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## Congressional Leaders Close to Unveiling Final Reform Bills

Even Sen. John McCain (R-AZ) begrudgingly concedes that the Democratic-controlled Congress will likely be able to pass health reform. Though there are still uncertainties about what will be included in the final health reform package, the Senate Finance Committee's ("SFC") legislative proposal appears to be emerging as the structural framework for a Senate bill which is expected to be sent to the Congressional Budget Office ("CBO") for scoring today and may be unveiled publicly as early as tomorrow. However, despite SFC Max Baucus' (D-MT) earlier protestations to the contrary, Sen. Majority Leader Harry Reid (D-NV) and other top Senate Democrats are now expressing optimism that the Senate *can* find 60 votes to pass health care reform which includes some sort of public insurance option. We should know very soon the nature of the public option which Senate leaders believe could garner this level of support.

Over this past week, Majority Leader Reid has turned his attention to a public insurance option which would give states the ability to opt out. This version of the public option appears to have gained some traction with moderate Senate Democrats or, at least, it has lessened their resistance to a public insurance option. Nevertheless, reports indicate that the White House has not embraced the state opt-out and still favors the public option "trigger" which Sen. Olympia Snowe (R-ME) – the only Republican who voted in favor of any of the five health reform bills – has indicated that she could support. The "trigger" approach would institute a public option only if private insurers are not able to ensure adequate competition in a particular geographic market. The White House does not want the thin veil of bipartisanship to evaporate if Sen. Snowe withdraws her support from the Senate health reform efforts. In addition, the White House is concerned that the final health reform bill not imperil the Blue Dog Democrats in the House whose re-elections in more conservative Congressional districts are at risk.

Meanwhile, in the House of Representatives, Speaker Nancy Pelosi (D-CA) still struggles to secure 218 votes to pass a health reform bill with a "robust" public option. A "robust" option is a euphemism for a federal government run health insurance plan which contracts with physicians and hospitals at or slightly above Medicare rates. Although Speaker Pelosi continues to assert that she has not abandoned the robust public option, if the Senate bill does contain some variation of the public option, there may be less pressure in the House to focus on a robust public option and more support for moving toward an option closer to the one contained in the yet-to-be unveiled Senate bill and which can be supported by the House's moderate Democrats. House leaders already have signaled an interest in moving closer to the Senate proposal in other key areas. Expectations are that a final House bill will be released later this week.

There is still much work that lies ahead for Congress to meet President Obama's timetable for passing health reform this year. Provided that we have final bills from the Senate and House this week, and the CBO is able to score these bills quickly, floor debates on the bills could begin as early as next week. Floor debates are expected to last for as long as a month, if not longer. During these debates, lawmakers will continue to propose and vote upon amendments to the health reform bills under consideration in the House and the Senate. Speaker Pelosi announced last week that she wants a vote on the House's health reform bill by Thanksgiving. Senate leaders, however, do not appear to be laboring under the illusion that Senate debates will have concluded by that time. Likely, it will take the remainder of the year and, perhaps, then some to achieve a health reform bill which has passed both houses of Congress and is signed by the President.

## CMS Issues Guidance for Medicare Advantage Plan Communications with Enrollees

The fate of Medicare Advantage ("MA") benefits has been a hot topic surrounding the health care reform debate this year. In an effort to pay for the reform package through savings initiatives, Democrats are proposing a number of cuts to the MA program that could raise as much as \$150 billion to pay for reform. Many argue that such changes would significantly reduce choice and remove favorable options that MA plans currently offer. Last month, in response to mailings that Humana Inc. sent its MA enrollees stating that the SFC's reform proposal would cause them to lose benefits, the Centers for Medicare & Medicaid Services

("CMS") issued a controversial order for Medicare-contracted health insurance and prescription drug plans to suspend "potentially misleading" mailings to beneficiaries about health care and insurance reform.

