Medicare Advantage

Marketing Rules and Scope of Appointment

In an effort to improve the consumer experience when enrolling in Medicare plans, we believe that the "scope of appointment" rules should be changed to allow for an initial needs assessment of financial and medical needs, and allows consumers to discuss their options under several different Medicare plan arrangements without the need to submit additional scope-of-appointment paperwork, but continues to protect the consumer.

Background

In 2003, Congress enacted the Medicare Modernization Act, which created a new prescription drug benefit for Medicare beneficiaries and encouraged greater participation in the Medicare Advantage program. Upon enactment and through the transition period of planning for the rollout of the initial enrollment in Medicare Advantage in 2005, the response from health plans was overwhelming. It was so great that some speculated as to whether plan participation should be curtailed or capped in some way. Ultimately, all carriers were welcome to compete. Competition for market share was fierce and distribution, which involves agent/brokers signing up and enrolling beneficiaries, was intense.

The need for a large marketing force was so great at that time that some carriers abandoned the standard practice of getting "state appointments" for their agent sales force, thinking it to be an unnecessary step since the Medicare Advantage program is a federally regulated program. The state appointment process is a consumer protection that ensures that only licensed agents are marketing insurance products to consumers, and it lets state commissioners know who is operating in their state. As a result of not using the traditional state appointment process, there were limited instances of "bad actors" being used to market Medicare Advantage who were not licensed and who began to switch people who were enrolled in one plan into another in order to meet sales quotas for bonuses and other incentives, a practice known as "churning." Seniors were reportedly approached in parks and other public places in order to meet these goals. When NAHU requested CMS provide names of these so-called rogue agents, they were unable to produce a single name because carriers had so little control over their sales force.

Due to complaints in the first year of the rollout, Congress and CMS took notice. As the primary regulator, CMS developed a set of marketing rules to enforce ethical enrollment of Medicare beneficiaries. These rules included a strict scope of appointment (SOA) statement to be

completed prior to meeting with a beneficiary, which required any conversations between an agent and a Medicare beneficiary regarding Medicare Advantage to be limited to specific topics agreed to at the outset by the beneficiary. Any new or different beneficiary concerns that came up during the initial meeting between the agent and the beneficiary required completion of a new statement regarding the scope of the appointment and a minimum 24-hour cooling-off period, which obviously required a return trip. Given the short enrollment period and great distances some agents travel to meet with beneficiaries, this was a particularly onerous requirement, leaving some beneficiaries without the level of agent support that they need and deserve.

After the tumultuous initial enrollment year, carriers began to realize the value of using the state appointment process again and the problem of rogue agents diminished. The state-appointment process gave both carriers and state regulators more control over who was marketing to Medicare beneficiaries in the state. This is in contrast to the strict federal marketing rules that limit access to agents and brokers instead of providing actual oversight of agents and brokers, which is provided through the state appointment process. Unfortunately, as carriers and states began enforcing these state requirements in the Medicare Advantage market, the very strict marketing rules and SOA rules remained. Today, these unnecessary and outdated rules put consumers at a disadvantage to be able to access agents who can provide the skilled resources needed to enroll in Medicare Advantage. Medicare beneficiaries have a variety of financial and health security needs. Each person has a different situation and it may not be possible to determine some situations prior to an initial interview. For example, a beneficiary may be a frequent traveler who would often be out of a Medicare Advantage service area and who might really be a better candidate for a Medicare Supplemental Plan. Or a beneficiary may have a chronic condition that would be served by a program that addresses both healthcare and long-term-care needs. Agents need to be able to conduct an appropriate needs assessment based on the initial interview to provide the customized service on which Medicare beneficiaries depend.

Licensed and appointed agents and brokers must meet educational and ongoing continuing-education requirements, and carry errors-and-omission insurance (similar to malpractice insurance). Many agents working with seniors are the most experienced agents in the business and are often close in age to the Medicare beneficiaries they serve. Providing outstanding consumer service that is tailored to each individual beneficiary is in the best interest of every agent and every Medicare beneficiary. The marketing rules established for the Medicare Advantage program need to be updated to allow agents and beneficiaries to work together to meet the specific needs and goals of the beneficiary at the time of their meeting.