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MEDICARE ADVANTAGE ANNUAL ENROLLMENT: CRACKING DOWN ON DECEPTIVE PRACTICES AND IMPROVING SENIOR EXPERIENCES

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MEDICARE ADVANTAGE ANNUAL ENROLLMENT: CRACKING DOWN ON DECEPTIVE PRACTICES AND IMPROVING SENIOR EXPERIENCES

WEDNESDAY, OCTOBER 18, 2023

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SH–216, Hart Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Menendez, Brown, Bennet, Casey, Hassan, Cortez Masto, Warren, Crapo, Grassley, Lankford, and Blackburn.

Also present: Democratic staff: Nicole Brussel Faria, Investigator; Melissa Dickerson, Senior Investigator; Eva DuGoff, Senior Health Advisor; and Joshua Sheinkman, Staff Director. Republican staff: Kellie McConnell, Health Policy Director; Gregg Richard, Staff Director; and Charlotte Rock, Health Policy Advisor.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Finance Committee will come to order. This morning, the Finance Committee gathers to discuss an emerging trend in Medicare Advantage: marketing middlemen. Now, there's a long history of rip-off artists in the private sector trying to take advantage of seniors who depend on their flagship health program, Medicare.

Since I served as the director of the Oregon Gray Panthers, something like a year or 2 ago, these unethical salespeople would often sell seniors 10 or 15 separate, unnecessary Medicap policies that were not worth the paper they were written on. Senator Daschle, Senator Heinz, Senator Dole, and I came in, and we pretty much drained that swamp.

The same thing happened at the start of Medicare Advantage. In fact, I think my colleagues were there. Then-chairman Baucus held a hearing on Medicare marketing, because scammers were actually going door to door in the south wearing white coats and stethoscopes around their necks to try to persuade seniors to enroll in these plans.

We got a few protections, but it was not enough. Last fall, I released a report that detailed some of the most outrageous marketing practices I had seen in Medicare Advantage, like vans

parked outside senior centers with "MEDICARE" splashed across the side and mailers designed to look like IRS documents. Many members of the committee joined Senator Casey and I in calling on the Centers for Medicare and Medicaid Services to make changes to protect beneficiaries from these slimy tactics.

CMS moved and moved quickly. Just yesterday, they reported that they rejected more than 300 ads because they were just so frigging outrageous and misleading. At the time, we also said we were not going to take any victory laps. As seniors experienced Medicare's annual open enrollment that started 72 hours ago, our investigators found that marketing middlemen are the latest set of sleazy private-sector scoundrels targeting seniors on Medicare Advantage.

Now we've got bad actors again gearing up, this time for the new enrollment period. So let's talk about who these people actually are and why they are such a big deal in Medicare Advantage. They are big private marketing companies, and they get in the middle between seniors and their health-care coverage.

These big marketing companies jump to get in front of seniors, and they especially want to do it during the annual open enrollment period. What these middlemen are doing is hijacking personal information from as many seniors as possible, and then they funnel the personal information to the health plans that pay these sleazy marketers the most money. Basically, we are going to describe this as a profit for these companies first, help for seniors and taxpayers last.

Now, some seniors' information gets passed multiple times from one money-grubbing hand to another. The marketers will sell seniors' data once. If they can, they will sell it twice. If they can, they will sell it as many times as possible. The wheel of deceit, friends, just keeps going round and round, ripping off seniors, ripping off taxpayers.

The seniors are the ones getting badgered by phone, targeted on the Internet, stuck with mountains of mail, and ultimately a plan that may not meet their needs. To sum it up, the marketing middlemen have made seniors their product, and they are trying to sell as much of the product as they can.

Now, it is also taxpayer dollars that are in effect lubricating all this, and these dollars line the middlemen's pockets. Insurance experts have told us that marketing cost taxpayers $6 billion in 2022 alone. Put your arms around that: 6 billion taxpayer dollars went to marketing middlemen who may have sold your elderly parents, your grandparents, or your neighbors the wrong plan.

It is outrageous, it is a rip-off, and it has got to stop. And that is why we have had our investigators launching a further inquiry, because we believe there is additional information with respect to these slimy practices.

One other quick issue, and then I want to yield to my friend, Senator Crapo. We are also in a related effort to stop what are called ghost networks. Now, a year and a half ago, nobody knew what a ghost network was. But a ghost network is what it sounds like. Somebody buys a mental health insurance policy, and they expect they are going to get some services. But after they buy it, after the contract is signed and they actually need it, the ghost network

basically has no "there" there. You cannot find a doctor; you cannot get information about what hours of services they might keep. There is just nothing to follow up on, and certainly nothing resembling the health-care services you thought you bought.

So, our investigators looked at a cross-section of mental health plans across the country. They contacted the providers; they asked if they could get an appointment for a family member. They were able to get an appointment 18 percent of the time. So, more than 80 percent of the time, their plan actually failed them.

Even if a senior could make an appointment with a provider—and get this—they may be exposed to extra cost if they have to go to a provider out of network. In other words, they paid for something, but there was not any service. They need some health services, they go out of network, and the person they gave the money to originally sticks them with a second bill.

So, we have a lot of work to do, and I just want to particularly commend my colleagues Senator Bennet and Senator Tillis. Like Senator Crapo and I and the Finance Committee, we try to be bipartisan. They have introduced a good bill I am pleased to be a cosponsor of, to try to make sure that seniors will get more accurate data about these services.

I will tell some of those ghosts that I find run around on Halloween that they are not going to be able to rip off seniors the way they have been doing.

Last point will be this. Over the years, I have come to believe that one of the pieces of the health-care puzzle that is not getting enough attention is the role of middlemen. Today, we are looking at marketing middlemen.

I am very appreciative that Senator Crapo has joined me in another effort, with Senator Stabenow's support and our colleagues here, and that is going after the PBMs, because there again, you have middlemen, in effect, insurance companies taking big fees and high salaries, rather than getting that money to patients.

Now, as Senator Crapo and I have described, these middlemen are not cut from a cookie cutter. They are not all the same. But I think it is important to be looking at this in the future. I intend to do it. We spend $4 trillion a year on health-care costs, folks, and we can get more value for those $4 trillion, and one of the areas I am going to be looking at are these middlemen.

I am very appreciative of Senator Crapo joining me, not just in today's project, but also on the PBMs.

Senator Crapo?

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you, Mr. Chairman. This hearing comes at a crucial time, as millions of Americans evaluate Medicare coverage options during the annual open enrollment period. During this window, seniors and many Americans with disabilities have the opportunity to select a Medicare Advantage, or MA, plan that best fits their needs.

I have long championed Medicare Advantage for its success in leveraging market-driven competition to offer patients access to a wide range of cost-effective coverage choices. The vast majority of our MA plans cover services not available under traditional Medicare, including for dental, vision, and hearing health needs.

With consistently high satisfaction rates and low premiums, MA's market dynamism serves as its strength, not as its weakness. That said, the complexity of the health-care system poses significant challenges for Americans from all walks of life, including those enrolled in MA plans.

Seniors need clear, credible, and accurate information to navigate the coverage and service landscape. Fortunately, a variety of resources and tools can help guide Medicare beneficiaries through the decision-making process this opaque system requires.

However, the Federal Government's Medicare Plan Finder, the decision support tool outlining coverage choices, can prove cumbersome and confusing, often displaying out-of-date or otherwise inaccurate data. As we consider options to ease enrollment, we should assess solutions that improve Plan Finder by integrating more relevant information and enabling more user-friendly navigation.

Furthermore, we should examine opportunities to empower effective insurance brokers who serve as key community-based resources and access points, including in the context of MA plan enrollment. Through common-sense patient protections and targeted transparency, we can promote a vibrant and competitive broker landscape, assisting seniors while preventing deceptive marketing and other problematic practices.

Practical guard rails, however, cannot come at the expense of patient privacy or a functional marketplace. With all policies under review, we have an obligation to consider both confidentiality concerns and administrative burden. I look forward to hearing thoughtful ideas about how to improve the enrollment process by better aligning the incentives and increasing transparency.

With common-sense, consensus-driven, and market-based solutions, we can ensure broad access for seniors to all of the tools needed to make crucial, informed coverage decisions.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Crapo appears in the appendix.]

The CHAIRMAN. I thank my colleague.

We've got terrific witnesses here. Senator Brown is in attendance, and he and I go way back in terms of fighting for senior rights, and I so appreciate his leadership. He is going to introduce our guest from Ohio.

OPENING STATEMENT OF HON. SHERROD BROWN, A U.S. SENATOR FROM OHIO

Senator BROWN. Thank you. Thank you, Mr. Chairman. It is very good to see you.

It is my pleasure to introduce Ms. Christina Reeg, who is currently the Program Director for the renowned Ohio Senior Health Insurance Information Program, so-called OSHIIP. OSHIIP provides education and counseling to assist older Ohioans in choosing

the best and most affordable health and prescription drug coverage plans for themselves and for their loved ones.

Ms. Reeg began her career at the Ohio Department of Insurance as an OSHIIP training officer, went on to work as a training supervisor and assistant director, prior to becoming Program Director about 2 years ago. She oversees the program's grant funding, operations management, outreach and education efforts, and consumer service and counseling.

Under her leadership, OSHIIP has received national recognition for the high-quality services it provides to Ohio's nearly 2.5 million Medicare beneficiaries. We are a State of 12 million. The importance of those 2.5 million people and the services you provide are really important.

She was selected to serve on the national SHIP steering committee from 2012 to 2018. She has served as chair for the last 4 years of that period.

Ms. Reeg, thank you for your commitment to making enrollment easier for Ohio Medicare beneficiaries. Thanks for helping them get better coverage and save money. Thank you for joining this committee today. I look forward to hearing your testimony. Thanks so much.

The CHAIRMAN. I thank my colleague.

And, Ms. Reeg, my mother always used to say after basketball games, "Dear, just make sure tonight you are running with the right crowd." You Ohioans are in the right crowd, and we are glad you are here. Thank you, Senator Brown.

Our next guest will be Cobi Blumenfeld-Gantz. Mr. Blumenfeld-Gantz is the CEO and cofounder of Chapter, a technology-enabled Medicare and retirement platform. Previously, he worked at Palantir Technologies, and got undergraduate degrees from the Wharton School and the University of Pennsylvania. He holds a master's in public policy from the University of Cambridge. We very much welcome you, sir, and look forward to your comments.

And then, our final witness will be Krista Hoglund, chief executive officer of Security Health Plan. She has been there since 2021. Security Health is part of the Marshfield Clinic Health System in Marshfield, WI. And she serves on the executive committee and the board of directors of the Alliance of Community Health Plans, and she is also an actuary.

So, we thank all of our witnesses. This is an important hearing. We are going to have everybody take 5 minutes for oral testimony.

We have plenty of questions, and, Ms. Reeg, let us start with you.

STATEMENT OF CHRISTINA REEG, OHIO SENIOR HEALTH INSURANCE INFORMATION PROGRAM DIRECTOR, OHIO DEPARTMENT OF INSURANCE, COLUMBUS, OH

Ms. REEG. Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee. Thank you for the opportunity to appear before you today. My name is Christina Reeg, and it is an honor to be here. I am the Program Director for the Ohio Senior Health Insurance Information Program, or OSHIIP, at the Ohio Department of Insurance.

We are one of 54 SHIP programs that are funded through a Federal grant to provide objective and unbiased information to individuals on Medicare, their family members, and their caregivers. SHIPs provide local and unbiased information to empower the consumer to make an educated and individualized decision regarding their prescription drug and health insurance coverage.

Twenty twenty-three marks my 26th year with OSHIIP, so I began as the boots on the ground, traveling Ohio's 88 counties, 29 Appalachian, providing one-on-one counseling about Medicare Part A, Medicare Part B, and at the time, maybe Medigap. This month, our program began counseling Ohio's now 2.5 million Medicare beneficiaries to help them make educated decisions for 2024 coverage.

We now operate in a hybrid model, providing information and education, both through virtual and in-person events that we advertise through social media, paid and earned media, and grassroots efforts. The information that we present now vastly differs from my early years with OSHIIP. Many of the counties that we counsel in, there are more than a hundred health plan options for us to review.

Most Medicare beneficiaries will not review or change plans because the task of comparing is too daunting. To help narrow the field, we do use Medicare's Plan Finder tool. This web-based tool allows us to determine if their current prescription medications are covered, outlining all out-of-pocket costs and plan details. But it does not include the plan network. It rather links to the plan's website.

The company websites can be difficult for Medicare beneficiaries to navigate alone. We use that as a launching point. We then ask the consumers to reach out directly to their providers that they are not willing to give up, and ask very pointed questions, right down to the contract number, to make sure they can continue to use those services.

Counseling Ohio's low-income and limited-health-literacy Medicare population brings added challenges. These individuals are more apt to join a plan solely for the added benefits, specifically the over-the-counter allowances and other cash rewards. Many are applying for the extra help on Medicare's assistance with prescription drug costs for the first time. Even when the application is automatic, there are delays, which can lead to affordability issues at the pharmacy window.

SHIPs assist by getting them into temporary programs like LI Net to help curb those costs. Also, special enrollment periods for low-income individuals are often misused, putting consumers into managed care plans more frequently than the quarterly allowance. OSHIIP's assistance is often reactive in those situations, when the beneficiary has found themselves having difficulty receiving needed medical care or prescriptions.

In my time with OSHIIP, I have seen extreme growth: growth with the Medicare population, growth within the scope of SHIP work, and extreme growth with the plan options. Our Medicare consumers are overwhelmed by the volume of options in each county and are flooded with marketing material—and often confused by the variants of plan details, networks, and these added benefits.

The desire to have benefits you are entitled to or added benefits often masks the need to look at critical plan data, such as the specific cost, the networks, and other restrictions they may encounter. This often leads to poor enrollment decisions and undesirable outcomes.

Medicare beneficiaries would benefit from additional oversight. A personalized Annual Notice of Change would assist beneficiaries in better understanding changes, such as higher costs from year to year. Stronger oversight on utilization of special election periods, such as the low-income or emergency special election periods, and a block on enrollments for those with cognitive impairments, could minimize improper sales to most vulnerable beneficiaries.

Reinstatement of measurable differences when approving plan contracts would help contain the volume of plans in each county. These actions could help make the process of choosing and enrolling into a Medicare health plan less intimidating.

I am happy to answer any questions, and remain dedicated to this population. Thank you.

[The prepared statement of Ms. Reeg appears in the appendix.]

The CHAIRMAN. Thank you very much, and I go way back with your organization in the Oregon chapter. So, great to see you.

Mr. Blumenfeld-Gantz?

STATEMENT OF COBI BLUMENFELD-GANTZ, CEO AND CO-FOUNDER, CHAPTER, NEW YORK, NY

Mr. BLUMENFELD-GANTZ. Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for inviting me to testify, and for dedicating time to this important topic. My name is Cobi Blumenfeld-Gantz, and I am the CEO and cofounder of Chapter, a technology-enabled Medicare navigation platform.

I started Chapter because the Medicare enrollment and navigation process is broken, and consumers deserve better. Fighting deception and improving the Medicare experience is personal to me. My parents were the first two people that Chapter helped, and they are the reason I started this company.

They needed help fixing mistakes they made following the advice of a broker, who had no obligation to prioritize my parents' interests over his own. My parents' experience of confusion and costly mistakes is the norm, not the exception. Choosing the wrong Medicare plan can add thousands of dollars of extra costs for consumers, and it can even make lifesaving medications unaffordable.

Before I highlight more of the challenges facing Americans on Medicare, I want to share Chapter's unique approach to guidance, which has afforded us insight into what consumers are up against. Chapter is a consumer-first Medicare navigation platform. The breadth of Medicare choices is overwhelming to most, but with good data and tools, choice is empowering. We have invested millions into building a Medicare data and technology stack from the ground up, to recommend the right plan tailored to each person's needs.

Our exceptional engineers and Medicare advisors are dedicated to demystifying Medicare for every American. But it should not require world-class data scientists to help an American choose their Medicare insurance. We have upended status quo incentive struc-

tures in the brokerage model. We consider the full scope of Medicare options from every carrier, and then we recommend the right one, even when we earn no money.

We operate this way because no consumer should enroll in a suboptimal Medicare plan simply because their broker earns a commission. Consumers are more likely to wind up on the right Medicare plan when their advisor's incentives are aligned with their own.

Every American who enrolls in Medicare deserves to do it with clarity and confidence. I wanted this for my parents, I want it for every person who works with Chapter, and I want it for myself someday. Here is how we get there: better data, ending deceptive marketing, and prioritizing consumers' interests.

Consumers deserve significant improvements in the quality and availability of data, specifically on provider networks, benefits, and prescription prices. Without these, consumers, along with the organizations trusted to guide them, will continue to struggle to make informed choices. CMS sponsors some of the tools with the greatest potential to help, like *Medicare.gov's* Plan Finder and their published data files.

These valuable resources are widely used by the industry and by State health programs. But if Americans need support making a fully informed decision, these tools are not enough. For example, Plan Finder cannot help a consumer understand which plans let them keep their doctors, and there are limits to the information on how much a prescription will cost on each plan.

Consider a consumer who sees three doctors. They might need to compare over 100 separate searches across each insurance company's website. It is not reasonable to expect a typical consumer to conduct this search. Insurance carriers owe it to consumers and to the industry that supports them to provide open, accurate provider network and other benefit data via APIs.