Many critics argued that CMS' order was an inappropriate and unconstitutional "gag order" on MA plans. Sen. Mitch McConnell (R-KY) and other Republican leaders warned Health & Human Services ("HHS") Secretary Kathleen Sebelius that "[u]ntil your department rescinds its gag order and allows seniors to receive information about matters before Congress, we

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## CMS Issues Guidance for Medicare Advantage Plan Communications with Enrollees (cont'd.)

will not consent to time agreements on the confirmation of any nominees to your department or associated agencies.” Republicans also argued that the order was a breach of First Amendment rights and demanded legal justification for CMS’ actions.

In order to clarify its order, on October 16, CMS issued a memorandum regarding the use of beneficiary information obtained from CMS by all MA Contractors, Part D Sponsors, cost contractors, PACE and MA demonstrations. In its memorandum, CMS explained that, by signing a Data Use Attestation, MA organizations or sponsors agree that, as a condition of having been granted permission to use and receive beneficiary information from CMS databases, they will restrict the use of Medicare data to those purposes directly related to the administration of the Medicare managed care and/or outpatient prescription drug benefits for which they have contracted with CMS to administer. The memorandum also explained that organizations and

sponsors agree not to use that information to develop, market or operate lines of business unrelated to their Medicare plan operations.

CMS classifies communications regarding federal and state legislation as information that is unrelated to the administration of plan benefits or is not related to health-related issues or other lines of business offered by the same organization. Thus, these communications must meet certain qualifications before being sent to enrollees. According to the new guidance from CMS, MA plans may communicate with their enrollees regarding pending legislation or grass roots advocacy so long as (1) the communication is not misleading; (2) the MA plan does not use federal money to do so; and (3) the MA plan obtains the enrollees’ permission to communicate with them about these matters or otherwise has obtained the enrollee contact information through permissible means.

## Marketing of Medicare Advantage and Part D Drug Coverage on CMS Agenda

While both health reform efforts in the Senate and the House of Representatives include changes in MA funding and Part D drug coverage for Medicare beneficiaries, CMS continues its push for more focused reform in the marketing of MA prescription drug plans and stand-alone prescription drug plans. Last week, CMS agency staff announced that they would be introducing new programs and procedures for 2010 as part of their increased enforcement of marketing guidelines for MA coverage (sold by private plans to seniors that replace original Medicare) and Part D drug coverage offered separately through independent carriers and sometimes as a part of MA products.

Compliance enforcement will be the focus for 2010, according to the CMS staff at the Medicare Part C and Part D Marketing Compliance and Network Operations Conference. Private carriers will be given notice of any deficiencies in their programs and will have only three days to respond to CMS with information concerning any needed changes. CMS will establish a surveillance database that will store compliance findings and resulting corrections by MA plans. Communication with MA plans will be via email from the “compliance console” to a designated plan official. Responses from the MA plan will help determine the type of enforcement action that CMS will take regarding the deficiencies. MA plans’ behavior during the surveillance activities, the size of the MA plans’ operations and complaints will contribute to a compiled “risk status” which will then establish the level of scrutiny from CMS.

New surveillance activities will include website accuracy and completeness audits to help ensure that MA

plans in areas with high non-renewal rates and service reductions are not using scare tactics to coerce enrollment, according to Michael Kavouras of the CMS Division of Medicare Advantage Operations. Other presenters at the conference highlighted problem areas in customer service with existing MA plans, including insufficient resources for access by people with hearing impairments through teletypewriters (“TTY”) or telecommunications devices for the deaf (“TDD”). Only about a quarter of the MA plans met CMS guidelines for these customer access lines and devices. CMS will distribute a memorandum to MA plans addressing call center best practices.

Agent compensation continues to hold a primary spot in CMS enforcement efforts. CMS plans to expand the use of its Medicare Drug Integrity Contractor (“MEDIC”) program, including the performance of agent/broker compensation audits and information sharing with the states that regulate agent licensing. The goal is to focus plans on correcting or disciplining agents who have large numbers of complaints or who are misrepresenting the Part D products. On the MA side, conference attendees were also told that, beginning in 2010, they will receive a list of MA plan enrollments as part of their “MARx monthly reports” that will reflect which enrollments qualify for higher “first year” agent compensation and which must be paid lower renewal amounts. CMS marketing guidelines require renewals to be paid at only 50 percent of initial sales commissions for new enrollees.