Opening Statement of Chairman Bart Stupak
Oversight & Investigations Subcommittee
"Predatory Sales Practices in the Medicare Advantage Program"
June 26, 2007

Our hearing will examine the program known as "Medicare Advantage" which provides insurance options for Medicare beneficiaries. One of its primary objectives was to provide Medicare beneficiaries a wide array of managed care choices. However, the proliferation of private Medicare insurance plans has come at a price. Investigators for this Committee have verified countless stories of deceptive sales practices by insurance agents who prey upon the elderly and disabled to sell them expensive and inappropriate private Medicare plans. These shameful marketing practices, targeting our most fragile and vulnerable citizens, are the subject of today's hearing.

As often happens in the process of our investigation - usually just before this Subcommittee holds a hearing - those being investigated make a changes in their practices to appear as though they are addressing the problems at hand. On June 15th, seven major health insurance companies – two of which are represented here today – voluntarily agreed to stop marketing one type of Medicare Advantage plan, Private Fee for Service Plans, in response to complaints about deceptive sales practices, including forged signatures and the enrollment of dead people.

Today we will explore how CMS and the insurance industry reached the point where they had to call a moratorium on marketing the Private Fee for Service Medicare Advantage Plans. We will also hear about the real life consequences of fraudulent marketing practices. Unfortunately, many seniors are coaxed into plans that don't adequately meet their health care needs. They don't understand that if they sign up for a Medicare Advantage plan, they no longer have the benefits of traditional Medicare coverage. In some instances, the private fee for service plans being sold to these individuals result in reduced coverage and higher out-of-pocket expenses that seniors on a fixed income can not afford.

What most people know about the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA"), is that it created "Part D" of Medicare and launched Prescription Drug Plans run by insurance companies. But what MMA *also* did was boost the payments to the insurance companies operating managed care alternatives to traditional Medicare, and call the private plans "Medicare Advantage." Before MMA, the government was paying these private plans 95% of the cost of traditional Medicare. Now, we are paying them 112% to 119% more. "Medicare Advantage" is aptly named -- it is richly funded to out-compete traditional Medicare.

The launching of "Part D," in combination with the boost in payments to "Medicare Advantage" plans has resulted in a dizzying array of choices for seniors and disabled persons. In Houghton, Michigan, one of the small towns in my district in the Upper Peninsula, Medicare beneficiaries have 54 Prescription Drug Plans to choose from plus 14 Medicare Advantage plans. And that is nothing compared to other parts of the country. For instance, in Miami, there are at least 57 Prescription Drug Plans and 55 Medicare Advantage plans available.

A May 2006 report by AARP documented the problems faced by seniors sorting through this maze, showing widespread confusion and even anxiety over the new Medicare Advantage and prescription drug plans. At what point does consumer "choice" become meaningless? When seniors and their families sit down at the kitchen table to figure out what health care insurance grandma and grandpa need, they should not have to hire an accountant to help them make the right decision

Now we have a glut of private plans that end up dispatching fleets of sales agents racing each other to get to the local retirement community, assisted living facility, or senior center first. We have telemarketers and insurance agents competing for commissions, prizes, and trips to Las Vegas based on who sold the most policies in the shortest time. These abusive sales practices under Medicare Advantage are very similar to the rampant sales problems witnessed with the launch of Medigap insurance in the 1980s. The regulatory model which eliminated Medigap sales fraud should be applied to Medicare Advantage. As with the Medigap plans, plans should be standardized, states should be able to regulate Medicare Advantage companies and agents, and insurers should be held accountable for their agents' actions.

Our first panel will explore the extent of the problem and the consequences of deceptive sales. We will hear first from David Lipschutz, a staff attorney for California Health Advocates. California has had a lengthy experience with government managed care programs, and has often served the role of "canary in the coal mine."

We are especially grateful today for the testimony of three victims of predatory sales practices. Ms. Barbara Clegg-Boodram, a resident of Judiciary House in Washington, DC, home to a large number of seniors and disabled persons a few blocks from here, will testify on behalf of her fellow residents, Edith Williams, Mary Royal, and Grady Hammonds. Ms. Williams, Ms. Royal, and Mr. Hammonds were victimized by an agent who failed to properly explain the consequences of their enrollment in Medicare Advantage plans.

Next we will hear from Kathleen Healey, the Director of the Alabama State Health Insurance Assistance Program (SHIP). SHIP is a national program in each state that offers one-on-one free counseling and assistance to people on Medicare. Also on this first panel is Mr. Lee Harrell, Deputy Commissioner of the Mississippi Insurance Department. Mr. Harrell will share with us some of the practical problems state regulators face when they investigate deceptive practices under the current structure.

We will hear from the insurance industry in our second panel. Fran Soistman from Coventry Health Care and Gary Bailey from WellCare Health Plans will testify about the efforts of their companies to combat marketing abuses. They are joined by Ms. Peggy Olson, a licensed insurance agent who has specialized in Medicare coverage since 1985. We will explore with this panel the role of independent agents, companies' relationships with field marketing organizations, general agents and sub-agents, and some of the inherent challenges these relationships pose. We hope each of you will share with us your candid assessments and your constructive ideas.

Finally, we will hear from the government regulators. Ms. Abby Block, the Director of the Center for Beneficiary Choices at CMS, will testify about CMS' oversight of Medicare Advantage. She is joined by Mr. Jim Poolman, the Commissioner of the North Dakota Insurance Department and Ms. Kim Holland, the Commissioner of the Oklahoma Insurance Department. These witnesses will discuss steps their Departments are taking to investigate questionable sales practices and to warn seniors in their states so they can avoid being victimized.

The financial windfall to the insurance industry attributable to the Medicare Advantage program has been likened to the "Gold Rush". We are bound to hear today that the industry and CMS have "zero tolerance" for deceptive sales practices. What we need, however, is zero abuse. Why do so many elderly and disabled continue to be enrolled, through confusion, if not trickery, in unsuitable and ultimately costly plans? Hopefully our hearing today will answer that question.