How can we expect consumers to make informed Medicare-related decisions when they lack the data and tooling to do so? Chapter has worked hard to solve this problem for consumers, but it has been an uphill battle. Accessible, transparent data is the first line of defense for any consumer making Medicare decisions among a barrage of misinformation. Last year, this committee published a report on deceptive marketing, and I commend the committee's ongoing focus on this topic.

Every fall, Medicare-eligible consumers are bombarded with mailers, TV ads, and phone calls rife with misleading and pernicious content. The bad actors are typically not local brokers who live in each community; rather, they are lead generators operating as marketing middlemen who traffic in scare tactics, imitate government agencies, and inaccurately advertise plan benefits.

CMS has proposed regulations to prohibit the transfer of consumers' personal information from one marketing middleman to another. This would have been a welcome change, but these updates were excluded from the final rule this year.

At Chapter, we have trained our experts to help consumers distinguish between scare Medicare ads and real government information. But the fact that we have to do this is an indictment of how brazen some Medicare advertising has become.

The current Medicare brokerage model is broken because there are no legal requirements for stakeholders to prioritize consumer interests the way we do at Chapter. This hurts consumers, and it hurts the reputation of the Medicare program. Brokers should be held to a higher standard of conduct and accountability.

Brokers could be required to consider all plans when making recommendations. Agencies could ensure that their salespeople are not incentivized to push plans that pay higher commissions. If we can commit to transparent data, honest tactics, and putting consumer interests first, we can help Medicare live up to its promise.

Thank you for your time, and I look forward to your questions.

[The prepared statement of Mr. Blumenfeld-Gantz appears in the appendix.]

The CHAIRMAN. Thank you very much, and I want you to know, I took notice particularly of your statement that we missed out this time on the rules with respect to marketing middlemen. That is going to change, and I thank you.

Ms. Hoglund?

STATEMENT OF KRISTA HOGLUND, A.S.A., MAAA, CHIEF EXECUTIVE OFFICER, SECURITY HEALTH PLAN, MARSHFIELD, WI

Ms. HOGLUND. Chairman Wyden, Ranking Member Crapo, and members of the committee, my name is Krista Hoglund, and I am the chief executive officer for Security Health Plan, a provider-aligned plan that is part of the Marshfield Clinic Health System. It is my honor to be here today to discuss this important topic of protecting Medicare beneficiaries.

Prior to my current role, I served as the chief financial officer and chief actuary at Security, with nearly 20 years of actuarial experience, including working on MA bids. And on a personal note, I am familiar with the consumer side as well, as both of my parents are Security MA enrollees.

Today I am here to share our experience about competition and marketing practices in the Medicare Advantage market. Security Health Plan has offered MA for 2-plus decades, proudly serving more than 60,000 beneficiaries today. This year for the first time, the majority of all Medicare-eligible beneficiaries use MA for their coverage, and it is growing quickly in popularity.

CMS estimates next year there will be an additional 2 million more MA enrollees compared to this year. However, in recent years, enrollment growth has not been evenly distributed among plans. In the most recent open enrollment period, two-thirds of national enrollment went to just two large national for-profit companies. We very much appreciate the attention this committee and CMS have paid to the issue of inappropriate marketing aimed at seniors, but more must be done.

While consumers get information from many sources when choosing a Medicare Advantage plan, the single most influential perspective does remain brokers. We value the important role brokers play in efforts to ensure our efforts to educate our consumers, sell our products, and support our members.

Local brokers are a trusted partner for Security Health Plan and health plans across the country. In fact, 85 percent of our MA enrollment at Security Health Plan comes from our more than 500

brokers that we are very proud to partner with. Unfortunately, we know some large firms and third-party marketing organizations leverage their influence for financial gain, rather than what is in the best interest of the consumer.

Many of these field marketing organizations receive add-on or incentive payments that go above and beyond the CMS-approved broker commission caps. Instead of collecting the maximum commission of $611 for a new enrollment, many brokers are collecting $1,300 or more. This additional compensation is marked as "marketing administrative dollars" and can include all kinds of additional add-on fees besides that.

This creates an environment in which beneficiaries and, ultimately, the Medicare program itself are paying out billions in unnecessary dollars. These aggressive marketing techniques have real-world consequences.

Just last week in a conversation with one of our trusted broker partners, he described the ambush that had already begun ahead of open enrollment, which is technically not allowed, with his clients receiving as many as five or more phone calls a day. And his team is barely able to keep up with their existing customers—answering their questions, making sure they understand what those calls are about—let alone seek to support new enrollees who might be interested in enrolling in MA.

In a previous Medicare open enrollment period, our team assisted a senior who was tricked into enrolling in another plan. We worked with the consumer to reenroll in the Security Health Plan product, not once but four times in a single open enrollment period. These aggressive tactics make it more difficult for smaller regional health plans like Security Health Plan to compete.

Less competition between MA plans means less pressure to keep costs low and less innovation. This is a disservice to beneficiaries and taxpayers. I urge you to engage with CMS to review the practice of add-on broker payments to ensure that unfair practices are inhibited, especially total payments above and beyond the CMS caps. Further, CMS and regulators must remain vigilant in enforcing marketing rules that protect seniors from misleading and aggressive marketing.

Three immediate changes that can be made to ensure that brokers remain sufficiently compensated for assisting beneficiaries, while also ensuring that health plans utilize Medicare dollars to compete for enrollment based on benefits and quality are: first of all, standardizing and limiting total compensation—so rather than a commission, a total compensation cap; thinking about creating incentives for enrolling beneficiaries in high-quality and value-based plans; and finally, transparency in requiring total broker and third-party marketing compensation, so that we can all understand all the dollars that might be flowing through these mechanisms.

Chairman Wyden, Ranking Member Crapo, and members of the committee, again I am honored to be here. Creating a well-functioning MA program that protects beneficiaries and supports them in making well-informed decisions is crucial to the long-term success and sustainability of this program. I thank you for the time this morning, and welcome the opportunity to answer questions.

[The prepared statement of Ms. Hoglund appears in the appendix.]

The CHAIRMAN. Thank you very much.

And this of course arrives at such a crucial time, at the start of the open enrollment season. Let me start with you, Ms. Hoglund. You gave us an example of what amounts to a jaw-dropping rip-off. You basically said that some of these plans are paying $1,300 or more for a new enrollee.

Is it right that when you add up all of these extra costs, all of the costs heaped onto the system by these middlemen, this comes to somewhere in the vicinity of $6 billion?

Ms. HOGLUND. Yes. I would say that that estimate might even be low. I mean truly, I think it is really important that we are recognizing the amount of dollars that we are talking about here. They are quite significant.

But we are continuing to see this growing trend in paying these field marketing organizations, these middlemen as you call them, all kinds of additional fees: technology fees, referral bonuses, marketing, health risk assessment, and on and on and on. The list of creative add-ons continues to grow.

And so, this has really become sort of an arms race and creating this anticompetitive environment where—to my colleague's point here—that folks are not necessarily being enrolled in the plan that is right for them. They are being enrolled in the plan where the largest incentive lies.

The CHAIRMAN. Yes, and the reality is, we want competition in the system based on coverage. I am thinking—my friend and I worked together back in 2009. We had a bipartisan bill—and Senator Stabenow was with us on it as well—that would have put the competition in terms of who would get the best for their health-care dollar, in terms of coverage and options.

That leads me to my last question for you. The way we stopped the rip-offs in traditional Medicare—and I mentioned when I was director of the Gray Panthers, I would go to a senior's house, and they would go to the back room and be kind of embarrassed, and bring out 10–15 policies that were not worth the paper they were written on.

They had these fancy subrogation clauses, and you basically got nothing. The way we drained that swamp is, we had some core, standardized principles around which traditional Medicare is offered. There is competition, but it is competition based on coverage, not who can win the arms race. Is that really what you are recommending here?

Ms. HOGLUND. Yes, absolutely. We want what you want, which is, sort of fair and equal competition. But competition, ultimately, is what is best for our seniors in making decisions based on the benefits offered, but not the financial incentives.

The CHAIRMAN. So you characterized it as an arms race. Paint the picture of what would happen if nothing is done. Supposing that Congress just says, "We are very busy. We do not have time to deal with it. And they are making a good point over there in Finance, but we have a lot of stuff on our plate."

I share your view. I think there will literally be a health care arms race. But paint the picture of what that would look like.

Ms. HOGLUND. Yes. I mean, I think the first thing is, we would continue to see add-on payments. As I mentioned, there already is a lot of creativity about what these things can be called, and I think we continue to see that number grow and grow if there is no cap or additional transparency, and ultimately that starts to inhibit competition as smaller regional plans in particular are not able to afford to keep up in that arms race and continue to make these add-on payments.

And so, I think that ultimately, it does lead to less competition, and not things that are in the best interest of the beneficiaries.

The CHAIRMAN. Mr. Blumenfeld-Gantz, just a question for you about ghost networks. And you know, my 10-year-old is always wondering why I am always talking about ghosts. You know, the point really is, 6–8 months ago, nobody knew really what this was about.

But this is about as stark a rip-off as I can imagine seeing, because if, say somebody in the audience or a family member buys a policy that they think will give them essential mental health services, and then they go to get them, they find that nobody is there. There are not any providers, and you do not get any information services, and there may not even be a directory in terms of where to go.

Why is this so serious? You have looked at this I know, in considerable detail. Tell the committee why it is so serious.

Mr. BLUMENFELD-GANTZ. There are a few aspects here, and it is a really serious issue. I think there are gradients of how this plays out in practice. On the one hand, on the far side, as you are alluding to, there are networks that just do not exist. They are straightout fraudulent. That is not legal today. It is an enforcement issue, not a policy issue, because that is not allowed, based on the rules.

But there is a really complicated gray area in the middle, where you have networks that do exist, but there are no open opportunities for patients to schedule appointments, for a host of reasons, either because the providers are overbooked and understaffed, or because the tooling is insufficient. There are a host of reasons.

But I think, even from the well-intentioned perspective, when there are good intentions, it can still be very challenging for consumers. And so, when we look at additional policies or regulations that we could consider, certainly better enforcement of the true ghost networks that just should not exist, and there should be better enforcement there.

But I do think there is an issue as well of provider networks that do exist that are just really hard to access.

The CHAIRMAN. Great.

Senator Crapo?

Senator CRAPO. Thank you, Mr. Chairman.

Protecting seniors' privacy should be a top priority during the enrollment process, because Medicare and Social Security numbers can be used to file false claims or enroll beneficiaries in plans without their consent. Federal regulation prohibits marketers, whether calling on behalf of a plan or a third party, from asking beneficiaries for this information. However, a recent survey of seniors over the age of 65 found that 10 percent of all respondents were asked for their Medicare or Social Security number.

Mr. Blumenfeld-Gantz, outside of the formal enrollment process, is there a time when a broker or marketer would need a beneficiary's Medicare or Social Security number?

Mr. BLUMENFELD-GANTZ. There should not be.

Senator CRAPO. What are some of the challenges that the Federal Government faces enforcing the current guidelines, and what additional steps should the administration take to conduct better oversight in order to protect the beneficiaries' privacy and to prevent fraud?

Mr. BLUMENFELD-GANTZ. Thank you. As I alluded to in my opening statement, there were proposals to make it more difficult for middlemen to sell and transfer data to multiple consumers. I think that is a really helpful step that would essentially make it illegal for a middleman to sell the same consumers' data to multiple additional middlemen, multiple third parties at the same time, which is the status quo. It is legal today, and it is what happens today. And that is, I think, one big step we can take.

Another big step we can take is making it easier to have more transparent information online. The status quo right now is that it is very simple, from a regulatory perspective, to provide information over the phone. It is extremely onerous for third parties and good actors, including Chapter, to provide that information online. It is much easier to provide it over the phone, based on the regulatory framework, and I think that should be inverted.

Senator CRAPO. All right; thank you. That is helpful.

Ms. Hoglund, in your testimony you stated that one entity alone cannot reasonably educate all current and potential MA beneficiaries about their plan choices. I also agree that brokers play a very important role in helping many seniors navigate their choices, to find the plan that best fits their need.

You mentioned that brokers are responsible for 85 percent of Security Health Plan's MA enrollment. Can you expand on how your company partners with brokers to better serve your beneficiaries?

Ms. HOGLUND. Yes, so I appreciate that question. So, as you know, the open enrollment period is a relatively short amount of time, and for a health plan of our size to be able to service all those enrollees that we would like to in that period of time is just not feasible.

So, we do believe strongly in partnering, particularly with our local brokers, who again, in most cases, want the same thing we want, which is to put the consumer in the plan that is best for them. And so, we do educational events to make sure that our communities, the brokers in our communities, understand what plans we can offer, how those might compare to other options, and make sure that there is education on an ongoing basis.

We also make sure that the regulations are communicated, what is allowed and not allowed in terms of practices. And we are very particular in who we partner with, making sure that, again, the brokers are aligned with us and making sure that they are committed to following the CMS regulations that are out there around how they interact with our beneficiaries.

Senator CRAPO. So, we are very fortunate that your plan is very responsible, and if we could get every plan to do the same, we would not have a lot of the trouble we are talking about here today.

How should CMS and Congress balance protecting seniors from fraudulent or abusive actors, while also helping plans to ensure that they continue getting the education and support they need to make these decisions?

Ms. HOGLUND. Yes. So I will just say that we certainly have shared the same concerns with CMS that we are sharing with this committee today, and they have been very interested and understanding and are, I think, committed to helping address this problem in the same way that this committee is. And we certainly think bipartisan support today would be something that would be very valuable in helping them move and take additional steps around addressing areas where there is abuse or misuse.

You know, we continue to partner with CMS when we have specific examples as well of where someone has not followed the regulations, and make sure that CMS has that ongoing awareness, so that they are in a position to address it.

Senator CRAPO. All right. Thank you very much.

The CHAIRMAN. I am going to go to Senator Stabenow in just 1 second. I also noted, Ms. Hoglund, that you talked about your sense that it is these big plans. You talked about two big plans that are the bulk of the problem, and there are a lot of people at the local level, brokers and others, who work with you and the like.

I want to—I am not going to take more time, because it is Senator Stabenow's time, but I am going to want to follow up with you on that. Thank you.

Senator Stabenow?

Senator STABENOW. Well, thank you, Mr. Chairman. A really important question that you just asked, and I want to thank you and our ranking member for holding this very timely hearing, particularly because we are now at the beginning of the annual enrollment period for Medicare.

And so, I do want to start by just stressing that the good news is that in this enrollment period, 65 million Medicare enrollees, seniors and people with disabilities, will see new savings on prescription drugs, thanks to the successful Democratic efforts about a year ago, such as the $35 cap on insulin, which is so important; free vaccines; an inflation cap on Medicare Part B drugs like cancer treatments that I know the chairman championed—and we appreciate your effort.

And we are also seeing Medicare begin the process. The first ten prescription drugs will be negotiated in terms of lowering price, which is long, long overdue. But at the same time, during this time, why we are here today is that it is critically important that beneficiaries get the coverage that is right for them and that they think they are signing up for, that they think they are paying for, and don't get deceived into selecting coverage that does not allow them to access the best and most important services that they want and need.

I think it is really important also to note that because—being involved in this initial discussion about should we open Medicare to Medicare Advantage, should the private sector, for-profit businesses be a part of Medicare—there was an argument around lowering costs and providing more benefits.

We now are paying 4-percent higher rates for Medicare Advantage than what is paid for under traditional Medicare, and that makes it even more concerning that we are seeing $6 billion in taxpayers' funds being used to pay for marketing middlemen or, Ms. Hoglund, as you said, it may be more. Actually, we do not know for sure.

But it is even more concerning, given the fact that Medicare Advantage is already receiving a bonus to participate and be a part of the Medicare system. I am particularly concerned about situations, as my colleagues have said, where people are seeking a particular benefit—special benefits: dental, vision, hearing, other additional behavioral health services—and then they find out after they signed up that they really are not getting the care that they need.

I wanted to speak specifically about, and ask a question about mental health, Ms. Reeg, because one out of four Medicare recipients, as we know, have a behavioral health condition—either a mental health issue or an addiction issue. Many of them are not able to get the care that they need. That has been a particular focus of mine for a long time.

But we know that there are so many barriers put up under Medicare Advantage plans, and we heard about those today: prior authorizations, required referrals, and so on. I remember discussing, when we did the Affordable Care Act and offered the amendment to make sure that we had parity, that you could not do that, and yet it is still happening.

Now we have President Biden coming out with additional rules they want to enforce on this whole question. But these things are still happening through Medicare Advantage. So, when you are counseling someone to find the best plan for them, how do you help them understand those barriers? How do you find out about the barriers, particularly when it comes to mental health care?

Ms. REEG. It involves that individual conversation, and really getting to know our community and the individuals that we are serving. With regards to mental health, I think you spoke accurately on the need to know the network and making sure that there is availability prior to signing up for the plan.

Additionally, where a lot of consumers miss the education piece is knowing if there is a prior authorization situation, where they have to have a relationship with their primary care physician as a gatekeeper to that specialty care. Those are things where the SHIPs can help assist.

