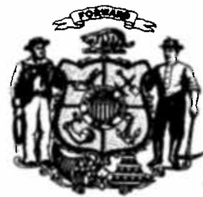
- These guidelines are designed to provide uniform standards on acceptable senior designations and to provide consumers with confidence in the professionals they choose to manage their finances.

- OCI sent out a consumer alert urging residents to be mindful of designations and credentials insurance agents sometimes use and to be careful when making financial decisions. OCI also issued a bulletin in May which applies to the marketing and sales of all life insurance and annuities, and requires the proper use of designations by producers.

FORWARD
E PLURIBUS UNUM

State of Wisconsin

Board on Aging and Long Term Care



Strategic Plan

2009 - 2010

Wisconsin Board on Aging and Long Term Care

STRATEGIC PLAN

Values

The Wisconsin Board on Aging and Long Term Care subscribes to the values of: respect for the individual; protection of the right of the individual to be free from threats to health, safety and quality of life; fairness in relationships with others; and clear and consistent communication with our clients. We respect our staff and volunteers and their ability to provide services consistent with the spirit and intent of these values.

Vision

The Board on Aging and Long Term Care is the premier resource for information and advocacy for our client population, and will continue as an integral part of the ever-changing system for long term care delivery in Wisconsin. The Board will increase its visibility by expanding its role and recognition as a leader and model of advocacy on the state and national stage.

Mission

The mission of the Board on Aging and Long Term Care is to advocate for the interests of the state's aging and disabled populations, to inform consumers of their rights and to educate the public at large about health care systems and long term care.

The Board on Aging and Long Term Care consists of the Board of Directors and the Agency which is composed of an Executive Director and staff who operate the Long Term Care Ombudsman, Volunteer Ombudsman, and Medigap Helpline Programs.

Goals and Objectives for 2009 - 2010

Goal 1: The Board of Directors will be advocates for the Agency and for those served by the Board on Aging and Long Term Care (BOALTC).

Objective A. :
Members of the Board of Directors will be given a comprehensive and continuing orientation to the activities of the Agency.

Objective B. :
Timely communication outside of Board of Directors meetings will be a priority for the Executive Director and the Chairperson of the Board in order that the Directors remain fully informed on significant issues of policy and Agency operations.

Objective C. :
The Directors will provide input to the Executive Director on significant issues relating to policies, budgets, staff recruitment and retention, and legislative advocacy.

Objective D. :
Board meetings will include presentations by program supervisors and field staff on issues relating to operations within both of the Agency's programs.

Objective E. :
The Directors will seek and receive from the agency counsel, information relating to legislative advocacy and legal issues affecting BOALTC operations and the interests of the Agency's clientele.

Objective F. :
The Directors will position the Agency to serve populations within emerging managed long term care systems. The Directors will consider strategies to address issues relating to Long Term Care Ombudsman program and Medigap Helpline program operations in this context.

Objective G.:
The Board of Directors makes recommendations for the improvement of the long term care system to the Governor, the Legislature and the Wisconsin Congressional Delegation.

GOAL 2: The Board on Aging and Long Term Care will provide consumer advocacy, education and information which will adapt to an evolving long-term care system.

Objective A:
Consumers will have easy access to the expertise of staff of the BOALTC.

Strategies:

i. The agency will make the most effective use possible of available technology systems in developing, collecting and disseminating self-empowering consumer information.
ii. The Ombudsman Program will produce and disseminate information designed to assist and support family education in long term care facilities.
iii. The agency will achieve an improved consistency in coding and timely entry of data into relevant data collection and security systems.
iv. Calls to the agency's incoming toll-free telephone lines will be answered by a live voice 75% of the time.
v. Calls to the Ombudsman Program's incoming toll-free telephone line will be given a response within 1 business day.
vi. Calls to the Medigap Helpline's incoming toll-free telephone line will be given a response within 2 business days.
vii. The agency will produce and distribute monthly press releases on topics of importance to consumers of long-term care.
viii. The agency will produce a publication that provides statistical data from each program regarding the number of contacts, complaints, cases, information consultations, educational programs given and other outreach information that will be disseminated throughout the state.
ix. In order to provide services to all potential clients, the agency will utilize language translator services as needed. The agency will communicate with governmental and private resource agencies to assure access by hearing and visually impaired individuals to BOALTC services.
x. Staff will receive cultural diversity training.

GOAL 2

Objective B:
BOALTC programs will respond rapidly, effectively and consistently to changes in long term care delivery and finance systems in order to provide the best possible information and advocacy services to benefit consumers.

