CMS Requires Broker Call Recording Oct. 1

Med Advantage Complaints Rise, Prompting Sen Wyden Letter 15 States

The federal government continues to grapple with complaints from seniors of aggressive marketing tactics used by Medicare Advantage (MA) plans. Senate and House members join CMS in consideration of potential solutions for this problem that continues to plague seniors, as we near the beginning of Medicare open enrollment on October 15th.

- **CMS addresses Medicare Advantage (MA) marketing complaints, not state DOIs.** CMS reports that beneficiary complaints regarding MA and Part D marketing plan materials have more than doubled from 2020 to 2021. CMS has received approximately 40,000 complaints so far. MA plan sponsors including CVS-Aetna, Humana, Blue Cross Blue Shield plans, Elevance Health, Centene and UnitedHealthcare are subject to rule changes.

- **Starting October 1st, Third-Party Marketing Organization calls must be recorded in their entirety.** See here for May 2022 CMS rules that revised MA and Part D regulations related to communications and advertising to address influx of complaints. Regulations went into effect on July 28, 2022. CMS notes it will not delay the Oct 1 implementation.

- **Although there is some industry pushback against the CMS Final Rules regarding marketing tactics, CMS states it will not delay the rule (past Oct 1).** See statement by member of National Association of Health Underwriters and Health Agents for America (NAHU) here. Final Rules are criticized on the basis of Overlooking that marketing calls may not originate from TPMOs. Medicare beneficiaries faced calls mainly originating outside of the US, claiming to be calling “Opt-In Data,” to find individuals willing to talk to TPMOs. Opt-In Data is not investigable and likely means of TPMOs skirting rules preventing “unsolicited contact” with seniors. The recording of calls required by Final Rules do not begin until the TPMO makes contact with the senior. Leaving out companies that do not have a contract with a plan sponsor**.** Marketing companies that conduct Facebook advertising, run television ads, and sell live transfer phone calls from overseas (phone calls that are rerouted to phone company's number) cannot be regulated**.** Failing to provide any support or guidance on call recording**.** Brokers are burdened by having to acquire software to record, store, secure call data, and make it available to regulators without adequate notice. Seniors’ data vulnerable. Brokers are concerned that with 100,000 agents trying to comply with rules without a secure infrastructure, information on recordings may be compromised and vulnerable to ransomware attacks.

- **CMS Oct 1 regulations for Third-Party Marketing Organizations (TPMO), such as GoHealth or SelectQuote, as well as brokers & agents.** TPMOs are defined as "organizations and individuals, including independent agents and brokers, that are compensated to perform lead generation, marketing, sales and any enrollment-related functions as part of the chain of enrollment." The term “individual” was added to the definition of TPMOs, clarifying that agents and brokers are TPMOs.

- **Under the Final Rule, MA and Part D plans must do the following – CMS says it will audit.** CMS will conduct audits and ask for phone call recordings (which must be stored for up to 10 years). These requests will likely be a combination of ones related to complaints and random sampling.

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(1) require TPMOs to use a standardized disclaimer (saying that other plans are available, if not all plans are advertised by the TPMO) on all marketing materials and in the first minute of a phone call,
(2) require contracts with TPMOs to include that subcontracted relationships and any staff disciplinary actions or violations to CMS rules are disclosed,
(3) require that all TPMO calls with beneficiaries are recorded in their entirety (including the enrollment process itself) starting October 1, and
(4) ensure that TPMOs disclose all lead generating activities to beneficiaries.

- **The Final Rule additionally implements other changes related to Star Ratings, medical loss ratio reporting, special requirements during public emergencies and disasters, network adequacy, and dual eligible special needs plans (D-SNPs)**. CMS also modified methodology aimed to better hold plans accountable for CMS rule violations through a demerit point system for corrective actions: corrective action plan (6 points), warning letter (3 points), and notice of noncompliance (1 point). This is used for determining if a plan will be prohibited from expansion or entering a new contract with CMS.

- **BACKGROUND: Surge in complaints from Medicare beneficiaries prompts Sen. Ron Wyden (D-OR) probe of aggressive marketing by MA plans.** On August 18, 2022, Senate Finance Committee Chair, Sen. Wyden (D-OR) wrote to 15 state insurance commissioners and state health insurance assistance programs, with a questionnaire of 18 key issues regarding the nature of deceptive marketing practices. Responses were requested to be submitted by Sep 15, 2022. The letters were sent to the following states: Arizona, California, Colorado, Florida, Georgia, Illinois, Massachusetts, Michigan, Missouri, New York, North Carolina, Ohio, Oregon, Pennsylvania, and Texas. Letters went to states with the highest MA penetration & can be found here..