In Ohio, our SHIP physically sits at the Department of Insurance. We are very fortunate that we are also home to the Mental Health Insurance Assistance Office, and we can collaborate to make sure that we have extended additional education to those consumers.

Senator STABENOW. Thank you.

I would just say that I still am so concerned, in general, that we look at mental health or addiction services somehow as specialty care, rather than just the continuum of health care. Health care above the neck should be treated the same as health care below the neck. It should be health care. And so, we start with barriers for people.

And so, I think at this point, my time is up, Mr. Chairman, but thank you very much.

The CHAIRMAN. And well said by my colleague, who is the point person in the U.S. Senate for advocacy for mental health, and we appreciate her comments.

Senator Cortez Masto is next.

Senator CORTEZ MASTO. Thank you.

Thank you, Mr. Chairman, and to the Ranking Member and all the panelists today for this important conversation. I have to say, in Nevada as of October of this year, roughly 50 percent of Nevadans eligible for Medicare are enrolled in an MA plan.

This is such an important issue for my State, and as we are hearing, of course we need to better leverage transparency tools across Medicare programs, including Medicare Advantage, with the enrollment, as we are hearing, and spending growing.

I am actually working on legislation that will help policymakers and researchers assess the value that these plans deliver to over 30 million Americans. For today's hearing though, I do want to focus a little bit on the importance of transparency for consumers. So, Ms. Reeg, I have heard from Nevadans, including staff in my own State, in my own office, who are trying to help their parents as they are trying to enroll in Medicare coverage for the first time.

They meet with a broker or see an advertisement about Medicare Advantage plans offering zero-dollar premiums and boundless supplemental benefits. Sounds good; sometimes too good to be true. Are advertisements like this misleading, and if they are, what should the Federal Government—what should we be doing about it?

Ms. REEG. They are, and this has gone on for years. In all of our public presentations and our counseling, we beg the consumers, do not choose your health plan, your prescription drug coverage based on an advertisement. The advertisements will focus on the zero premium, zero copay for primary care, maybe no copay for generic medication.

But we really want them to look at things like, what is the copay for inpatient hospitalization per day? When it comes to Medicare Advantage, also know that maximum out of pocket, which would be a limit to their financial risk. So, the advertisements over the years have gotten more aggressive, and they do focus on those added benefits—specifically cash allowances, debit cards, money to go into the local drug store and purchase items that are not covered.

We have counseled numerous individuals, especially over the past open enrollment year. They were very upset with us, because we could not use Medicare's Plan Finder tool to order the plans in order of the highest debit card to the lowest. When we try to circle back to things like their specific providers, mental health needs, and other critically needed services, they really want to focus on those added benefits, and that has been a challenge for us, due to the advertisements.

Senator CORTEZ MASTO. So is there—and I understand the Federal Government's recent steps to curb deceptive marketing, to help seniors sign up for Medicare coverage. Is that helping? Do you see some of that——

Ms. REEG. We are cautiously optimistic. We will know more as plans go into effect in 2024. Personally, I have seen a bit of a difference in the commercials that are aired on television and the online ads. But they are still, you know—and I get it. Consumers with limited incomes, limited resources, to have those added dollars each month for groceries or utilities is a need.

But if we can focus on the critical need, which is their health care and their medical needs, it could hopefully redivert them into plans that are best suited to them.

Senator CORTEZ MASTO. And would your recommendation be stronger oversight on utilization of special election periods, such as the low-income subsidy special enrollment period and the block on enrollments for those with cognitive impairments? Would that help if we were to provide more of that oversight in these areas?

Ms. REEG. Yes, I would agree with that. Thank you, Senator.

Senator CORTEZ MASTO. Thank you.

And then, Ms. Hoglund, broker fees. This is an issue for me as well, and I just—it astounds me that this is happening, but I am not surprised. I am not surprised. Any time there is an opportunity to make a profit, you are going to see people trying to take advantage of that.

I am very curious. How do the brokers earn these extra incentive payments, and are some of them considered, what we are hearing now, junk fees? I mean, what is going on here?

Ms. HOGLUND. Yes. So I would say the add-on fees really do vary significantly, and some—perhaps there could be some value to an FMO, the middlemen we are talking about. They have some administrative costs, right, to be set up in an ongoing business.

But when we hear things like they are being paid for health risk assessments, we do not see a lot of value in having an agent or a broker complete an HRA with a member. That is not something where we can get the data and really use it. And so, there are more and more of those types of things, where we do not see there being true value. It is just, what creative way can we come up with to shift more dollars to incent enrollment in certain plans?

Senator CORTEZ MASTO. So, thank you.

And I know my time is up, but, Mr. Chairman, I too think we need to address not just the deceptive marketing, but what we are seeing with the broker fees. The goal here is to make sure this is not as complex for seniors, so they can access it and keep more money in their pockets, and not some other predator who is out there. So thank you.

The CHAIRMAN. My colleague, as usual, is way too logical. And heaven forbid, as we talk about these administrative costs—and going back to those Gray Panther days, we always were talking about it. I fail to see how $6 billion in marketing costs in Medicare Advantage is a reasonable allotment for administration.

So we are going to work closely with you, and I look forward to hearing more about your bill.

Next in order of appearance would be Senator Lankford.

Senator LANKFORD. Mr. Chairman, thank you. Thanks to all the witnesses for your ongoing work, and for being here and your preparation today. I really do appreciate it. I am like a lot of other folks: my family is taking care of elderly parents, and MA has been

a huge asset to us, because it keeps everything all together. We are able to help manage all that and to be able to go through the options on it.

So I am one of many folks who are grateful for it, but I also have questions on how it actually operates and how things actually work. The medical loss ratio piece about this, and the gift cards that we have already talked about and such, where that actually gets listed and how plans actually file that as medical expenses gets a little iffy in the process.

Are there specific things that you could share that you would say we can solve some of this by just not allowing the gaming of the system and how they define these gift cards and things and what they apply for, to be able to make sure people are actually focused in on the health-care side of things, rather than on the free cash side of things? Is that a definitional issue that we need to resolve? And I am fine with anyone who wants to take that on.

Ms. HOGLUND. I would say, I appreciate you pointing out there technically is a limit on what is supposed to be spent on administrative costs. But I think this is where I would say that more transparency—to your point, perhaps a better definition of what are administrative costs, what truly are benefits costs—could be very helpful. And then, any time you require that transparency, making sure there are enough audits to verify that folks are completing as intended, and not getting creative with how they complete the forms.

Senator LANKFORD. Okay. Any other suggestions on what that definition could or should be?

Mr. BLUMENFELD-GANTZ. Thank you for the question. I think about this as really a combination of health and financial expenses. Many people, when they are enrolling in a Medicare plan, do have to make both health and financial tradeoffs.

And so, the question is, how do we make it more transparent to consumers—the all-in costs, the all-in health coverage that they are getting? And whether those dollars come out of Part A or Part B or Part C or Part D with regard to the plan, and which budget allocation, I think, is secondary to the consumer but probably very important to the system.

Senator LANKFORD. I want to drill down a little bit more on what Senator Cortez Masto was talking about: the advertising. Advertising is one thing, things that are coming in online or on the television. It is another issue when I've got seniors who literally, every single day, get a call. Day after day, they are getting calls on it.

They are furious about it, obviously, but again, this is a business that is trying to be able to reach out to potential customers. We also have that we want to be able to maintain the options and the awareness of it. How do we strike a balance on that, because my seniors are sick of all the calls coming in on it?

Ms. REEG. If I may, our seniors are sick of it too. When we are at public events, they approach us afterwards with their phone, saying how do I make it stop?

And we ask them if they are on the Do Not Call list, but that is not enough. And Ohio also is home to, I think, over a quarter-million independent agents that want to do right by their consumers, and that is not where these calls are generated from. It is

often the lead agencies and these third parties. And I believe that if the plans were held accountable for the actions of those middlemen, those entities, it might curb some of those calls.

Senator LANKFORD. Okay. What would that accountability look like?

Ms. REEG. I think punishments for the plans. And whether it impacts their star rating on the Medicare tool or financial penalties, that would be determined up above.

Senator LANKFORD. Okay.

Let me follow up with another question on this. Medicare Advantage—and this takes us a little bit off topic on this, but the issue with some of my rural hospitals especially, they are getting more and more frustrated with the denials that happen. Just an automatic, it is going to be denied.

So, trying to get the preauthorization in process so that they are not going to have denials, or to be able to have a predictability in the process—what we are seeing is literally, in my State, we have some hospitals now that just will not take Medicare Advantage, period. They just cut everybody off and said, "We cannot do it because we cannot afford the cost in chasing for all the denials."

So that is exactly the opposite of what we want to be able to create here. What are you hearing on that, and what are alternatives that you would see?

Ms. HOGLUND. So, I appreciate the question. In particular, we serve a very rural population, and our goal is always to partner. I mean, we are part of an integrated health system, so I think that really helps us in thinking about the provider's perspective when it comes to a variety of issues, including prior authorization, as you mentioned.

But we spend a lot of time making sure we work closely with our rural facilities. It is absolutely imperative, right, that our seniors can get in for care when they need it, and that we are not putting up unnecessary barriers to necessary care. So, this is a priority for us, to make sure that we are partnering, particularly in those rural areas where there are not a lot of options, so that our seniors can get in for care when they need it.

Senator LANKFORD. Okay; thank you.

Mr. Chairman and Ranking Member, thank you for holding a hearing on this. But this is something we have talked about before. If they are on a provider list but they are actually not a provider that is out there, that is frustrating in many ways.

But if you are a provider and you are told that Medicare covers this and you just get an automatic denial for it every time, that also disincentivizes them to be able to be a provider. So I do think we need to work on both sides of this issue as well.

The CHAIRMAN. It is an important point.

Senator Grassley is next.

Senator GRASSLEY. My turn?

The CHAIRMAN. Yes.

Senator GRASSLEY. Okay. I am sorry I missed your testimony because I had to be in the Budget Committee, also dealing with something with Medicare and Medicaid.

I am going to start with Ms. Reeg, a couple of questions. I have heard from Iowa independent agents and brokers about the new

Federal requirements to record all phone calls with seniors and to store the audio files for 10 years. So, can you say, is this the most effective way for Federal regulators to conduct oversight, and are there more effective ways to ensure quality?

Ms. REEG. Thank you, Senator. While the SHIPs are impartial and focus on the Medicare beneficiaries—the patients, the caregivers—as a SHIP that sits within Insurance, I know that that was a struggle for many of the independent agents, to take on that added request for recordings.

And as shared previously, those typically are not the bad actors. It is oftentimes the large brokers, activity that happens out of State, that is consequential for our Medicare beneficiaries ending up in the poor plans. I believe recording the calls from the lead agencies, the third-party marketing, and the out-of-State brokers may have had an impact.

I am unaware if there have been results or data taken from that. I am not sure if it was effectual with the independent agents.

Senator GRASSLEY. Another question for you. In addition to the current Medicare open enrollment, Medicare Advantage enrollees can change plans or switch to original Medicare in the first 3 months of the year. This was added in 2016. Currently, this open enrollment is not available for Medicare Part D plans.

Iowans have told me that sometimes their Medicare Part D plan's pharmacy benefit manager switches the tier placement of a patient's drug during the plan year. This change can increase the patient's out-of-pocket cost. Is this a common problem, and should there be an additional open enrollment period for Medicare Part D?

Ms. REEG. Yes. SHIPs, I believe, would support that. So, we have the open enrollment every fall, October 15th to December 7th. Ideally in a perfect world, every Medicare beneficiary would accurately review their health and drug options and be in the best plan come the New Year.

However, we often have to use January, February, and March to review different Medicare Advantage plans, and we do not have that option for the individuals that are currently in original Medicare with a stand-alone plan.

Senator GRASSLEY. Ms. Hoglund, Medicare Advantage enrollment continues to grow as a percentage of Medicare enrollment. When I led, in the past, the 2003 Medicare Modernization Act, 5 million seniors were enrolled in private health plans. Today it is 30 million. Why are seniors choosing to enroll in Medicare Advantage plans compared to the original Medicare?

Ms. HOGLUND. I appreciate this question. I agree. I mean, I think Medicare Advantage is an undeniable success. It offers pretty high-quality coverage to a lot of Americans. It is one of the only Federal programs that measures and rewards high quality.

So I think there is an element of that, that beneficiaries can see what plans are considered high-quality, and that is something that is an advantage over other programs. It also, I think, can be a very valuable program for rural populations and underserved populations, and so I think that is another reason perhaps why we have seen some of the success.

As was noted earlier, definitely the additional benefits are also some things that really do appeal to our seniors and can help with

more well-rounded support for all of their needs, not just their medical needs, perhaps some of their social determinants as well.

Senator GRASSLEY. Mr. Blumenfeld-Gantz, a question about PBMs for you. They can have a significant impact on a seniors' access to prescription drugs and how much they cost at the counter where they get their drugs. How does your company help seniors navigate challenges created by PBMs so seniors can access a local pharmacy of their choice?

Mr. BLUMENFELD-GANTZ. At Chapter, we look at every single Part D plan, and every single prescription, and every single option of where someone could fill that prescription. That data is unfortunately not available online. The government does not publish it; insurance carriers do not publish it.

Chapter is the only organization in the country where you can actually get accurate information on where to find a prescription at a specific price on a specific Medicare plan.

That should not be true. It unfortunately is. So what we do is, we look at all of that data, and we recommend a plan that minimizes costs, given someone's prescriptions and given any potential prescriptions they may need to take throughout the year.

Senator GRASSLEY. Yes. And for you and Ms. Reeg, this question: what steps have your organizations taken to ensure that rural Americans receive quality and timely information?

Ms. REEG. For the SHIP program, we rely on partnerships—partnerships with the local Area Agencies on Aging, partnerships with faith-based organizations, partnerships really with anybody that will partner with us in those communities—to disseminate information timely and accurately to those populations, just as we would those in our metropolitans.

Senator GRASSLEY. Mr. Blumenfeld-Gantz?

Mr. BLUMENFELD-GANTZ. I think it is really important that we continue to provide more information to consumers so that they can make these really difficult decisions. I think without that, and without better regulation oversight over brokers themselves, there won't be much improvement.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague.

Next in order of appearance would be Senator Blackburn.

Senator BLACKBURN. Thank you, Mr. Chairman. And I am so pleased we've got a hearing today on the MA program, and I find it so interesting that for the first time, most Medicare beneficiaries have selected an MA program, and it really has marked a shift, I think, in the thinking of our Medicare enrollees from fee-for-service over to a value-based system.

And, Ms. Hoglund, I want to come to you first. In your testimony, you talked about MA enrollment growth not being evenly distributed through the marketplace, with a concentration in a few national companies. So I want you to drill down on that a little bit, about how you see this affecting the overall competitiveness of the MA program, and what changes would you suggest we look at as we try to promote competition?

Ms. HOGLUND. Yes. So, absolutely this is a huge area of concern, as we talked about earlier. I think competition in Medicare Advan-

tage is what is best. It is what is best for the consumers; it is what is best for the Federal Government in terms of spend.

In particular on this topic, what can we do—I would start with transparency, transparency in all of the dollars that are flowing over and above that CMS cap, because we do think that is a lot of what is driving the beneficiary choice. It is not necessarily what is in the best interest of the consumer, but where those dollars are flowing.

And so, I think it would be very interesting to track that data and see—with transparency around total payments—is there a correlation between those dollars and where we see the enrollment lining up? And then the second thing there would be—once we understand and have transparency—to talk about true maximum caps that encompass not just commission, but total payments.

And so again, then we are making sure that folks are not using financial incentives, and it is really about placing the beneficiary in the plan that is the best fit for them.

And then finally, thinking beyond about, how do we make sure that that is directed toward high-quality plans and that sort of thing?

Senator BLACKBURN. Okay. You touched also on some of the aggressive and misleading advertising in the MA space. So, a couple of questions there. Can you give us some specific examples of impacts on seniors, and what you are seeing there? And second, for people who have been enrollees, have you conducted satisfaction surveys to know what they saw as being aggressive and misleading?

Ms. HOGLUND. Yes. So one of the things that we do is, we watch our disenrollments. We stay right on top of those, and we often will follow up with consumers when we see those come through. And it is fairly often that our seniors were not even aware they were switched. So that is how aggressive the tactics are, and they are not even understanding.

It might be as basic as, would you like to have your groceries covered, and the person says "yes." And pretty soon they are switched. That was the key, so they have no idea that the question is leading to them being switched on a plan.

We have, as I mentioned in my testimony, a trusted partner who said, ahead of open enrollment when they are not even supposed to be allowed, their clients are receiving five, six, seven calls a day. And so, just call after call after call, and they are spending a lot of time trying to help reeducate their consumers on, this is what you have, this is why we think it is right for you.

Senator BLACKBURN. Okay. So it is some of those consumer protection items that you are wanting to see enhanced.

Mr. Blumenfeld-Gantz, I do have a question for you, but I am almost out of time, and I know others want to ask their questions. So let us have you do this one in writing and submit it. I would like to know what you see as the differences between Chapter and other Medicare advisors. And then with it being a tech-enabled platform, how do you address the needs of older enrollees and allow them into your program?

And with that, I will yield back, Mr. Chairman.

Senator BENNET [presiding]. Thank you, Senator Blackburn. Thank you for your questions.

Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman.

