MEDPAC Medicare Payment Advisory Commission

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July 14, 2008

Kerry Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4131-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS-4131-P

Dear Mr. Weems:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) proposed rule entitled Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Benefit Programs, published in the *Federal Register*, vol. 73, no. 96, pages 28555 to 28604 (May 16, 2008). We appreciate your staff's work on improving the Medicare Advantage (MA) and Part D prescription drug programs, particularly given the competing demands on the agency.

Below are our comments on the proposed changes to marketing rules for plans and other beneficiary protections, followed by our comments on the special needs plan (SNP) provisions. Although it does not pertain directly to the proposed regulations, we have a final comment regarding the collection of data that can be used to compare the health status of Medicare beneficiaries in MA and the traditional fee-for-service program.

Marketing reforms and other program improvements

CMS has proposed measures that would improve the program in three areas—the disclosure of information to beneficiaries, protections for beneficiaries with respect to premium billings, and standards for health plan marketing practices. For example, the proposed rule would change the way in which a civil monetary penalty for a marketing violation is imposed, making it a dollar amount for each beneficiary affected rather than a dollar amount for each set of cases involving a sanctionable activity (§422.760 and §423.760). This is a strong measure that will be of great help to CMS in addressing marketing abuses and other plan practices that can be subject to civil monetary penalties.

In general we believe the proposed changes in the three areas represent the right direction to take in improving the MA and Part D prescription drug programs. Below we provide more detailed

comments about certain specific provisions in the proposed regulations on marketing and member appeals.

Circumstances under which a physician may pursue a pre-service reconsideration (§422.578 and §422.582)

The proposed rule would allow a physician to appeal an "organization determination" (i.e., plan decision) to deny a proposed service. A "pre-service" request for reconsideration of an adverse decision could be made by a physician acting on behalf of the beneficiary if the physician (a) is treating the beneficiary, and (b) provides notice to the enrollee of the physician's reconsideration request. As noted in the proposed rule, this eliminates the need to formally appoint the physician as the enrollee's legal representative, as would currently be required. As written, the proposed service may be any service proposed to be provided by any provider. The physician filing the appeal would not necessarily be providing the care that is the subject of the appeal. The proposal would make the rules regarding the physician's ability to request a pre-service reconsideration more consistent with the statutory provisions regarding expedited reconsiderations (1852(g)(3)(A)(ii) of the Social Security Act). Under the expedited reconsideration rules of the statute, any physician, whether treating the patient or not, can request an expedited reconsideration and does not need to be appointed as the beneficiary's representative.

CMS's health plan regulations must strike an appropriate balance between ensuring beneficiary protection and access to care, on the one hand, and the need to provide flexibility to plans in how they manage care. CMS appears to make this proposal as a beneficiary protection, stating that "after a number of years of experience with the Part C program" CMS has found that "in some cases, requiring that the physician take the step of being appointed by the enrollee is a burden that does not serve the enrollee's interest." However, it is not clear that beneficiaries are being denied necessary care because they themselves have chosen not to pursue a request for reconsideration, or did not appoint a physician representative. We are thus concerned that the change may lead to a large number of reconsideration cases in which the original plan decision is upheld, resulting in increased administrative costs to plans, without strong evidence of an underlying problem. MedPAC would be hesitant to support this proposal without more detail on the rationale, including information on the extent to which beneficiaries are being denied access to necessary care, and information on the reasons physicians choose to file appeals in these circumstances.

Limiting the scope and timing of in-home marketing presentations (§422.2268(g) and (h); §423.2268(g) and (h))

The rule proposes to require that the scope of sales discussions be agreed upon in advance and documented by the plan in writing, and the sales presentation and discussion can only be within that scope. The proposed rule would permit the sale of other health-related products only if there is a separate appointment, which cannot occur until at least 48 hours after the first appointment.

We understand that the proposal is intended to avoid "bait-and-switch" tactics and to avoid having beneficiaries buy products they had not initially considered buying because they are persuaded to do so by a face-to-face marketing presentation. Part of the reason for the proposed provision is that there have been reports of beneficiaries who request a marketing presentation in their home for a stand-alone prescription drug plan (PDP) but are then enrolled in a Medicare Advantage prescription drug plan (MA-PD)—a product that typically has a much higher commission for the sales representative than a PDP. This is a problem when, as has been reported, beneficiaries enrolled in such situations were not aware of the nature of the MA-PD product and continued to use non-network providers, for example. This indicates that the beneficiary may not truly have been interested in buying an MA-PD product and succumbed to the pressure of a face-to-face sales presentation.

The proposed remedy may be too limiting in the sense that the need to set up a new appointment will be cumbersome for a beneficiary who realizes, during the course of a sales presentation, that he or she is interested in a different type of product (MA-PD rather than PDP, or vice-versa, for example). The proposed requirement would seem to be easily circumvented if, for example, as a routine matter the scope of all at-home presentations was made very broad, encompassing all possible products offered by the insurer or by the agent or broker.

An alternative way of addressing the problem is for CMS to ensure that plans effectively implement the required after-the-fact confirmation of sales and confirmation of the beneficiary's understanding of their enrollment (as currently required under 42 CFR §422.80(e)(2)(ii)). CMS should also be more proactive in its use of fines and other corrective actions. We would suggest that the regulations include a requirement that CMS must impose sanctions on health plans when agents or brokers are found to use prohibited marketing practices, in addition to whatever action would be taken against the agent or broker.

