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Featured Article

Written by Nidhi Saxena // December 7, 2015

Navigating The Minefield Of MA Compliance

Medicare Advantage plans are here to stay. This government subsidized program injects public money into private insurance plans in order to provide enhanced coverage for aging populations.

For insurance agencies, MA plans present a tremendous opportunity for growth. Hugely increased participation in MA and a growing enrollment base in the program are anticipated. There is also the prospect of developing countless innovative product lines to appeal to different target audiences that have specialized needs or requirements. The growth in the number of prospects combined with the growth in choices lead to selling more policies.

MA is a high volume business, not a high margin business

But there's another side to the MA story, one rife with potential pitfalls. There are strict guidelines on agent training, how the plans are marketed, which provider referrals are permitted, and how agents get compensated for the sale of a policy.

Moreover, these guidelines are updated annually, so the goalposts are constantly being moved.

The regulations are implemented to make sure that MA enrollees are getting the level of services promised, while instituting an anti-fraud shield that prevents payers and providers from walking off with the subsidies.

We know that the government is obliged to provide health care to the aging population. The government looks to private insurers and small health carriers to offer products that meet the health care needs of the senior market, while subsidizing these programs. As mentioned previously, this is an enormous opportunity for the small agency; but there also is great potential to fall afoul of the regulators.

An important factor is the fear that when government subsidies are involved, "free money" becomes a temptation for many of the participants, and pricing schemes may neutralize the value of the subsidy to the subscriber. As a result, it's important to ensure that the funds are used for their original intent, which is to provide enhanced care for the policyholders. Therefore, a cap is placed on the amount of profit agencies can make on these MA policies. According to the Centers for Medicare and Medicaid Services: "The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR)." To summarize, insurers can't say that out of $100 of profit, $99 goes toward administrative costs, and only $1 goes toward servicing the policy. Companies need to have money allocated toward service and support, to maintain the quality of the product. This means that there isn't a huge profit margin on these policies.

As a result, strict government guidelines affect the way commissions are calculated and paid. More policies and multiple types of policies, each with their own levels of compensation, introduce an additional layer of complexity. With greater complexity come additional challenges to compliance.

As soon as a small agency tries to get into the business of selling Medicare Advantage products, they must ensure they are in compliance with the guidelines. These include calculations of agent payouts, the kinds of plans they can offer, the margins they can put on these plans or the administrative costs they have on top of the plans.

For example, they must prove that certain certifications are in place, and that program training has been completed in order to sell certain products. For the government to contribute to the company providing these services, the company must abide by these rules. Let's take a look.

The CMS challenge

Given the level of subsidy and the potential for fraud or abuse of the system, CMS has developed a web of rules and guidelines that it imposes on the MA world. Anyone who wants to sell MA products must become familiar with these regulations. Agents who are knowledgeable of the CMS's Agent and Broker Training & Testing Guidelines will recognize of the stringency of these requirements. They include:

- All agents and brokers who sell Medicare products must be trained and tested annually on Medicare rules, regulations and details specific to the plan products they sell. This includes employees, subcontractors, downstream entities and/or delegated entities.
- Training and testing procedures must be put in place to ensure each individual is taking the test independently, maintaining the integrity of the training and testing program.
- Information on training and testing programs must be provided to CMS upon request. CMS may request information that includes training tools, training exams, policies and procedures, as well as documentation demonstrating evidence of completion.

The CMS guidelines also include a sample test of 19 suggested questions for determining agent compliance. These questions cover Medicare basics, enrollment and disenrollment, beneficiary protections, marketing regulations and materials for agents and brokers, agent/broker compensation, and Medicare marketing activities. Looking only at the Agent/Broker Compensation sample questions, we can see that there is complexity and potential confusion built in a section such as:

15) A beneficiary enrolled into Acme Health Plan in 2012 as an initial enrollment and has remained in the plan since. How much should Acme pay in CY2015 to the agent that facilitated the enrollment?

1. 50% of CY2012 fair market value
2. 60% of CY2012 fair market value
3. Up to 50% of CY2015 fair market value
4. Up to 60% of CY2015 fair market value

16) A beneficiary enrolls into Acme Health Plan in November 2014 as an initial enrollment. Assuming the beneficiary remains enrolled in the plan in 2015, in what month does their first renewal cycle begin?

1. December 2014
2. January 2015
3. November 2015
4. December 2015

17) If a beneficiary makes a plan change to a plan offered by another organization, and the new organization doesn't use agent and brokers, what happens to the payment?

1. The new organization would continue to make payments to the enrolling agent from the previous organization
2. The initial organization would continue to pay the enrolling agent for one full renewal cycle
3. The new organization would not make payments and the initial plan would have to recoup for the number of months the member was not in the plan.
4. None of the above

You probably get the idea here. With this level of complexity built in at the regulatory level, it's little wonder that agencies and carriers, however well meaning, have trouble clarifying their position with regard to staying on the right side of the law. To add insult to injury, the fines for noncompliance are hefty — even if it's because of benign neglect, without any criminal intent whatsoever. (The answers, by the way, are C, B and C.) Is there anything that can be done to help make the situation better?

Technology: Help or hindrance?

In a world where manual processes are still the norm — such as in many smaller agencies — it is very easy for a carrier or an agency to tip into the error margin. Take compensation, for example. You have a matrix of policies paying commissions at different rates, which make even the above CMS questions seem simple. It's not unknown for carriers to have underpaid their agents for months until the error is identified. Even the five leading MA agencies have experienced challenges with this. So you can only imagine what the smaller agencies

have to deal with, when they must rely on manual processes to track compensation and compliance at every juncture in the process.

The big five providers in the MA market have embraced technology that supports their compliance with CMS rules and guidelines. But many of the smaller plans distributing products through a small sales force (200-1,000 agents) juggle the tradeoffs of revenue, the demands of CMS marketing guidelines, limited bandwidth of critical resources, and costs in order to realize profits.

We've worked with large carriers as well as distributors that deal with 200-300 carriers. We've found that they're well equipped technologically, they can sell a lot of product, and they're able to come up with innovative pricing and payment for their agents. But because they don't have appropriate processes in place — a CMS compliance process, and a process to manage payroll and generate payments for agents — even these giants struggle with profits and often wind up losing a lot of money.

Meanwhile, smaller health plans may think that automation, whether for CMS compliance or compensation, is completely unaffordable. But they actually are in a good position to get started from the ground up. Systems are available for smaller carriers to pay a minimal subscription cost with no big upfront commitment. The key thing to keep in mind when getting started is that it's about re-engineering processes as much as a software solution.

Automation — or the lack of automation — introduces a challenge in keeping up with regulations, commissions, and recording or assessment of what part is commission and what part is agency profit. Automation brings transparency into compensation for carriers and agencies, and shows to what extent they're being compensated for making sales. For agencies and carriers, these kinds of issues can be reduced if both sides are equipped with the right resources, processes and systems.

CMS compliance for Medicare Advantage impacts not only the way companies market, promote or structure customer service; it has an even greater impact on managing their data. CMS mandates intake of enrollments and updates based on its own coding of transactions, appropriate tagging of statuses and eligibility criteria, and the correct use of data in adhering to marketing and compensation guidelines.

Agencies and carriers should get smart now about automation, and invest in only the level of technology they need to keep swimming in the fast-moving waters of Medicare Advantage — and the constantly changing regulations that go along with it.

End of Article

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