CMS has recently implemented changes to reign in misleading Medicare Advantage marketing practices. Yet marketers are finding ways around these requirements. As a matter of fact, the number of complaints that have been filed has nearly doubled. A recent Commonwealth Fund survey found that 10 percent of respondents reported that marketing callers would ask for their Medicare or Social Security number, which is not permitted under Medicare law. Further, while cold calling is specifically prohibited, three out of four respondents reported receiving unsolicited calls.

So, Ms. Hoglund, what should CMS be considering to step up enforcement and hold bad actors accountable?

Ms. HOGLUND. Yes. I think that is a great question, and you are absolutely right that, despite some new guidance—and we talked earlier, there has been improvement in some spaces. But we are certainly seeing, in many spaces, the aggressive tactics really continue.

So, having CMS be in a position to respond quickly as these are reported, I think, is really a critical piece, and we believe they are. I just will share—we continue to hear from our broker partners on an ongoing basis that this is an issue: their clients are getting called.

We know sometimes sweepstakes or contests are used as a way to get them in the door, with folks not even maybe understanding that they actually have given their information out. So that is another tactic that we hear that is being used that perhaps could be addressed.

Senator MENENDEZ. All right, because this is a particularly, potentially vulnerable class.

Ms. Reeg, as you know, State Health Information and Assistance Programs, known as SHIPs, are trusted sources of information for many seniors and people living with disabilities. These federally funded resources are tasked with educating and assisting Medicare-eligible individuals through outreach, counseling, training, and specifically support for low-income individuals, those with disabilities, and individuals who are dually eligible for Medicare and Medicaid.

Given your experience as a Program Director, how could providing more resources to SHIPs support efforts to protect low-income individuals and those with disabilities?

Ms. REEG. Well, it would certainly support the added counseling that we have been doing for that particular population. In Ohio, many of our lower-income individuals are going through the redetermination, some signing up for Medicare for the first time or enrolling in the low-income subsidy, and they need extended counseling and assistance to get sometimes into temporary drug programs to curb the high costs.

So our counseling for that population is taking longer. In addition, our population has grown. The scope of options and benefits has grown, and we are trying to keep up with that. We are fortunate to have our base grant funds and priority one from MIPPA

funds, but it is not keeping up with growth. Additional funding could support that.

Senator MENENDEZ. Yes. And I am troubled by reports that vulnerable individuals, particularly low-income and dually eligible individuals, are being targeted by deceptive marketing tactics and are often enrolled in plans that just simply do not meet their needs.

What else can be done specifically to better support these populations and ensure that the care plan that they need is the one that they get?

Ms. REEG. For SHIP programs, many of us utilize direct entry into Medicare's Complaint Tracking Module, or CTM. And as I shared earlier, a lot of times we are reactive. They are already in a plan that is not a good choice for them, and we are trying to get them either back or into a plan that is a good choice.

If the plans were required to include the agent on record in those complaints, it would help us with the investigatory aspect of it. We are a SHIP, again, that sits within the Department of Insurance. The only regulatory authority that the States have really is on agent activity, and it would help us identify some of the bad actors.

Senator MENENDEZ. Finally, Mr. Blumenfeld-Gantz, we know that seniors often find the process of selecting their coverage to be confusing, difficult, overwhelming. I was looking at it, now that there is open enrollment, and I am not sure that, even as someone who is pretty well-versed in some of this, I would know how to make the best decisions.

Many Medicare beneficiaries rely on a broker to assist them with choosing their coverage. Almost one in three people ages 65 and older said they used a broker or agent to help them choose Medicare coverage. Yet they still very often do not end up in plans that are best for them.

What do you think consumers should know about making their plan decisions?

Mr. BLUMENFELD-GANTZ. First, brokers are not required to put consumers' interests first, and I think that needs to change. We operate differently at Chapter. We do put consumers' interests first, but that is by far the exception and not the norm.

So I think it is important for consumers to know what the incentives of their advisors and their trusted guides are. And then I think there is a whole host of data challenges that need to be solved to make sure that the information is available to consumers so that they can make informed choices, because today it is very challenging.

Senator BENNET. Thank you, Senator.

Senator Hassan is next.

Senator HASSAN. Thanks, Senator Bennet. Thanks to the witnesses for being here today. I really appreciate you and your work.

Ms. Hoglund, I want to start with a question for you. As we have heard today, Medicare Advantage plans are an important option for individuals on Medicare who are looking for more comprehensive benefits, such as prescription drug coverage, vision, hearing, and dental. It is essential that we preserve this option for seniors, but we also need to ensure that plans are fairly and accurately representing their benefits. I have unfortunately heard too many con-

cerns from constituents with Medicare Advantage plans who are unable to afford the medications that their doctors prescribe.

While Medicare Advantage plans often advertise comprehensive benefits, many people are not explicitly told, as we are hearing today, by marketing agents that their plans do not include prescription medication benefits. Even for Medicare Advantage plans that do include those benefits, patients sometimes do not get appropriate information about whether or not their medications will be covered, or if the coverage will change.

So, my office recently heard from a constituent in North Conway. She has a Medicare Advantage plan, but it has scaled back her prescription drug coverage. She uses several medications to treat her autoimmune disease, two of which were originally covered as preferred Tier 1 drugs under her plan, with a low copay. However, the plan partially stopped covering the medications a few months later, after she had already signed up, which added to her financial burden. And she previously had a different Medicare Advantage plan that repeatedly denied her coverage for a third medication that she has relied on for more than a decade to manage her autoimmune disease, forcing her to rely on samples provided by her physician.

Too often, consumers feel that the Medicare Advantage plans overpromise and then they underdeliver on results. Now you, Ms. Hoglund, as a CEO of a small health plan with a good record, know what it is to do this well and right. How can we best ensure that these big plans provide the benefits that seniors need? What would you recommend we look at?

Ms. HOGLUND. Yes, I appreciate this question. So certainly, I cannot speak to the specific example, but you know, we have heard stories like this before.

I mean, one of the things that we are really committed to is making sure that we maintain a comprehensive and affordable list, and really working with the individual to address if there is a change in formulary but their provider indicates that this is a necessary drug or there are concerns about side effects for transitioning, and really work with the individual to make sure that they maintain coverage through an exception process.

And so, perhaps there could be some more work around how could that exception process work better, to make sure that there is consistency across plans.

Senator HASSAN. Right.

Ms. HOGLUND. The other thing that we talked about a little earlier is, would a large enough change in the prescription benefit perhaps be something that could trigger an option for them to select another plan, because currently that may not be the case.

Senator HASSAN. Got it. Thank you so much.

Ms. Reeg, I also recently heard from a constituent in Bedford, NH who unfortunately has experienced the kinds of marketing practices that we have heard about in the hearing today. This constituent cares for her 26-year-old son who has a developmental disability and is eligible for Medicare.

Her son was on traditional Medicare, but a Medicare Advantage marketing agent called his cellphone and got him to agree to switch his insurance. This company took advantage of him during

a 5-minute conversation, leaving him with a plan that would not fully cover his health-care needs.

The good news is that his family found out about it the same day and was able to undo the changes just in time. But unfortunately, there is nothing stopping, as we have heard, this kind of unscrupulous marketing for these plans, and nothing stopping them from targeting the most vulnerable patients who may not have the resources that they need to navigate this kind of conversation.

So, Ms. Reeg, how can we prevent these kinds of tactics from impacting our most vulnerable populations?

Ms. REEG. I agree. I am sorry to hear that story, but it is a story we hear time and time again. We have counseled individuals both under 65 on Medicare due to disabilities, and individuals over 65 but with extreme cognitive impairments. And the record that we are able to view on the Medicare system through MARx shows an enrollment almost every month, which is far exceeding what the low-income subsidy special enrollment period allows. So, we do file the complaints, and I think again, knowing who that agent on record is would allow us to take a step further in enforcing those rules.

Senator HASSAN. Right. Thank you very much, and thank you, Mr. Chair.

Senator BENNET. Thank you, Senator Hassan, for your questions.

The good news for all of you is, I think I am the last person, and I have a few questions that I wanted to ask. Ms. Reeg, let me start with you. Medicare Advantage plans have grown in popularity in recent years. Over 50 percent of Colorado seniors have selected MA plans over traditional Medicare.

While this private insurance provides seniors with more options, we need to provide appropriate oversight and protect seniors from deceptive marketing and properly steward taxpayer dollars. And I think that is why we are all here today.

I have heard from hospitals across Colorado, like San Luis Valley Health, about the challenges they face to get their patients timely care with Medicare Advantage plans. Consistently, hospitals and their patients experience hospital admission denials, delays in care, and plans refusing to pay after they have approved service.

In fact, the head of San Luis Valley Health, Connie Morton, told me that in the past 6 months, the hospital has made 45 hospital admission requests from MA plans, and every single one of them was denied. This is in stark contrast to a 93-percent approval number across other private non-Medicare plans.

This is utterly unacceptable, and I plan to follow up with the plans directly, plan to follow up with the plans. I have that plan. [Laughter.] We have to follow up with the plans, and she was actually quite specific about who the folks were. I think we are going to have a conversation.

But our seniors deserve better than this. Coloradans with Medicare Advantage consistently tell me, tell my office, that their surgeries are delayed, often for months, and that they were lied to about their level of coverage, or that their plan was too expensive, and that their claims are denied when they are told services should have been or would have been covered.

All of this demonstrates, I think, that we need greater transparency. And so, Ms. Reeg, as a Director of a State Insurance Department, do you have access to Medicare Advantage plan denial rates or approval turnaround times, and if you had access to that data, how would that change your ability to guide seniors toward the plan that is best for them and their health-care needs?

Ms. REEG. Thank you, Senator. At this current time, no, we do not have access to that level of information. Having access to that detailed information and accuracy rate would greatly help us in choosing plans for consumers, and allowing them to have confidence and peace of mind when enrolling into those plans.

Senator BENNET. Thank you for that answer, and I have a follow-up question for you, Ms. Reeg. Coloradans with Medicare Advantage plans often do not recognize that their private plans do not cover their doctors until it is too late. In 2018, the Centers for Medicare and Medicaid Services reviewed 52 Medicare Advantage plan directories and found that over a third of providers were erroneously included, either because the provider did not work at the listed location or because the provider was out of the plan's network.

These are often known as "ghost networks." Ghost networks make it difficult for a beneficiary to determine if their doctors are in network at all, and this misinformation often leads to unexpected and higher out-of-pocket costs for Colorado seniors. And that is why I worked with my colleagues, Senator Ron Wyden and Senator Thom Tillis, to introduce the REAL Health Providers Act, which will strengthen requirements for these private Medicare Advantage plans to maintain adequate provider directories. It would also ensure that seniors do not pay out-of-network costs for appointments with doctors who were inaccurately listed as in network.

Ms. Reeg, when you help counsel seniors, as I know you do, how important is it for them to know that their current doctors are actually in the network, and do you feel confident telling them that the provider directories they rely on are accurate?

Ms. REEG. Network information is vital to choosing a plan. As shared earlier, no, we do not rely on the directory or even the Plan Finder linked to the company's website page. We use that as a springboard for them to work directly with their provider offices, to see if they are in specific Medicare Advantage plans.

Network information, not just in network versus out of network, but also knowing if there is a prior authorization to utilize specialists, are hurdles that we often go over with Medicare beneficiaries.

Senator BENNET. I do think—I am at an end, so I am not going to ask my third question. I will submit it for the record.

But I appreciate your testimony very much. To me, this is just one more place where seniors are having to spend their golden years fighting, fighting, fighting just to get the health care that people in other countries have relied on. And when it comes to Medicare, that is something that people generally, I think, feel pretty good about in our country.

So thank you. We are going to fix this problem, and I really appreciate your testimony here today.

Senator Casey, you are next. I am going to turn it over to you. Thank you.

Senator CASEY [presiding]. Thank you, Senator Bennet. I want to thank the witnesses. I was at another hearing, so we had a conflict, so I did not hear your testimony. But I am grateful for your willingness to be here today and to testify about these important issues.

Ms. Reeg, I will direct both of my questions to you. In your testimony, you mentioned the kind of information and marketing tactics that "often lead to poor enrollment decisions and undesirable outcomes." Medicare, as we all know, is a promise, and here is the basic promise: guaranteed access, no questions asked; guaranteed access to health care after a lifetime of hard work.

Unfortunately, that promise is not often enough fulfilled. Despite this promise, which everyone, every member of the U.S. Senate and House, is bound by, despite this promise, we know that many older adults and people with disabilities still have a hard time getting quality coverage because they are either confused by the enrollment process, or influenced by misleading marketing, or both.

Ensuring that there is both clear information and accurate information about enrollment in different health plans is the very least that government can do, so that Medicare-eligible individuals are appropriately educated on how to make the most of their earned health-care benefits. That is consistent with keeping the promise.

I have introduced the so-called BENES 2.0 Act—the Beneficiary Enrollment Notification and Eligibility Simplification Act—with Senator Young of Indiana. The bill would provide advanced notice to individuals approaching Medicare eligibility, as well as timely information on when to sign up for Medicare.

So here is my question. How important is the role of SHIP counselors like yourself in ensuring Medicare beneficiaries can make the best decisions for their needs?

Ms. REEG. We feel it is vital. We provide objective and unbiased guidance. No one affiliated with the SHIP program can have a financial gain or a conflict of interest in dealing with the information that is going out there.

We provide that, and unfortunately, we see the same. Just this month, we were working with a gentleman who was undergoing active cancer treatment, and he got a phone call and enrolled in a different managed care plan that none of his specialists were involved in. We were able to get him back into his other plan and back on his plan of care.

Senator CASEY. We appreciate the work that you do. And I am also concerned about a question that has arisen, I know, in a lot of these discussions, which is that SHIPs may not have the resources they need to meet the growing demand, due to growing demographic trends and other challenges.

Medicare funding to SHIPs and other resources for low-income outreach and enrollment efforts may be in jeopardy, because it was not included—not included—in the recent continuing resolution. How can you speak to the needs for continued resources for SHIPs, given the demands and challenges you are facing and the implications for low-income older adults if funding is not extended this year?

Ms. REEG. I think it is important to note that the SHIPs are very good stewards of Federal funding. The return on investment—with both volunteer counselors and the hours that they put in and the dollars saved by enrolling consumers in the most cost-effective plans, signing up for the low-income subsidy or extra help with their prescription drugs, and the influx of assisting consumers with applying for Medicare savings programs—far outweighs the dollars that are included in the current grant models.

But the growing population, the growing scope, and the demand in every State, would warrant the additional dollars.

Senator CASEY. Well, thanks very much, and thank you for your testimony.

And now I will turn it over to Senator Warren.

Senator WARREN [presiding]. All right. Thank you, Senator Casey.

So this week, millions of people will begin the process of choosing a Medicare plan through open enrollment, and one option is to stay with traditional Medicare. The other is to enroll in one of the many Medicare Advantage plans, or MA as people often refer to it, which allows these for-profit health insurance companies to offer Medicare coverage.

Now in theory, these private companies should compete on the merits of the coverage they offer. Instead, big MA insurers with a war chest of advertising money use deceptive marketing tactics to lure seniors into the wrong plans. These companies exaggerate benefits, they claim that seniors can keep seeing doctors that are actually out of network, and they deceive seniors about how much they will spend for out-of-pocket care. This is harmful to seniors, and that is a big part of what this hearing today has been all about. But I want to focus on a different point. It also drowns out competition from smaller insurers, even when they offer a better product.

So, Ms. Hoglund, you are the CEO of Security Health Plan. This is a small community-based plan that participates in Medicare Advantage.

So, let's start with this: how does your marketing budget compare to the marketing budget, for example, of United Health or Cigna?

Ms. HOGLUND. Well, I obviously do not know the specifics of what that number might be, but I can tell you it is pennies on the dollar, a fraction of what we would have to spend.

Senator WARREN. Okay. So, everybody is out there trying to sell their plans to people, and some folks have got huge marketing budgets, and you have a little sliver of that. So where do these big insurance companies get the budget for all of this advertising?

Well, think about the structure here. The government pays MA plans a set amount of money per beneficiary. If a beneficiary is sicker, then the amount of money that the government pays can go up, and then whatever the insurers do not spend on care, they get to keep in profits.

Now, as a result of this structure, giant insurance companies have built an entire business around making beneficiaries look as sick as possible by stuffing their medical records with as many diagnosis codes as possible, which means the government pays insurers more money. This is called "upcoding," and government watch-

dogs have uncovered hundreds of billions of dollars in overpayments that result from insurance companies gaming the system like this.

Ms. Hoglund, are Medicare Advantage plans permitted to spend the money they make off this upcoding on advertisements?

Ms. HOGLUND. So, there is some amount of discretion in how the dollars can be spent. I do want to say I really do appreciate this question and how you framed it. I would agree with you that we should be competing on the merits of coverage, not on the financial incentives.

We certainly believe at Security Health Plan in care, not coding, with care as the focal point.

Senator WARREN. I am very glad to hear this, because my understanding is, these plans can spend about 15 percent of the money they get from the Federal Government—these are your tax dollars at work—on overhead and marketing.

Nothing prohibits them from using the payments they get from gaming the system to actually draw more people in, so they can keep that practice up. So the way I think of this is, the Medicare Advantage plans that game the system get billions of dollars in overpayments. They then turn around and use that money to flood seniors with deceptive ads, to lure them to join their plans.