Renewal commissions (§422.2274(a)(1) and §423.2274(a)(1))

The rule proposes to limit broker commissions for renewed policies by limiting the commission payable in the first year to an amount no greater than the commission of subsequent years. We support CMS's desire to develop a policy that will address the issue of "churning" (brokers or agents re-contacting beneficiaries to have them enroll in a new plan so that the broker receives the higher commission for the new plan rather than the lower renewal commission the broker would receive if the beneficiary remained in his or her current plan).

We suggest that you clarify the proposed regulatory language because it is ambiguous as currently written. The current proposed wording states that "the commission…in the first year could not exceed the commission…in all subsequent years." We assume the intended meaning is that the first year commission may not exceed a subsequent year's commission for a given year (as opposed to the sum of all commissions in "all subsequent years").

Assuming that is the case, the language should be "in each subsequent year" rather than "all subsequent years" to clarify this meaning. We would also note that if the first year commission cannot be greater than the commission of any following year, and the agent or broker receives no commission in some later year, then technically no commission is payable in the first year.

The phrasing of the proposed rule on when a commission can differ among types of products should also be more precise. From the preamble language we infer that commissions should be uniform across MA-PD products, and they should be uniform across the stand-alone PDP products of one organization. However, an organization that offers both MA-PD products and PDP products could have commissions that differ between its MA-PD and PDP products. MA-PDs would have a higher commission than PDPs because of the higher total value of plan revenue for the MA product. We would suggest that the proposed regulatory language should state the policy more clearly.

Changes in requirements for special needs plans

Ensuring special needs plans serve primarily special needs individuals (§422.4)

The rule notes that special needs plans (SNPs) can currently enroll non-special needs beneficiaries, as long as they enroll special needs individuals in a proportion greater than such individuals exist in the plan's area. Under this rule, disproportionate-percentage SNPs have proliferated, and a significant number of disproportionate-percentage, dual-eligible SNPs may have between 25 to 40 percent of their enrollment composed of non-special needs individuals. The rule proposes to limit SNPs' new enrollment of non-special needs individuals to no more than 10 percent of new enrollees. We support the proposal's goal of requiring SNPs to focus on serving special needs individuals, but feel that it should go further. In the March 2008 *Report to the Congress*, the Commission recommended that SNPs' enrollment be composed of at least 95 percent special needs individuals. We are concerned that allowing SNPs with memberships composed of as little as 60 to 75 percent special needs individuals to continue to enroll other beneficiaries could unnecessarily delay the proposal's goal. We suggest that CMS consider requiring SNPs with low enrollment of special needs individuals to accept only these beneficiaries as new members.

Other SNP provisions

We strongly support the rule's proposals to

- clarify that SNPs must establish a process to verify that potential enrollees meet the SNP's specific eligibility requirements (§422.52),
- require that SNPs have a documented relationship with states in their service area to verify applicants' dual eligibility and share information on Medicaid providers and benefits (§422.107),
- require that SNPs have additional formal arrangements with states to coordinate benefits within three years (§422.107), and

- require that all MA plans with dual-eligible members specify in their contracts that providers not charge these members cost sharing when the state is liable for the cost sharing (§422.504(g)(1)).

Data collection on the health status of beneficiaries

As enrollment in MA plans grows and as new MA plan options such as SNPs and PFFS plans have been introduced and grown especially rapidly, there has been renewed attention given to the evaluation of the quality of care beneficiaries receive in MA. For SNPs in particular, CMS has been proactive in developing quality measures that are appropriate for these plans and which are to be reported at the plan level (rather than the current practice of reporting at the contract level). The additional SNP reporting will supplement the reporting already required of SNPs as MA coordinated care plans. This effort to learn more about the quality of care in SNPs will enable CMS to better monitor the SNP program and will provide valuable information for beneficiaries and for other stakeholders—including MedPAC, in our role of monitoring and evaluating the MA program.

While we have been able to monitor the performance of MA plans on quality measures based on the available data, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Healthcare Effectiveness Data and Information Set (HEDIS®), there is little data that can be used to directly compare quality in MA to the quality of care beneficiaries receive in the traditional fee-for-service (FFS) program. One of MedPAC's long-standing recommendations is that the Secretary should develop measures to compare FFS and MA on quality indicators (reprinted in our March 2008 *Report to the Congress*). Legislation that the Congress has passed calls for MedPAC to study ways in which quality can be compared between the two sectors.

Given our interest in having data that allows valid and reliable comparisons of the quality of care for FFS beneficiaries and MA enrollees, we would like to comment on a recent change that CMS has instituted in the CAHPS® surveys of beneficiaries in FFS. The CAHPS-FFS surveys fielded in 2000 through 2004 and in 2006 included SF-12® Health Survey questions on self-reported health status. These data are very valuable because they may be used along with results from the Medicare Health Outcomes Survey, which captures patient experiences of care in MA plans, to compare important dimensions of quality in MA and FFS. However, it is our understanding that CMS has discontinued the collection of SF-12® data in the most recent CAHPS-FFS survey. We urge CMS to reconsider the decision to discontinue the collection of this information. The SF-12® information collected through the CAHPS-FFS survey is one of the few sources of data that allows direct comparisons between MA and FFS on quality measures.

MedPAC appreciates the opportunity to comment on the proposed rule and we commend your efforts to strengthen oversight of the MA and PDP programs and improve the SNP program. If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

GMH/cz/jp/jr