Strategies:

i. The agency's programs will work to assure accurate information sharing and timely referrals of clients to advocacy partners across the state.
ii. The Medigap Program will develop standard operating procedures to assure consistent responses by staff.
iii. The Medigap Program will meet quarterly with staff of the Office of the Commissioner of Insurance to assure strong lines of communication that will benefit consumers.
iv. The Medigap Program will develop information for public dissemination relating to Medicare Advantage Plans and other Medicare platforms.
v. The Ombudsman Program will provide information and support to Resident Councils at least twice each year.
vi. The Ombudsman Program will strengthen and refine its liaison with the Division of Quality Assurance (DQA) in order to achieve improved resident care and treatment by providers.
vii. The Ombudsman Program leadership will meet quarterly with DQA to assure coordinated services are provided to long-term care consumers.
viii. The Ombudsman Program leadership will meet quarterly with staff of the United States Department of Justice offices for the Eastern and Western Districts of Wisconsin and other concerned agencies to monitor development, implementation and enforcement of federal law and state regulation.
ix. The agency will evaluate, consider and implement where appropriate, recommendations from various organizations addressing issues of concern to the agency. These resources include, but are not limited to:
    1. The Assisted Living Forum hosted by DQA
    2. The Long Term Care Reform Council
    3. The Nursing Home Advisory Council
    4. The Person-Directed Care Coalition
    5. The Wisconsin Long Term Care Workforce Alliance
    6. The SeniorCare Advisory Council
    7. The Wisconsin Volunteer Coordinators' Association
    8. Coalition of Wisconsin Aging Groups Legislative Forum
    9. Disability Rights Wisconsin
x. The agency will continue to provide oversight of units within the Department of Health and Family Services as required by statutory mandate to promote the highest possible quality of life and care for the residents and consumers who are served by both segments of state government.

GOAL 2

Objective C:
The Long Term Care Ombudsman Program will expand the scope of its advocacy services.

Strategies:

i. Ombudsman staff will educate and inform residents and families about the benefits of Family Councils.
ii. The Volunteer Ombudsman Program will maintain and refine a system of procedures to be consistently applied to facilitate training to assure continued excellence in advocacy.
iii. Ombudsman staff will visit each assisted living facility serving the agency's target population at least annually.
iv. All Ombudsman staff will maintain involvement in Volunteer Program trainings, inservices, and recognitions.
v. Ombudsman staff will collaborate with organizations including, but not limited to, citizen advocacy groups, regulators, FamilyCare, Aging and Disability Resource Centers, county human services agencies, other public health organizations, and provider industry groups to deliver information to consumers on the availability of Ombudsman Program services.
vi. Ombudsman Staff will work with the Family Care administrators within the Department of Health and Family Services to deliver information and assistance focusing on community empowerment to encourage individual autonomy for participants.

GOAL 3: The Board on Aging and Long Term Care will distinguish itself among employers as a workplace where workers are valued, supported and encouraged to grow.

Objective A:
The BOALTC will support its most valuable resource, its staff.

Strategies:

i. Agency management will work with the Office of State Employee Relations to re-evaluate employee classifications to assure that the classes appropriately reflect the needed skill sets and responsibilities.
ii. Staff of the Medigap and Ombudsman Programs will be encouraged to submit articles to local and national publications.
iii. Agency program inservices will use and enhance the opportunities for staff to share knowledge and best practices.
iv. Staff will be encouraged in their efforts outside of the workplace to enhance their professional development.
v. Staff will be encouraged to participate as presenters at in-state public and professional conferences on issues relating to long term care consumers.
vi. Staff will represent the agency on local, regional, and statewide task forces and committees.
vii The Executive Director will designate, as appropriate, individual staff members who will represent the position of the agency in testimony before legislative or administrative committee hearings.
viii. Staff will be allowed the necessary work schedule flexibility to participate, as good citizens, in the exercise of civic responsibility or in activities promoting personal or professional growth.

GOAL 3:

Objective B:
BOALTC will maintain a system of staff recognition events.

Strategies:
i. The Board of Directors will host an annual event at which employees will be recognized for length-of-BOALTC-service milestones of five year intervals.
ii. Management will publicly recognize significant achievements.

Objective C:
BOALTC will maintain a system of volunteer recognition.

Strategies:
i. The agency will recognize the valued contributions of its volunteers.
ii. The Board of Directors will present the Louise Abrahams Yaffe Volunteer Ombudsman Program Award annually.
iii. The agency will utilize a range of media to spotlight volunteer achievements.