But there is one more twist in this. Once people sign up, once the companies make them look as sick as possible, these giant insurance companies refuse to deliver on the care that they actually promised. Now in 2019, the Health and Human Services Inspector General found that Medicare Advantage insurers improperly denied payment for care in roughly one out of five claims, leaving seniors with piles of unpaid medical bills.

And in just 2 months last year, the giant insurance company Cigna used a computer algorithm to instantly deny payment for 300,000 claims, even though trained doctors are supposed to make those determinations.

Ms. Hoglund, giant Medicare Advantage insurers are overcharging the government, they are peddling false promises, and then they are turning around and denying care to seniors and people with disabilities. So this is why CMS has taken steps to start to crack down on deceptive marketing and unfair denials of care. Do you think that the government's proposals go far enough?

Ms. HOGLUND. No. I think there is more opportunity, and again, that is why we are here today. One of the things that we specifically have suggested around the marketing tactics that are currently out there, and the additional payments that we see going to FMOs or middlemen, is to really require some additional transparency so that it is very clear what all the dollars are and how they are flowing, to understand who might be the bad actors so that those can be addressed specifically, and then really thinking about, once we understand how the money flows, how do we put true maximum caps on some of these items so that they cannot continue to be leveraged for financial gain?

Senator WARREN. Well, I very much appreciate it, very much appreciate your help in trying to expose these problems today, and I appreciate the help from all of you. You know, it is simple: responsible insurers do not lie and cheat seniors to make a buck.

But it is clear that the big Medicare Advantage insurers are not playing by the same set of rules as some of the smaller insurers. I appreciate the steps that CMS has already taken, but they need to go further by making the Medicare Advantage insurers publish accurate data on patient care and out-of-pocket costs, and cracking down on practices like upcoding—doing all of this to the full extent of their authority.

So, thank you all for being with us today. And with that, for the information of the Senators, questions for the record will be due by 5 p.m. on October 25th, and this hearing is adjourned.

[Whereupon, at 11:45 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF COBI BLUMENFELD-GANTZ, CEO AND CO-FOUNDER, CHAPTER

INTRODUCTION

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for inviting me to testify. My name is Cobi Blumenfeld-Gantz. I am the CEO and co-founder of Chapter, a technology-enabled Medicare and retirement navigation platform.[1] I started Chapter because the Medicare enrollment and navigation process is broken, and consumers deserve better. I want to thank and commend the committee for holding this hearing and dedicating time to this important topic.

This topic is personal to me. My parents were the first two people that Chapter supported because they needed help fixing mistakes they made when following the advice of a traditional broker. Through building Chapter to serve a growing portion of the approximately 65 million Americans who benefit from Medicare, I've learned that my parents' experience of confusion and costly mistakes was far from unique.

When my parents first enrolled in Medicare several years ago, a broker advised them to choose a plan that was more expensive than an identical alternative. The broker had no obligation to consider every plan option or to prioritize my parents' interests over his own.

While CMS, consumer advocates, and policymakers have made significant progress since my parents enrolled in Medicare, further steps are needed to improve the consumer experience, quality and availability of data, and the behavior of brokers and third-party lead generators and advertisers.

The Medicare program is tremendously complex. Medicare Advantage plans can each have different networks of health-care providers, different coverage for prescriptions, different medical and prescription copays, and differences in dozens of nonmedical benefits like dental services, transportation allowances, and hearing aids. The number and diversity of plans creates broad choices for consumers looking to maximize their savings, benefits, and coverage. But the complexity and optionality also means that consumers deserve the option of working with a trusted guide to support them with these consequential decisions.

Today, Medicare navigation and enrollment is far too confusing, costly, and consumer unfriendly. The system is rife with misaligned incentives and data opacity. Consumers should be able to easily navigate plans and have a trusted guide to support them. Mistakes in coverage selection can result in hundreds or thousands of dollars of extra annual costs for consumers, and even the inability to afford lifesaving medications or to see preferred doctors without the risk of paying completely out of pocket.

CHAPTER'S APPROACH

Before I highlight some of the significant challenges impacting consumers navigating Medicare, I want to share our unique approach to providing Medicare guid-

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[1] Memoir, Inc., d/b/a Chapter ("Chapter") is a privately owned, data and technology-enabled advisory that helps older Americans navigate retirement *(www.askchapter.org)*. Licensed insurance agency services are provided through Chapter's wholly owned subsidiary, Chapter Advisory LLC. In California, Chapter Advisory LLC does business as Chapter Insurance Services.

ance. This work has afforded us insight into what consumers are up against. Unlike other insurance agencies, we did not start working on Medicare as just another offering to complement other insurance products. We built Chapter to focus specifically on issues related to Medicare and retirement, and we designed our model around the distinct needs of this consumer group and the unique characteristics of Medicare plans.

At Chapter, we help Americans decide when to enroll in Medicare and how to cover costs and services not covered by original Medicare. To do this, we've had to engineer a Medicare plan data model from the ground up. We've built a plan recommendation platform that considers every option in the country across Medicare Advantage plans, Medicare supplements, Part D prescription plans, and Special Needs Plans for those who are dual-eligible or have chronic conditions. Our platform tailors recommendations based on consumers' health-care providers, prescription drugs, additional benefit needs, lifestyle choices, risk preferences, and budget. The result is a coverage recommendation suited to the consumer's particular needs and preferences.

Our interactions with consumers are far from a one-time transaction. Consumers who rely on Chapter work with a consistent Medicare advisor who guides the consumer through the process of choosing coverage and signing up for a plan. The process frequently includes several conversations with the same advisor as a consumer is preparing to retire, for example.

We also support consumers with challenges beyond their enrollment. We help them navigate their Medicare coverage, including by finding specialists who are in-network, determining the most cost-effective way to purchase prescriptions, activating and accessing benefits, and answering the maze of other questions that arise.

Critically, our plan recommendations are based solely on the needs of the consumer, and they are never limited to the subset of insurance companies with which we have contracts—nor are they influenced by those contracts. To maintain consumer-first incentives for our licensed Medicare advisors, their compensation does not vary based on which coverage a beneficiary selects. Consumers are less likely to wind up on the wrong plan when the incentives of their advisors are not stacked against them.

We operate this way because no consumer should enroll in a suboptimal Medicare plan simply because a broker recommends or contracts with a limited number of plans.

We have made significant efforts to put consumers first. But it is not easy. We have a team of exceptional engineers, data scientists, product managers, and Medicare advisors dedicated to demystifying Medicare for everyday Americans, and we've invested tens of millions of dollars into building an unbiased platform.

There are many challenges that confuse and deceive consumers. I'd like to highlight three areas where improvement is needed.

1. Improving plan data availability.
2. Eliminating deceptive marketing.
3. Putting consumers' interests first.

IMPROVING PLAN DATA AVAILABILITY

Consumers deserve significant improvements in the quality and availability of data, specifically on health plans' networks, benefits, and other features. This data should be publicly available and easily accessible. Without improvements, consumers—along with the many organizations trusted to guide them—will continue to struggle to make informed Medicare coverage choices.

One of the tools with the greatest potential to help consumers is *Medicare.gov's* Plan Finder, which is also used by consumer advocacy groups and many organizations providing telephonic support. While Plan Finder is a useful resource and the team at CMS has made great strides in improving access to data, limitations in the current offering illustrate data-quality and availability issues.

Specifically, Plan Finder lacks integrated provider network data, and it has insufficient information on ancillary benefits included in Medicare Advantage plans, such as dental services, hearing aids, transportation, and over-the-counter benefits. These limitations significantly impede a consumer's ability to choose the right plan. In addition, despite recent policy efforts, provider network data is not widely available via public APIs.

Consider a consumer who has three doctors and wants to determine the network status of their doctors across local plans. Because of the large number of Medicare Advantage plans locally available to the average consumer, this consumer might need to conduct over one hundred separate searches across each insurance company's website and track the comparisons independently. It is not reasonable to expect a typical consumer to do this, and it is no surprise that many consumers may not fully understand the network status of their doctors across each plan.

Additionally, a consumer requiring hearing aids and dental coverage cannot use the Plan Finder to compare plans based on the amount of dental coverage or copays for hearing aids. While consumers can sort by whether a plan has *any* dental or hearing coverage, the binary filter is not sufficient because the annual benefit amounts can vary in the hundreds or thousands of dollars across plans.

ELIMINATING DECEPTIVE MARKETING

The second set of challenges relates to confusing and often deceptive marketing tactics, particularly those employed by third-party lead generators. Last year, this committee published a report outlining many of these marketing issues,[2] and we commend the committee's ongoing focus on this topic.

Every fall during the Medicare annual enrollment period, Medicare-eligible consumers are bombarded with mailers, advertisements on television and the radio, and phone calls. While the sheer volume and noise of these materials is itself a challenge, the misleading and pernicious content of these advertisements presents the most concern.

We frequently hear from consumers that they are confused by mailers and other ads because the materials are designed to look like they're from the government or because they make misleading claims.

There are a variety of bad actors in the Medicare lead generation space. The bad actors are typically not local brokers who live and work in each community. Rather, they are lead generation businesses that traffic on scare tactics, imitate government agencies like the Federal Medicare program, and inaccurately advertise plan benefits that either simply are not available to all consumers receiving the advertisements or that fail to acknowledge trade-offs like the fact that plans offering certain benefits might leave consumers' preferred doctors out of network.

Furthermore, these advertisements don't clearly display the organization that the consumer is being prompted to contact. The obfuscation may be intentional because these actors often generate leads for the purpose of selling them onward to a variety of brokers, insurance companies, and even other lead generators.

Deceptive marketing is even more problematic when Medicare plan information is less accessible to consumers and industry participants. Without the ability to easily compare benefits across plans, it is challenging for consumers and well-intentioned brokers alike to make informed coverage decisions based on that marketing.

These deceptive marketing practices should stop, and consumers deserve to understand who is contacting them. CMS previously proposed regulations to prohibit the transfer and sale of consumers' personal information from one third party lead generator to another. However, the provision was not included in the final marketing rule for the 2024 plan year.[3] While there are other regulations designed to protect consumers that are newly effective as of this year's annual enrollment period, there is further opportunity to strengthen the transparency and clarity of regulations around third-party lead generators.

PUTTING CONSUMERS' INTERESTS FIRST

The current Medicare brokerage model is broken because it does not require brokers and other stakeholders to put consumers first. There are no legal requirements that mandate prioritizing consumer interests in the way that we do at Chapter. The lack of such requirements and related lack of consumer awareness is a significant problem facing consumers navigating and enrolling in Medicare options.

Brokers should be held to a higher standard of conduct and accountability. There are policy pathways for accomplishing this. For example, brokers could be required

[2] *https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.*

[3] 88 Fed. Reg. 22120 at p. 22235.

to consider all plans when making recommendations, and agencies could ensure that their salespeople are not incentivized to push plans that pay higher commissions. We would support such a higher standard that prioritizes consumers' interests.

I want to close by summarizing a few principles for consideration as the committee continues its work on Medicare Advantage and the broader Medicare marketplace.

- ***Consumer-first standard:*** **Any trusted guide used by a consumer should be obligated to place consumers' interests first.** There are thousands of Medicare plans available across a variety of plan types. This diversity of options means that consumers can find truly excellent coverage, but they often need a trusted guide to help them through the process.
- ***Information across all types of Medicare plans:*** **Consumers deserve to be informed about all types of Medicare plans that are available to them.** These include Medicare supplement plans, stand-alone Part D prescription plans, coverage under original Medicare, Medicare Advantage plans, and Special Needs plans for people with both Medicare and Medicaid or people who have qualifying chronic conditions, for example.
- ***Complete coverage search:*** **Any trusted guide—whether a broker or another entity—should be obligated to search among all options available to the consumer.** Consumers should never receive a limited set of options or a suboptimal recommendation simply because a broker works with a limited number of carriers.
- ***Transparent and accessible plan data:*** **Consumers and their trusted guides must be able to easily search and compare plans based on their full features.** These include plans' provider networks, formularies of covered drugs, ancillary benefits, and the premiums, out-of-pocket limits, and costs of each service, prescription, and benefit. The complexity of Medicare plans requires clear transparency on the specific differences between plans, and consumers cannot reasonably be expected to wade through hundreds of pages of Summaries of Benefits or Evidences of Coverage to understand these items.
- ***Transparency in advertisements:*** **Third-party marketing and lead generators should be required to clearly identify who they are and the specific organization that will contact the consumer—or which the consumer is being prompted to contact.**

I am grateful to the committee for your ongoing work to improve the Medicare navigation and enrollment experience for Americans.

QUESTIONS SUBMITTED FOR THE RECORD TO COBI BLUMENFELD-GANTZ

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. I worked closely with my colleague, Senator Hatch, on the CHRONIC Care Act to give Medicare Advantage (MA) plans the flexibility to offer supplemental benefits to help people with chronic conditions stay healthy. For example, under the CHRONIC Care Act, MA plans can offer air conditioners to enrollees more likely to suffer from extreme heat or grab bars to improve bath safety.

However, Medicare Plan Finder provides limited information about the generosity, copayments, provider networks, prior authorization, and other limitations on supplemental benefits. This limited visibility into supplemental benefits makes it difficult to predict whether a senior will be able to use the benefit available to them.

Based on your experience working with clients, how important are supplemental benefits?

Answer. Supplemental benefits offered by Medicare Advantage plans frequently fill critical gaps in services not covered by original Medicare. Beneficiaries often choose plans based on not only coverage of preferred providers and prescriptions, but also benefits like dental and vision services, hearing aids, transportation to doctors' visits, over-the-counter allowances, grocery support, and many others.

That said, Medicare Advantage plans vary not only based on their inclusion of these benefits, but also on amounts of each benefit. For example, some plans may cover only a few hundred dollars in dental care or towards the cost of a new pair

of hearing aids, while others may cover thousands of dollars annually. It's critical that consumers have the information and tools to search among plans not only based on the inclusion of a particular benefit type, but also based on the magnitude of each benefit. Equally, consumers need to understand how to activate and use certain benefits, which are often redeemable through a maze of third-party organizations with which insurance companies contract to administer those benefits.

Unfortunately, *Medicare.gov*'s Plan Finder does not currently support the ability to search based on the size of the benefit, nor does it inform consumers on how to use those benefits.

Question. How do you help seniors navigate these options? Can you tell whether their dentists will be in network or if they might qualify for a Supplemental Benefit for the Chronically Ill?

Answer. At Chapter,[1] we help consumers understand not only whether certain plans have benefits, but also the size of each benefit. Our platform categorizes and extracts benefits information—including the amount offered for a benefit, like the number of rides or dollar value of dental services—from plan documents like Summaries of Benefits or Evidences of Coverage, as well as from raw data provided from insurance companies to CMS but not made searchable on Plan Finder.

Of course, there are limitations to the available data, and we support much stronger requirements for insurance carriers to publish structured data on provider networks, including dental networks. This would help to ensure that we have the most accurate information when guiding Americans.

We also have a team of member advocates who help consumers to understand, activate, and use their benefits. This full-time team also helps consumers with emergent health or dental needs to find in-network providers and troubleshoot other nonclinical issues that arise with their coverage.

Question. What kind of information would you like to have to help your clients choose the plans that best fit their needs?

Answer. Several types of additional data would be helpful:

- *Publicly available provider directories via API:* Most carriers do not provide publicly available APIs with information on which providers (*e.g.,* hospitals, doctors, dentists) are in network versus out of network with respect to each plan. While some carriers provide their networks via private data vendors and intermediaries, many carriers do not. We agree with CMS that this information should be publicly available in API format *(https://www.cms.gov/priorities/key-initiatives/burden-reduction/faqs/provider-directory-api.)*
- *Data on prior authorization turnaround times and denial rates for common procedures:* While carriers do disclose whether certain types of services are subject to prior authorization, we have heard from consumers and providers alike that prior-authorization requests are sometimes slowly adjudicated and that denial rates can be quite high. It would be helpful for us to know the turnaround times and denial rates for each plan across common procedure categories, like inpatient hospital admissions via emergency rooms, major joint replacements, etc.
- *Better data on supplemental benefits:* We spend significant time and effort structuring data on supplemental benefits that are found only in Summaries of Benefits or Evidences of Coverage. We would urge broader and more standardized disclosure of supplemental benefits, their amounts, and the third-party vendors (if any) used by carriers to administer those benefits. Furthermore, we would support clearer disclosure regarding the process for activating supplemental benefits, as activating benefits is often challenging for the typical consumer. Sometimes, the process to activate a benefit can be so onerous that consumers report they are unable to access money or services that were marketed to them.

  Carriers should also make it possible for consumers to designate third parties who can query carriers for data on utilization of benefits, such as the remaining balance on a grocery or over-the-counter allowance. This data will help

[1] Memoir, Inc., d/b/a Chapter ("Chapter") is a privately owned, data and technology-enabled advisory that helps older Americans navigate retirement *(http://askchapter.org/).* Licensed insurance agency services are provided through Chapter's wholly owned subsidiary, Chapter Advisory LLC. In California, Chapter Advisory LLC does business as Chapter Insurance Services.

designated third parties build tools that help consumers to understand and use the benefits that were marketed to them.