  - Questions include: “How many complaints about MA and/or Part D plan marketing have you received in 2019, 2020, 2021, and 2022?” “In your state, what are the responsibilities of the agent or broker to protect consumers from potentially false or misleading marketing?” “Are there certain geographic regions where complaints of false or misleading advertisements are more common?” See more below.

  - Mary Beth Donahue, President and CEO of Better Medicare Alliance (BMA), a major representative of MA plans, pushed back here. BMA highlighted that (1) MA plans marketing materials are already subject to more than 50 pages of federal guidelines (read here), (2) MA plans have a near perfect beneficiary satisfaction rate of 94%, as reported by a December 2021 Morning Consult poll (See here), (3) Seniors make an active choice to enroll in MA, and (4) almost half of seniors on Medicare still do not know that MA exists, referencing the 2021 Morning Consult poll again. She also called attention to BMA recommendations made in 2020 to streamline Medicare enrollment (Read recommendations here).

- **State insurance commissioners argue that they are better equipped to oversee MA plans and their marketing practices.** Read letter here. On May 5, 2022, the National Association of Insurance Commissioners (NAIC) wrote to Senate leaders Sen. Chuck Schumer and Sen. Mitch McConnell asking for states to have oversight capabilities beyond just solvency and licensing regulation, as limited by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Read here). NAIC thinks that states can better protect seniors from aggressive marketing than the federal government, addressing complaints made to the State Departments of Insurance.

- **House Progressives recommend specific changes to rein in aggressive marketing tactics.** On Sep 7, 2022, House Ways and Means Health Subcommittee Chair Rep. Lloyd Doggett (D-TX), Chair of the Congressional Progressive Caucus Rep. Pramila Jayapal (D-WA), and Co-Chair of the Task Force on Aging & Families Rep. Jan Schakowsky (D-IL), led 30 other Democratic members, in

responding to the CMS request for information. Read letter here. Recommendations involve (1) rescinding changes made in 2019 to the Medicare Communications & Marketing Guidelines (MCMG) (Read here) which are accused of blurring the lines between educational and marketing materials, (2) increase transparency surrounding complaints and enforcement actions, and (3) require agents to sign testimony that product sold is appropriate for the beneficiary, as required for Medigap plans, among other changes.

- **MA Plans continue to be the subject of federal scrutiny, as federal watchdog OIG found that MA plans at times may deny or delay care.** Read report here. The HHS Office of Inspector General (OIG) reported in April 2022 that at times, MA organizations may limit beneficiary access to health services that meet Medicare coverage requirements. 13% of prior authorization denials and 18% of denied payment requests met Medicare guidelines. Plans did at times reverse decisions upon disputes by patients or providers. A MA Prior Auth bill in the Congress could pass by Dec 2022, but the $16 B price tag does not help odds of passage.

- **In other MA news, RADV Final Rules are expected this fall, due by November 1 per HHS.** Key provisions to watch out for are CMS plans to (1) extrapolate in the recovery of RADV overpayments, with an n of 200 sample size, and (2) not apply a fee-for-service (FFS) adjuster to the RADV overpayment determination, and (3) potentially make RADV audits retrospective, in addition to prospective, starting with payment year 2011 contract-level audits. See Capitol Street 9-9-2022 memo for more details

- **NEXT STEPS:** As Medicare Advantage open enrollment draws closer, starting October 15, marketing tactics will continue to be scrutinized by CMS and members of Congress. We do not expect CMS to delay the rules that start October 1. This fall, we expect (1) Fall Technical Rule & Landscape files, in addition to (2) RADV final rules (due by Nov 1). Once the Trust Fund becomes a Congressional issue likely in 2023+ we expect plans to be a source of funds, along with all other Medicare providers.

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BACKGROUND

Deceptive marketing practices have historically been an issue.

- In 2009, the Government Accountability Office (GAO) reported that CMS took enforcement action against at least 73 organizations with MA plans between Jan 2006 and Feb 2009, for inappropriate marketing. CMS adopted GAO recommendations in 2014 to gather more information on marketing cases that result in a request for enrollment change and track retrospective and prospective special enrollment period requests due to inappropriate marketing on a monthly basis. Read GAO report here.

- In 2010, the HHS Office of the Inspector General (HHS OIG) conducted a similar investigation. They found that even after sales agent marketing regulations were implemented, the number and topic of complaints remained the same. OIG also found some bad actors. Five out of six of the plan sponsors examined used sales agents that were unqualified, in that they had not passed the 2009 marketing test or were not licensed at the time of undertaking Medicare beneficiary applications, not adhering to CMS regulations at the time. Read HHS OIG report here.

- Proactive disclosure as required by CMS Final Rule: "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options." This disclosure is not required if the organization does offer every plan available.

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