- *Better ways to help consumers confirm Medicaid or LIS/Extra Help Status:* Many lower-income consumers are unsure if they are eligible for programs like Medicaid or the Low-Income Subsidy, or they are uncertain of their level of support. Eligibility for these programs can often materially reduce the copays or out-of-pocket responsibility that consumers face for certain medical services and/or prescriptions, and accordingly impact the plan selection process. It would be helpful for brokers to have direct access to reliable systems to help consumers verify their Medicaid and LIS/Extra Help status, contingent on receiving appropriate consent from the consumer. Without this information, consumers risk making poorly-informed decisions about their Medicare choices.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

Question. Part of the information overload that so many older Americans experience when trying to enroll in a health plan is a result of deceptive marketing from private insurance companies.

Around this time of year, older Americans are inundated with advertisements, phone calls, and mail regarding Medicare enrollment.

CMS has reported that complaints related to marketing for Medicare Advantage plans—run by private insurance companies—more than doubled in 1 year, from less than 16,000 in 2020 to nearly 40,000 in 2021.

And many plan directories list inaccurate information about providers—further complicating the process.

In an investigation led by Chairman Wyden last year, this committee found two Medicare Advantage plans in Ohio where 75 percent of the providers listed as in network were inaccurate or unavailable. This is unacceptable.

What can Congress do to continue to improve the oversight of these harmful marketing practices?

Answer. As I mentioned in my written testimony, we support the following principles that Congress and policymakers can consider as part of their work to improve Medicare Advantage marketing and the broader Medicare marketplace.

- *Consumer-first standard:* Any trusted guide used by a consumer should be obligated to place consumers' interests first. This is not the status quo. Most Medicare guides put consumers' interests below their own. There are thousands of Medicare plans available across a variety of plan types. This diversity of options means that consumers can find excellent coverage, but they often need a trusted guide to help them through the process. Government programs like State Health Insurance Assistant Programs and 1–800 Medicare, while helpful, cannot provide the personalized, plan-specific, and longitudinal support that private Medicare brokers can provide to guide consumers. Furthermore, efforts to further standardize broker compensation, while well-intentioned, do not solve the fundamental issue if brokers are still permitted to contract with—or search—a subset of insurance plans. We believe that only an affirmative ethical and regulatory obligation to put consumer interests first, in part by requiring a search of all available options (as discussed below), will be sufficient to fix many of the issues plaguing Medicare marketing.
- *Information across all types of Medicare plans:* Consumers deserve to be informed about all types of Medicare plans that are available to them. These include Medicare Supplement Plans, standalone Part D prescription plans, coverage under original Medicare, Medicare Advantage plans, and Special Needs plans.
- *Complete coverage search:* Any trusted guide—whether a broker or another entity—should be obligated to consider every option available to the consumer. Consumers should never receive a limited set of options or a suboptimal recommendation simply because a broker works with a limited number of carriers. Today, there are very few, if any, resources—aside from Chapter—that check every option available to a consumer.

- *Transparent and accessible plan data:* Consumers and their trusted guides must be able to easily search and compare plans based on their full features. These include plans' provider networks, formularies of covered drugs, ancillary benefits, and the premiums, out-of-pocket limits, and costs of each service, prescription, and benefit. The complexity of Medicare plans requires clear transparency on the specific differences between plans, and consumers cannot reasonably be expected to wade through hundreds of pages of Summaries of Benefits or Evidences of Coverage to understand these items.
- *Transparency in advertisements:* Third-party marketing organizations and lead generators should be required to clearly identify who they are and the specific organization that will contact the consumer—or which the consumer is being prompted to contact.
- *More online transparency:* CMS and carriers should make plan information available through open APIs that brokers and others can use to make comparisons more understandable and transparent for consumers.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. I've heard from multiple constituents enrolled in Medicare Advantage that their trusted providers were removed from their insurers' networks without notice. One constituent enrolled in a Medicare Advantage plan without realizing that his network of providers would be very limited. At one point, he was seeing a University of Washington doctor for a knee injury. The doctor recommended a knee replacement, and the constituent wanted to move forward with the procedure. However, his Medicare Advantage plan then told him that the doctor he saw was no longer in network and told him he had to use a different surgeon. The surgery was not urgent, so my constituent was able to wait until he could switch plans during the next enrollment period and then saw his surgeon of choice.

The lack of transparency around who is and is not in network creates administrative headaches and confusion for patients. When people are choosing their plans, they sometimes cannot find clear information about which providers are in network at each plan. Across health insurance plans, networks are often outdated. Some insurance plan directories even include listings for doctors who are no longer accepting insurance or have died. This confusion is unacceptable. Medicare recipients should not be forced to spend hours calling around to figure out whether their plan will let them see their doctor. It's also devastating for them to build trust with a provider, only to then find out that the network changed and they have to start over with someone new.

In your written testimony, you describe how *Medicare.gov's* Plan Finder could be a useful resource to help patients pick a plan based on its network of providers if it was structured in a more user-friendly way.

What should *Medicare.gov* change to make this tool more useful for consumers?

Answer. We would suggest several changes:

- Medicare.gov *should provide structured data via APIs on all relevant benefit components, including prescription retail prices and provider networks.* While *Medicare.gov* does provide a significant amount of data via APIs, there is more it must provide to adequately inform consumers. There are many private organizations that can build helpful tools for Americans, but *Medicare.gov* does not provide sufficient data today to support this innovation ecosystem.
- Medicare.gov*'s Plan Finder should be improved to allow consumers to search or rank plans based on provider network status.* It is not possible to search provider network status on *Medicare.gov* today.
    - This improved functionality will require *Medicare.gov* to collect and structure data on every plan's providers, National Provider Identifier (NPI), site of practice, and network status with respect to each Medicare Advantage plan.
    - The Medicare Advantage program permits and encourages insurance companies to design networks of preferred providers to promote quality and cost-effective care, but the Medicare program and insurance carriers must do a better job in making network information available to consumers.

- *Consumers should be able to search plans' supplemental benefits in a more effective manner.*
    - Currently, consumers cannot use the tool to compare plans based on the size of a benefit, like the amount of coverage for dental services.
    - Consumers can only search for plans that have *any* level of coverage for services like dental care or hearing aids, but the amount of coverage for these benefits varies tremendously across plans.
- *Prescription costs from direct-to-consumer options:*
    - While *Medicare.gov* does allow consumers to input prescription drug information and search among plans, it does not allow consumers to see if there are more cost-effective options for filling their prescriptions.
    - For instance, many retail drug discount programs or direct-to-consumer pharmacies currently offer more affordable copays on several prescriptions, relative to the majority of Part D plans. If *Medicare.gov* surfaced copays not only across Part D plans (and the Part D benefits included in many Medicare Advantage plans), but also across these direct-to-consumer options, consumers could save significantly more on their medications.

Question. The American Psychological Association has noted that workforce shortages and inaccurate networks make it particularly hard for mental health patients to find care. Sometimes, a listed provider is overwhelmed and cannot actually accept new patients.

Should networks be required to display a "limited availability" marker to indicate whether a provider can accommodate new patients?

Answer. Yes, provider networks should show accurate and up-to-date information on whether a provider is accepting new patients.

While some carriers already provide this information, it is often inaccurate or out of date.

However, I should also acknowledge that providers share a significant part of the responsibility here. It is not reasonable to expect an insurance company to independently track whether any given provider—who likely also sees patients from many other insurance companies—is able to accept new patients. Solving this problem will likely require collaboration across providers, insurance companies, and CMS.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. I'm excited to hear the ways your company has harnessed technology and data analytics to provide consumers with transparent information about their Medicare benefits. Medicare Advantage provides consumers with options to choose a plan that works best for their health-care needs.

In your testimony, you mention that Medicare Plan Finder currently lacks sufficient data to provide transparent information on the differences between plans. In your experience, how can this exchange of data from plans to CMS be improved? How have companies like yours addressed this problem?

Answer. At Chapter, we integrate data from many sources to build a more complete picture of a Medicare plan. We ingest data from *Medicare.gov* and other government sites, as well as from insurance carriers and private data providers. We ingest data from multiple sources because there is no single source that has all of the data required to make a comprehensive or consumer-first Medicare plan recommendation. We also provide longitudinal support to ensure a positive beneficiary experience that allows us to support the user over time.

We would recommend that CMS provide more data via API to third parties. While *Medicare.gov* does provide significant data to third parties, it does not provide information on provider networks or retail prices at pharmacies. This means that if Chapter relied only on *Medicare.gov*'s data alone, we would not have access to provider network or prescription pricing data—two of the most critical inputs into plan selection.

Furthermore, insurance carriers should share provider network data with CMS and with the public. Insurance carriers should also share structured data on plan benefits and how to use them with CMS and with the public.

PREPARED STATEMENT OF HON. MIKE CRAPO,
A U.S. SENATOR FROM IDAHO

This hearing comes at a crucial time, as millions of Americans evaluate Medicare coverage options during the annual open enrollment period. During this window, seniors and many Americans with disabilities have the opportunity to select a Medicare Advantage, or "MA," plan that best fits their needs.

I have long championed MA for its success in leveraging market-driven competition to offer patients access to a wide range of cost-effective coverage choices. The vast majority of MA plans cover services not available under traditional Medicare, including for dental, vision, and hearing health needs.

With consistently high satisfaction rates and low premiums, MA's market dynamism serves as its strength, not its weakness.

That said, the complexity of the health-care system poses significant challenges for Americans from all walks of life, including those enrolled in MA plans. Seniors need clear, credible, and accurate information to navigate the coverage and service landscape. Fortunately, a variety of resources and tools can help guide Medicare beneficiaries through the decision-making processes this opaque system requires.

However, the Federal Government's Medicare Plan Finder, a decision-support tool outlining coverage choices, can prove cumbersome and confusing, often displaying out-of-date or otherwise inaccurate data. As we consider options to ease enrollment, we should assess solutions that improve Plan Finder by integrating more relevant information and enabling more user-friendly navigation.

Furthermore, we should examine opportunities to empower effective insurance brokers, who serve as key community-based resources and access points, including in the context of MA plan enrollment. Through common-sense patient protections and targeted transparency, we can promote a vibrant and competitive broker landscape, assisting seniors while preventing deceptive marketing and other problematic practices.

Practical guard rails, however, cannot come at the expense of patient privacy or a functional marketplace. With all policies under review, we have an obligation to consider both confidentiality concerns and administrative burden.

I look forward to hearing thoughtful ideas about how to improve the enrollment process by better aligning incentives and increasing transparency. With common-sense, consensus-driven and market-based solutions, we can ensure broad access for seniors to all of the tools needed to make crucial, informed coverage decisions.

PREPARED STATEMENT OF KRISTA HOGLUND, A.S.A., MAAA,
CHIEF EXECUTIVE OFFICER, SECURITY HEALTH PLAN

Chairman Wyden, Ranking Member Crapo, members of the committee, it is my honor to be here today to represent Security Health Plan and our clinical partners at the Marshfield Clinic Health System to discuss Medicare Advantage (MA). Today, more than half of eligible seniors across the country receive their Medicare coverage through an MA plan. By 2030, the Congressional Budget Office estimates that more than 6 in 10 seniors will choose MA. Creating a well-functioning MA program that empowers beneficiaries to select a plan that meets their needs while protecting against misleading and aggressive enrollment practices, as well as unscrupulous marketing tactics, is crucial to the long-term success and sustainability of the program.

While work by this committee has helped improve marketing practices, more work remains. Today, creative new payments flowing through independent third-party entities are adding unnecessary costs and fueling misleading marketing practices in the MA market. At a time when the solvency of the Medicare trust fund is paramount, I urge Congress and the Centers for Medicare and Medicaid Services (CMS) to protect enrollees and taxpayers with reasonable limits on total compensation and stop misleading and aggressive enrollment practices.

BACKGROUND

Headquartered in central Wisconsin and serving 225,000 members across Wisconsin, Security Health Plan is the fifth largest health plan by membership and sixth largest by premium volume in Wisconsin. Security Health Plan is a not-for-profit health plan with group commercial coverage for large and small employers, individuals, and families through the federally facilitated marketplace, Medicare and Medicaid beneficiaries, plus benefit administration for self-funded employers.

Security Health Plan was founded over 50 years ago as one of the first physician-sponsored health maintenance organizations in the country. The goal of the organization then was to offer high-quality, affordable health coverage for the communities we serve. This mission has not changed. We are pleased to continue this legacy of serving the communities we call home. Security Health Plan has routinely been recognized as a quality leader, earning four stars or above from the Centers for Medicare and Medicaid Services (CMS) for our MA program, as well as recognition for superior customer service and enrollee satisfaction.

We are part of the Marshfield Clinic Health System, an integrated health system serving Wisconsin and northern Michigan. Our 1,400 providers deliver care for 3.5 million patient encounters each year across our eleven hospitals (including 3 critical access hospitals) and over sixty ambulatory clinical sites in over 40 communities. Half of the ambulatory facilities are in communities of less than 4,000 people. Marshfield Clinic Health System is one of the largest fully integrated health systems serving residents from locations in rural communities. The system's primary service area encompasses over 80 percent of the rural population of the State of Wisconsin. We are the largest provider of primary and specialty care in our region including services provided to children through our very own Marshfield Children's Hospital. Marshfield Clinic Health System is also a teaching health system, providing over 1,300 students with over 2,300 educational experiences annually throughout our system. The Marshfield Clinic Research Institute is the largest privately funded research entity in the State of Wisconsin.

I have had the pleasure of serving as the CEO of Security Health Plan for the last 2 years. Prior to my role, I served as the chief financial officer and chief actuary at Security. With nearly 20 years of actuarial experience, I am perhaps the rare CEO with firsthand experience developing MA products, Part D plans, and many other benefit offerings. In addition to my CEO role, I also serve on the executive committee of the board of directors of the Alliance of Community Health Plans (ACHP), the only national group representing nonprofit, provider-aligned, regional health plans. As a result, I have a multifaceted understanding of the MA program, its competitive landscape, and the needs of the enrollees served by the program.

SERVING RURAL WISCONSIN

A vast majority of Security Health Plan's service area comprises the most rural areas of Wisconsin. Research has shown that residents of rural communities are older, sicker, and poorer than their urban and suburban contemporaries.[1] They are also more likely to face chronic conditions, and social factors that negatively impact their health.[2] In Wisconsin, our demographics are shifting significantly; in over ten counties we serve there are less than two workers for every Medicare beneficiary.[3]

As a provider-sponsored health plan, Security Health Plan is committed to working with our clinical partners to create a true system of care. This allows us to deliver the best care for members and maximizes the value of the health-care dollar. For Federal programs such as MA, that means lower costs to the taxpayer and senior.

MEDICARE ADVANTAGE

MA is the choice of America's seniors—nearly 32 million and counting. CMS projects that MA enrollment will reach nearly 34 million in 2024. In 22 States—and growing—a majority of Medicare-eligible seniors are enrolled in the managed care alternative to traditional fee-for-service Medicare. Most beneficiaries enjoy access to zero-dollar premium plans with prescription drug coverage and other additional benefits included.

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[1] Centers for Disease Control and Prevention, Rural Health, *https://www.cdc.gov/ruralhealth/about.html.* Updated May 9, 2023.

[2] *Ibid.*

[3] Bureau of Labor Statistics, county employed as of July 2022. Medicare data source: Centers for Medicare and Medicaid Services, Medicare county enrollment as of July 2022.

MA serves a diverse population, including a majority of Hispanic, Black, and Asian American seniors. Without sacrificing quality, MA enrollees spend almost $1,600 less a year on out-of-pocket costs compared to those enrolled in traditional Medicare. Most MA beneficiaries also pay no premium. With consistently high quality ratings, expanded benefits, and a record of reaching minority populations, this public-private partnership is an undeniable success.

Security Health Plan has offered MA for 2-plus decades, proudly serving more than 60,000 beneficiaries today across central, western and northern Wisconsin. Our MA offerings provide beneficiaries a wealth of choices from $0 premium plan options to benefit-rich, minimal out-of-pocket cost plans and a dual-eligible Special Needs Plan.

However, in recent years, enrollment growth has not been evenly distributed across the MA market. For example, in the most recent Medicare open enrollment period, two-thirds of the Nation's enrollment went to just two national companies. More than 80 percent of total MA enrollment went to for-profit companies. It is imperative to support broad participation by plans to ensure a thriving MA program. This leads to more consumer options, program innovation by plans, and better stewardship of Medicare dollars.

In the last 2 years, Security Health Plan has experienced double the historical average attrition, after sustaining retention rates of over 95 percent for the previous decade. Coupled with declining net growth in the MA market among smaller plans, this clearly signals a shift in the environment.

Unfortunately, nearly 100 percent of these members are moving to competitors who have higher administrative costs. This equates to higher rates for the Medicare trust fund and more costs for seniors. Worst of all, members are not always getting the coverage that they deserve or that would be most beneficial to them. We must ask ourselves whether this trajectory is in the best interest of Medicare beneficiaries and the Medicare program overall.

MEDICARE ADVANTAGE MARKETING—PROTECTING SENIORS AND THE FEDERAL DOLLAR

As MA grows in popularity, it is vital to ensure that beneficiaries receive comprehensive and accurate advice throughout the selection and enrollment process. At Security Health Plan, our priority is to assist beneficiaries in selecting a plan option that best fits their needs and budget—even if that means referring them to another company. Each year we engage beneficiaries in our local communities with educational and product seminars and online webinars.

We continue to be very supportive of the marketing changes made by CMS and appreciate the Senate Finance Committee's MA marketing investigation and report which propelled action last year. It has started to make a difference, but it must be acknowledged that we still have a lot of work to be do.

According to recent research by the Commonwealth Fund, seniors are inundated with information about MA, and marketing materials attempting to influence their decision. The study found nearly all people aged 65 and older said they received some plan marketing last year, with three-quarters seeing one or more television or online ads per day. One in three reported receiving seven or more phone calls per week even though cold calling is prohibited by CMS marketing guidelines.[4] During Medicare open enrollment, it is difficult to turn on a television and not see a MA ad. For all the progress we have made, challenges still exist. Just last week, in a conversation with a trusted broker partner, he described the ambush that has already begun with his clients receiving as many as five phone calls per day. Clients are overwhelmed with the promise of false benefits so much that his team is barely even able to keep up with the confusion and questions, let alone seek and support new enrollment.

BROKERS AND FIELD MARKETING ORGANIZATIONS

The task of educating current and potential MA beneficiaries about their options cannot be accomplished by one entity. CMS plays a crucial role in educating beneficiaries about their options. And, from our own market research, we know recommendations from friends and family also play a large role in the decision-making

[4] "The Private Plan Pitch: Seniors' Experiences with Medicare Marketing and Advertising." The Commonwealth Fund, Issue Brief, September 12, 2023.

process However, the single most influential perspective in choosing a MA plan remains advice from a broker.[5]

Let me be clear, we value the important role that brokers play in our efforts to educate, sell our products, and support our members. Brokers are a trusted partner for Security Health Plan, and health plans across the country. In fact, 85 percent of our MA enrollment at Security Health Plan comes from more than 500 brokers across our service region that we are proud to partner with. Unfortunately, we know that some large firms and third-party marketing organizations leverage their influence for financial gain rather than what may be in best interest of the consumer.

The explosion of large field marketing organizations in recent years has created a compensation structure that makes it more difficult for smaller, regional plans and their local independent agent partners, to compete. Many of these field marketing organizations receive "add-on" or incentive payments that go above and beyond the CMS-approved broker commission caps. Instead of collecting the maximum commission of $611 for a new enrollee, many brokers are collecting $1,300 or more. This additional compensation is marked as marketing or administrative dollars and can also include incentives for members completing a health risk assessment or vague application of referral bonuses.

There have also been reports of large carriers financing service expansion into new territories with the expectation of the brokers supporting preferred plans. This creates an environment in which beneficiaries, and ultimately the Medicare program itself, are paying out additional and unnecessary dollars.

Colleagues from across the country have shared anecdotes of large carriers and third-party marketing organizations implementing quotas or exclusivity for enrollment and threatening to terminate contracts if targets are not met. This may explain the incentive for such aggressive sales tactics.

These dynamics result in real-world consequences. Just last week, an MA member called our plan to complain that an agent falsely representing Security Health Plan was cold calling her to market another plan. In a previous Medicare open enrollment period, our team assisted a member who was tricked into enrolling in another plan. We worked with the member to re-enroll with Security Health Plan not once, but four times during that single open enrollment period.

WHAT DOES THIS ALL MEAN?

The result of these and other practices is that consumer's options can be unfairly and unnecessarily skewed because of perverse incentives when it comes time for a consumer to select an MA plan. The current structure creates an unlevel playing field. The ability of smaller, regional health plans like Security Health Plan, to compete against larger, national carriers is drastically impacted. Less plan choice and less competition will not serve our beneficiaries well. Less competition between MA plans will mean less pressure to keep costs low, less innovation and less incentive to add additional benefits. This is a disservice to beneficiaries and taxpayers.

In competitive markets like ours, the current structure not only limits our ability to be successful, but it also runs counter to our long-standing commitment to be a good steward of the Medicare dollar. We have been forced to make tough decisions between adding extra benefits for seniors and lowering costs or increasing our administrative budget to keep pace with national competitors in order to retain and grow enrollment. This is a position no health plan should be in. Our goal should be to limit administrative expenses, maintaining our primary focus on designing well-rounded benefits that support the health and well-being of our members.

WHAT CAN BE DONE

Medicare enrollees deserve a robust and competitive insurance marketplace, where competition between plans benefits them, as well as the overall program. Unfortunately, trends in the market point toward a more difficult operating environment for smaller, regional health plans. The consequences of this will be decreased MA offerings for beneficiaries, and likely higher costs for seniors, and the Federal Government.

I urge you to engage with CMS to review the practice of add-on payments to ensure that competitively unfair practices are inhibited, especially total payments above and beyond the CMS approved levels. Further, CMS and regulators must re-

[5] *Ibid.*

main vigilant in enforcing marketing rules that protect seniors from misleading and aggressive marketing tactics. Brokers must be compensated fairly, while removing misaligned incentives for large third-party organizations. Limiting or capping these payments would protect the integrity of the Medicare program and its beneficiaries as well as make great strides in restoring the competitive balance among Medicare Advantage plans.

As a board member of ACHP, I endorse the organization's *MA for Tomorrow* initiative. *MA for Tomorrow* includes specific proposals to safeguard beneficiaries and ensure an unbiased enrollment process by regulating the total compensation health plans may pay to brokers. Valuing the essential role brokers offer in helping seniors understand the coverage options available and to find the health plan best suited to their needs, ACHP offered three immediate changes to ensure brokers remain sufficiently compensated for assisting beneficiaries while ensuring health plans appropriately utilize Medicare dollars to compete for enrollment based on quality and care.

1. **Standardize and limit the add on payments tied to broker compensation.** Curbing the growth of broker add on payments would address misaligned incentives. CMS has the authority to build on compensation standards to protect the integrity of the Medicare dollar by limiting total broker payment and preventing steering based on broker compensation.
2. **Create incentives for enrolling beneficiaries in high-quality and value-based plans.** Brokers should be rewarded if they match a senior with a health plan that is high quality (star rating of 4 or higher) and advances value-based care.
3. **Require plans to report total broker compensation.** Consistent and annual reporting would shed light on an issue that currently has little to no data. Transparency on how much of a health plan's marketing dollars go to brokers (not just the commission) is an essential step toward evaluating the MA broker market.

CONCLUSION

Chairman Wyden, Ranking Member Crapo, members of the committee, again I am honored to be here today advocating on behalf of Security Health Plan, other health plans, and most importantly MA beneficiaries. MA is a vital and popular program enriching the lives of seniors across our Nation. Continuing to support its evolution to meet the needs of beneficiaries is crucial. Creating a well-functioning MA program that protects beneficiaries and supports them in making well-informed decisions is crucial to the long-term success and sustainability.

I thank you for your time this morning and welcome the opportunity to answer your questions.

QUESTIONS SUBMITTED FOR THE RECORD TO KRISTA HOGLUND, A.S.A., MAAA

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

Question. I am very concerned about the impact that current Medicare Advantage marketing and enrollment practices have on patients who live in areas without many options for providers and experience high costs in affording their health care.

In Ohio, more than half of all Medicare beneficiaries choose to enroll in a Medicare Advantage plan—but many do so without knowing that the area where they live may have limited options for in-network providers.

You mentioned in your testimony that nearly two-thirds of enrollment in Medicare Advantage went to two national companies.

Can you elaborate how this impacts people living in underserved areas, particularly rural ones?

Answer. First, it is important to recognize what you mentioned, that Medicare Advantage is a very popular and effective coverage option for individuals in underserved areas, including rural areas. In the past, there has been a strong misconception that MA was only viable for enrollees in more populous areas. The fact is, the vast majority of eligible individuals have access to plans that can meet their needs, no matter where they live.

Market concentration in MA growth, especially in recent years, has primarily impacted enrollees by creating situations where larger MA organizations theoretically use their market influence to force contract concessions by providers in their service areas. This can affect rural areas different than other service areas because of the limited access to care for residents. Care providers can be forced to accept disadvantageous contract terms, or exclude MA plans altogether. Both of these circumstances harm patients and their ability to access the care they need in the most appropriate and convenient setting. Concurrently, it can limit their ability to choose programs like MA in the first place, limiting their ability to benefit from the program's track record of helping enrollees maintain their health and well-being.

This all results in a less competitive marketplace. Plans have less incentive to control costs, or be strategic in pricing their products. This means less innovation and creativity in building impactful and effective plans that responsibly control Federal Medicare spending. This also means that plans may have less incentive to expand their service area. In fact, these circumstances may force plans to make the difficult decision to reduce their offerings in certain regions. Altogether, this means less options and less competition in the MA market.

Question. Part of the information overload that so many older Americans experience when trying to enroll in a health plan is a result of deceptive marketing from private insurance companies.

Around this time of year, older Americans are inundated with advertisements, phone calls, and mail regarding Medicare enrollment.

CMS has reported that complaints related to marketing for Medicare Advantage plans—run by private insurance companies—more than doubled in 1 year, from less than 16,000 in 2020 to nearly 40,000 in 2021.

And many plan directories list inaccurate information about providers—further complicating the process.

In an investigation led by Chairman Wyden last year, this committee found two Medicare Advantage plans in Ohio where 75 percent of the providers listed as in network were inaccurate or unavailable. This is unacceptable.

What can Congress do to continue to improve the oversight of these harmful marketing practices?

Answer. MA enrollees need to be guaranteed that they can access care in a reasonable time frame when they need it, and close as practical to their homes. That being said, overly prescriptive or arbitrary time and distance standards can sometimes be onerous. They create undue burden on MA sponsors that dilute our ability to construct provider networks that effectively and responsibly balance patient access with cost controls that in the end benefit enrollees and the program's finances overall.

The issue of ghost networks that you speak of are a disservice to the MA program, and to the enrollees in the program. I know that Security Health Plan, and many other plans, commit significant resources to construct thoughtful networks that meet the needs of our patients. However, even under the best of circumstances, it can be difficult for health plans to maintain perfect records of providers available as providers change location, retire or change their offerings. Offering misleading information to induce an individual to enroll in a particular plan is wrong. Consumers should have faith that the information they are relying on will be as factual as possible. Unfortunately, they often discover the truth in the worst possible way, at the worst possible time. I appreciate the work that the committee has done on this topic to date and urge you to continue to remain vigilant on this issue moving forward.

Collectively, we must do more to ensure that enrollees have a complete picture of the network that they are engaging with. At the same time, I urge you to recognize that health plans can only do so much in regard to maintaining good data. We invest significant resources and energy to do all that we can to have as current of provider directories as possible, but we are at the whim of data that providers offer. Any further regulation of provider directories should have specific considerations related to intent of any discrepancies or omissions that may be identified through audits or investigations, and have mechanisms to determine which party is most responsible for these omissions/errors.

QUESTION SUBMITTED HON. JOHN THUNE

Question. In your testimony you discuss how Security Health Plan has prioritized lowering administrative costs. For several years I've led legislation with Senator Brown—the Seniors Timely Access to Care Act—that seeks to streamline the prior authorization process and address the administrative burden prior authorization can have on physicians in Medicare Advantage. I believe improving the transparency of prior authorization can bring efficiencies to the health-care system that will ultimately reduce cost and improve access to care.

Where do you see opportunities within your prior authorization process to reduce administrative burden and reduce costs for Medicare beneficiaries?

Answer. Security Health Plan uses prior authorization as an important tool to ensure members receive evidence-based care, at the right time and in the right setting. When functioning optimally, utilization management helps to not only ensure the safety of members, but also helps to keep premium costs affordable by avoiding unnecessary or inappropriate care.

Opportunities exist in the form of removing barriers in communication between providers and the health plan and looking for new ways to ensure that members are getting evidence-based care that meets their needs while not adding to their out-of-pocket costs for health care. This is an area which integrated system plans like Security Health Plan are uniquely positioned to innovate and find ways to streamline processes. Our connection with our clinical partners allows for easier data exchange, and quality control for recurring errors that may occur. The most common reason for delays in the processing and appeals of initial findings is incomplete data.

The emergence of new technologies offer exciting opportunities to streamline prior authorization even more than today. Systems are being developed and tested where artificial intelligence can be use responsibly to conduct preliminary analyses that are then reviewed and either affirmed or rejected by a clinician. These efficiencies expand that ability of staff to give more attention to complex situations, as well as instances where more information is necessary. Security Health Plan has found success in removing authorizations that are no longer providing value because providers are following the evidence-based guidelines whenever possible. Leveraging analytics we can facilitate faster turnaround for those providers with proven track records, and also create objective standards for providers to understand the steps they need to take to achieve this higher-level approval.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. A Washington State constituent worked with a broker when picking his Medicare plan, and that broker omitted critical information that would have helped my constituent make an informed decision about his coverage. The broker told him about various benefits of Medicare Advantage, like lower premiums, but did not disclose the downsides of Medicare Advantage such as limited networks. My constituent also did not know that the broker was being paid more to enroll people in Medicare Advantage plans than traditional Medicare.

In the end, my constituent trusted that the broker was sharing the whole truth with him and signed up for the Medicare Advantage plan. The broker got his higher commission, but my constituent was surprised when he faced burdensome prior authorization requirements and limited provider options because of his Medicare Advantage plan.

This problem is not limited to constituents in Washington State.

Research conducted by the Commonwealth Fund confirmed that brokers and agents are indeed paid more to enroll people in Medicare Advantage plans than traditional Medicare. In fact, one broker said they were paid three times more for selling a Medicare Advantage plan. These incentives are clearly misaligned. People should be making coverage decisions based on their health-care needs, not the sparse information brokers decide to share with them—especially when brokers are financially incentivized to enroll people in Medicare Advantage plans.

The Centers for Medicare and Medicaid Services has a $611 payment limit per enrollee for brokers enrolling new beneficiaries, but companies are not being transparent about opaque fees they pay their brokers to circumvent the rules. Research found that brokers can earn over $1,300 per consumer who enrolls in a Medicare Advantage plan.

Should there be more transparency in how much brokers are actually receiving in additional payments?

Should plans be required to publicize how much they pay their brokers?

Answer. Yes, there should be more transparency about how much payment brokers receive for each enrollment, that is both commission and the additional payments outlined in my prepared testimony. Not only is transparency needed, but I urge the committee to support efforts by CMS to cap overall broker compensation through regulatory action.

I am sorry to hear about the experience of your constituent and am frustrated by the fact that I know he is far from alone in this predicament. That being said, I do not want to lose sight of the vast majority of brokers that are critical partners to my organization and organizations across the country. Broker colleagues are trusted partners in educating and engaging with enrollees.

The best course of action is to eliminate the incentive to utilize field marketing organizations, third-party marketing organizations and inappropriate marketing practices that harm seniors and unfairly skew the market. A functioning market will ensure sufficient competition between a number of plans that will benefit enrollees, as well as incentivize innovation among plans to expand benefits while keeping costs low for individuals and the Federal Government on a macro level.

Question. According to the Commonwealth Fund, one in three Medicare beneficiaries use an insurance broker to help them pick a plan.

Is there enough regulatory oversight over how much these brokers are paid?

Answer. The short answer is no. CMS has long established the maximum commission a broker can receive for a new enrollment, or a reenrollment in the same plan. However, in recent years, we have seen a number of creative payments that seek to circumvent these regulatorily established limits. The result is that the marketplace is skewed in favor of the organizations that are able to pay brokers more for enrollments. This reduces market participation and competition, especially among smaller regional plans like my organization.

What we need is a cap on overall broker compensation that goes beyond the commission payments. This would create a more equal playing field for all sizes of plans. This would result in greater options for consumers, and a reduction in the costs to the Medicare program.

Question. Long wait times for prior authorization approvals delay necessary care for patients, which often leads to worse health outcomes.

The Improving Seniors' Timely Access to Care Act, which I support, will increase transparency and standardize the prior authorization process in Medicare Advantage to help ensure that care is not needlessly delayed.

I support the administration's efforts to adopt many of the provisions of that bill, and I urge the committee to continue to pursue policies to ensure that MA plans are not throwing up unnecessary barriers to care.

What are your internal processes and timelines for prior authorization approvals, and do you think that greater guard rails around prior authorizations in MA plans would be helpful for smaller plans like yours to fairly compete?

Answer. Security Health Plan makes utilization management decisions of pharmaceutical, medical and behavioral health benefits in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Maximum time frames are defined by CMS and must be followed by all MA plans. However, we strive to make decisions as soon as possible, taking into account the clinical urgency of the member's situation.

Effective utilization management in any insurance program should use the best available information, data and clinical guidelines to make decisions that are in the best interests of patients and their well-being. Innovation in this space is moving at a rapid pace. The integration of new tools and technologies in a responsible and ethical manner are crucial to supporting a functioning system. As new technologies become operational, I would urge regulators to ensure oversight that is thoughtful and geared toward protecting patients. Steps should be taken to guard against bias and unfair processes in new technologies like artificial intelligence. Further, access to new tools and technologies should not be unfairly limited. New technologies and innovations will also require significant investment that will need to be addressed

to ensure that some actors are not unfairly advantaged to the detriment of competition in the market and the enrollees that rely on a variety of types of plans.

PREPARED STATEMENT OF CHRISTINA REEG, OHIO SENIOR HEALTH INSURANCE INFORMATION PROGRAM DIRECTOR, OHIO DEPARTMENT OF INSURANCE

Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee. Thank you for the opportunity to appear before you today to share the State of Ohio's work to ensure Ohioans receive factual and unbiased information to make decisions regarding their health and prescription drug coverage.

My name is Christina Reeg, and it is an honor to appear before you. I am the Program Director for the Ohio Senior Health Insurance Information Program (OSHIIP) at the Ohio Department of Insurance. OSHIIP is one of 54 Federal grant programs providing objective counseling and education to Medicare patients, their families, and their caregivers. SHIPs provide factual and unbiased information, empowering consumers to make educated and individualized decisions regarding their health and prescription drug coverage. OSHIIP prides itself on excellent customer service and consumer protection, evident by our top ratings in all five national performance measures.

Two thousand twenty-three marks my 26th year with OSHIIP, my 11th year as the director. I began my career traveling to Ohio's 88 counties (including 29 Appalachian), providing in-person Medicare counseling, education, and program development—I was literally the "boots on the ground." I really enjoyed my time as a training officer meeting with aged and disabled Ohioans to discuss Medicare Part A, Medicare Part B, and the 10 standardized Medigap plans as needed.

This month our program began counseling Ohio's now 2.5 million Medicare beneficiaries, to help them make educated decisions for their 2024 coverage. To accomplish this, OSHIIP operates in a hybrid model to provide education and counseling both in person and virtually. Additionally, we use social media, paid and earned media, regional phone banks, and grass-root efforts to promote our services.

The information we present now is vastly different from my early days with OSHIIP. For example, if we are counseling a beneficiary in Cleveland, we are reviewing 85 Medicare Advantage Plans, 29 Special Needs Plans, three Medicare-Medicaid Plans, 21 stand-alone prescription drug plans, in addition to original Medicare and Medigap. Most Medicare beneficiaries won't review or change plans because the task of comparing seems too daunting.

To help narrow the field of choices, OSHIIP uses the Medicare Plan Finder. This web-based tool helps determine if a Medicare beneficiary's current prescriptions will be covered, share all possible out-of-pocket costs, and plan details. *Medicare.gov* does not provide a network list for managed care plans, but links to the companies' websites. Plan websites are often hard for beneficiaries to navigate alone, and lists may be outdated. We encourage beneficiaries to contact their preferred providers directly and ask pointed questions. For example, we provide the beneficiary with specific Medicare advantage plan information including the contract number and stress the importance of being specific when communicating with their providers.

Counseling Ohio's low-income and limited-health-literacy Medicare population brings added challenges. These individuals are more apt to join a plan based on added benefits, specifically over-the-counter allowances, or other cash rewards. Also, many are applying for Extra Help, Medicare's assistance with out-of-pocket drug costs, for the first time. Delays in that application process, even when automatic, often lead to affordability issues at the pharmacy window. Finally, the special enrollment for low-income individuals is often misused placing consumers into managed care plans more often than the quarterly allowance. OSHIIP assistance is often reactive when a beneficiary finds themselves having difficulty receiving needed care or medication.

In my time with OSHIIP, I have witnessed extreme growth. Growth of the Medicare population, growth within the scope of SHIP work, and extreme growth in plan options. Our Medicare consumers are overwhelmed by the volume of options in every county, they are flooded with plan marketing and often confused by the variance in plan benefits, networks, and added benefits. The desire to have the advertised "benefits you are entitled to," or the cash benefits for over-the-counter goods, utilities or other wants masks the need to review critical plan health benefits, pre-

scription drug coverage, and plan networks. This often leads to poor enrollment decisions and undesirable outcomes.

Medicare beneficiaries would benefit from additional oversight. A personalized Annual Notice of Change (ANOC) would assist beneficiaries in better identifying plan changes, such as higher premiums and copays, from year-to-year. Stronger oversight on utilization of special election periods, such as the low-income subsidy special enrollment period (LIS SEP), and a block on enrollments for those with cognitive impairments could minimize improper sales to our most vulnerable beneficiaries. Reinstatement of measurable differences when approving plan contracts would help contain the volume of plans in each county. These actions could make the process of choosing and enrolling in a Medicare plan less intimidating.

I am happy to answer any questions and remain dedicated to providing unbiased information and providing the highest level of consumer protection for Ohio's Medicare beneficiaries.

QUESTIONS SUBMITTED FOR THE RECORD TO CHRISTINA REEG

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. For 2024, seniors in Tillamook County, OR will no longer have access to a Medicare Advantage plan. With no other carriers offering Medicare Advantage plans, my constituents in Tillamook County who want Part D drug coverage and supplemental health coverage in addition to Medicare will need to purchase a Medicare supplement and/or a stand-alone drug plan.

While there is a 60-day special enrollment period (SEP) for those interested in joining Medigap, after that period seniors no longer have important enrollment protections such as no underwriting and no waiting periods for preexisting conditions. For those who have been covered by an MA plan for over a year, switching to a Medigap plan means Medigap companies can require medical underwriting after the SEP.

When seniors first choose between Medigap and Medicare Advantage, what do you think they should know?

Answer. Medicare beneficiaries often confuse Medigap and Medicare Advantage. It is imperative that beneficiaries, especially those new to Medicare, have a clear understanding of their Medicare health plan options and the pros and cons of each option from an unbiased source. Education for those new to Medicare is critical for making educated and individualized health and prescription drug plan choices. Medicare beneficiaries should have a good understanding of the enrollment periods, costs, coverage, and convenience (networks and other restrictions) of all options prior to selection. For Medigap, this should include education on the specifics of each of the standardized plans, how they pay after (and only after) Medicare Part A and Part B, comparison of the premiums for each plan sold within their State, including Medigap Select policies, Medigap open enrollment and guaranteed issue situations. For Medicare Advantage, this education should include detailed information about how all plans operate independent of original Medicare, all possible out-of-pocket costs, details on how plan contracts change annually, added benefits, open enrollment, annual Medicare Advantage open enrollment, special election periods, and a plan comparison for their county.

Question. What else would you suggest Congress consider to make it easier for MA enrollees like those in Tillamook, who don't have an MA plan choice, to choose a Medigap plan?

Answer. To make it easier for MA enrollees who do not have an MA plan choice, it is vital that they understand their guaranteed issue right to purchase a Medigap policy without underwriting and the timeframe to do so. While most States follow the Federal guidelines, some States have more generous protections. As stated above, it's important for a beneficiary to receive comprehensive, individualized, and local counseling on all Medigap policies for seamless coverage. SHIPs can assist by providing detailed information about all Medigap plans and cost comparisons.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

Question. While there are a lot of resources out there to help individuals make decisions regarding their health-care coverage during open enrollment, sometimes this information overload can be confusing.

OSHIIP has been nationally recognized for the services it provides to Ohioans when it comes to navigating a cost-free, simple process, with clear options, so they can choose a Medicare plan that works best for them.

In your testimony, you mentioned that many Medicare beneficiaries find the task of comparing plans to be daunting, and that they can be overwhelmed by the massive number of plan options.

While OSHIIP has been successful in assisting Ohioans throughout this process, not all State health insurance assistance programs have the capacity to meet their residents' needs.

What can Congress do to make things easier for beneficiaries navigating this complex system?

Answer. Medicare beneficiaries could better navigate the complex system with a reasonable number of options. At a recent roundtable with insurance commissioners, CMS shared research that showed a correlation between areas with more than 15 options and poor enrollment decisions for marketplace enrollees. Ohio's aged and disabled population in the Cleveland area are currently navigating more than 117 health plan options during a 6-week period. Medicare beneficiaries would benefit from CMS requiring measurable differences when approving plan contracts.

A personalized Annual Notice of Change that reflects how the changes for the upcoming year will directly impact a beneficiaries costs, benefits and access to preferred provider networks would make it easier to navigate their options. Highlighting such information on the cover or first page would encourage beneficiaries to review and compare plans annually.

Medicare currently has an internal system for Medicare Advantage and prescription drugs called MARx. SHIPS used to have access to MARx, but usage is now restricted. Expansion of MARx to SHIP users would directly benefit Medicare beneficiaries in the most complex and critical cases. MARx provides detailed information on current and future plans to assist beneficiaries that do not know what coverage they have; provides details on any uncovered time frames allowing SHIPs to assist with penalties and appeal rights; shows eligibility for Medicaid and Extra help, allowing SHIPs to assist with Low-Income Network (LI Net) access for low-income individuals needing critical medication; provides accurate details for SHIPs to include when filing complaints directly in Medicare Complaint Tracking System; and allows SHIPs to help the most vulnerable beneficiaries by providing a clear and accurate picture of their benefits. For example, OSHIIP assists beneficiaries that have lifelong disabilities and lack family/caregiver support that reside in group housing. When plans change annually, these institutions rely on OSHIIP to assist with enrollment assistance. Our access to MARx is vital to aid the volume of residents, find appropriate coverage and facilitate enrollments.

Question. I have been working closely with my colleagues, including Senator Thune of this committee, on the bipartisan, bicameral Improving Seniors' Timely Access to Care Act.

This legislation will streamline the prior authorization processes in the Medicare Advantage program, reduce administrative burdens, and protect older Americans from unnecessary delays in treatment.

It is just one of the many ways we can make Medicare Advantage work better for Americans.

At our urging, earlier this year, CMS announced a proposed rule that would accomplish much of what our legislation does.

I am hopeful that the agency finalizes this important rule soon, and I have encouraged them to do so. But there's more we can do here in Congress to help protect beneficiaries.

The Improving Seniors' Timely Access to Care Act will help standardize and streamline the prior authorization process for routinely approved items and services. From your experience, how does standardization of prior authorization benefit individuals looking to enroll in a Medicare Advantage plan?

Answer. In my experience, Medicare beneficiaries do not clearly understand Medicare Advantage when enrolling. Many, especially low-income and limited health literacy population, mistake Medicare Advantage as a "free" Medigap policy. They are unaware of the network restrictions and the need for prior authorization for services. OSHIIPs assistance is often reactive in these cases helping beneficiaries navigate the plan rules. Standardization of processes will assist in counseling, appealing, and advocating for these individuals. The reduction of administrative burdens, delays in treatment, and standardization amongst plans may lessen the number of providers leaving plan networks.

Question. Part of the information overload that so many older Americans experience when trying to enroll in a health plan is a result of deceptive marketing from private insurance companies.

Around this time of year, older Americans are inundated with advertisements, phone calls, and mail regarding Medicare enrollment.

CMS has reported that complaints related to marketing for Medicare Advantage plans—run by private insurance companies—more than doubled in 1 year, from less than 16,000 in 2020 to nearly 40,000 in 2021.

And many plan directories list inaccurate information about providers—further complicating the process.

In an investigation led by Chairman Wyden last year, this committee found two Medicare Advantage plans in Ohio where 75 percent of the providers listed as in network were inaccurate or unavailable. This is unacceptable.

What can Congress do to continue to improve the oversight of these harmful marketing practices?

Answer. Medicare Advantage plan networks are largely misunderstood by beneficiaries. Many beneficiaries do not realize that providers may leave plan networks during the course of the year. When that happens, beneficiaries are often outside of any plan election periods. It would be helpful if plan contracts with provider networks followed the same calendar year as the plans contract with Medicare. If changes to the network were announced in accordance with all other annual changes, Medicare beneficiaries may utilize the fall open enrollment to make wise enrollment decisions.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. Every year around this time, 65 million seniors and people with disabilities face a barrage of advertisements asking them to choose from a complex patchwork of Medicare plans. Since open enrollment happens only once per year, it is essential that these people choose the right plan that fits their budget and coverage needs. However, marketing tactics can range from annoying and misleading to downright deceptive. Beneficiaries are often not told the whole truth about their coverage and benefits.

A Washington State constituent told me that she received a call every single day for a week urging her to enroll in a Medicare Advantage plan—including calls as early as 6:30 in the morning. Another constituent was convinced to enroll in a Medicare Advantage plan over a traditional Medicare plan because Medicare Advantage plans offer lower premiums and additional covered services including vision, dental, and hearing.

What he wasn't told was that Medicare Advantage plans require prior authorization and referrals to see a specialist. He soon discovered a lump on his earlobe, so his primary care provider submitted a request to the Medicare Advantage plan for a dermatologist referral. After several weeks of silence, he followed up with his plan and discovered that his insurer had subcontracted out the prior authorization process and his request was lost in the change. He was only able to get the surgery 7 months after submitting the authorization request. Had he been on a traditional Medicare plan, he would not have needed a referral to see a dermatologist in the first place.

For people like my constituent, delays in care can result in deadly consequences. That is why it is so important that people are well informed about their choices and able to evaluate the benefits and drawbacks of the different Medicare plans without getting confused by persistent, misleading advertising. Last year, private insurers

and brokers ran more than 640,000 commercials on TV alone, but two out of three seniors still said that they would like to learn more about their options.

This shows that seniors are aware that they are not getting the whole truth. We must do more to empower them with the correct information to make critical decisions about their health insurance.

The Biden administration published a final rule in April this year that would increase protections against predatory behavior and require Medicare Advantage plans to have better oversight of marketing materials from agents and brokers.

Do you think that this rule addresses the heart of the issue concerning misleading information?

Answer. This rule is a good step in addressing the national issue of misleading information by Medicare Advantage plans. We will know more about the effectiveness of this rule in 2024.

Question. Could more be done to increase oversight of Medicare Advantage plan marketing?

Answer. Yes, many inappropriate enrollments occur when lead agencies or third-party marketing organizations are involved. These entities are often out of State, unaware of the local landscapes, and fail to ask critical enrollment questions.

Question. Do you agree that misleading Medicare Advantage marketing materials lead to poor health outcomes and additional costs for beneficiaries?

Answer. Wholeheartedly, yes. Oversight on plan enrollments, specifically the special election periods, would help protect beneficiaries from poor enrollment decisions. OSHIIP is currently assisting a gentleman that saw a TV commercial in May advertising "Free Medicare" and "Entitled Benefits!" He called the number on the ad and was enrolled into a Medicare Advantage product outside of any special enrollment period. The agent told this gentleman that he would no longer have to pay for anything else, and to stop paying any other Medicare premiums and cancel all other coverage. The gentleman was responsible for both a Part A and Part B premium, a Medigap premium, and a Part D premium, all of which were reimbursed by his retirement health reimbursement account (HRA). When he followed the direction of this agent and stopped paying all premiums, he was disenrolled from his HRA, Medicare A and B, his Medigap, his Part D plan and subsequently this new Medicare Advantage plan. He was left with no health or drug coverage and is out of needed medications. If that improper Medicare Advantage plan enrollment had been reviewed in May, this retiree would have full coverage all paid for under his health reimbursement account. OSHIIP assists too many in similar situations after enrolling in plans based on misleading advertisements.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

This morning the Finance Committee gathers to discuss an emerging trend in Medicare Advantage: marketing middlemen.

There is a long history of rip-off artists in the private sector trying to take advantage of seniors who depend on their flagship health program, Medicare. Since I served as the director of the Oregon Gray Panthers, something like a year or 2 ago, these unethical salespeople would often sell seniors 10 to 15 separate, unnecessary Medigap policies that weren't worth the paper they were written on. Senators Daschle, Heinz, Dole, and I came in and drained that swamp.

The same thing happened at the start of Medicare Advantage. In this committee, Chairman Baucus held a hearing on Medicare marketing because scammers were going door-to-door while wearing white coats and stethoscopes around their necks to enroll seniors into these new plans. We got some protections then, but it still hasn't been enough.

Last fall, I released a report that detailed some of the most egregious marketing practices that I've seen in Medicare Advantage—like vans parked outside senior centers with "MEDICARE" splashed across the side and mailers designed to look like IRS documents. Many members of this committee joined Senator Casey and I in calling on CMS to make changes to protect beneficiaries from these slimy tactics, and CMS delivered. Just yesterday it was reported that CMS rejected more than 300 ads because they were so deceptive and misleading.

At this time, it's not possible to take any victory laps. As seniors experience Medicare's annual open enrollment—which started 72 hours ago—our investigators have found marketing middlemen are the latest sleazy set of private-sector scoundrels targeting seniors on Medicare Advantage. These bad actors are gearing up for this new enrollment period.

So, who are these marketing middlemen, and why are they so prevalent in Medicare Advantage?

They are big, private marketing companies in the middle between seniors and their coverage. These big marketing companies are jumping to get in front of seniors during annual open enrollment. These middlemen hijack personal information from as many seniors as possible and then they funnel this personal information to the health insurance plans that pay these sleazy marketers the most. Basically, it's "profit for us first, help for seniors and taxpayers last."

Sometimes seniors' information gets passed multiple times from one money grubbing hand to another. The marketers will sell seniors' data once. If they can, they'll sell it twice. If they can, they'll sell it as many times as possible. The wheel of deceit goes round and round. And seniors are the ones left getting badgered by phone, targeted on the Internet, stuck with mountains of mail—and ultimately, a plan that might not be the right fit for their health needs.

To sum it up: these marketing middlemen have made seniors their product, and they are trying to sell as much as they can.

And what's more, it's your taxpayer dollars that are lining these middlemen's pockets. In fact, insurance experts have estimated that marketing cost taxpayers at least $6 billion in 2022 alone. Let that sink in, folks. Six billion taxpayer dollars went to marketing middlemen who may have sold your elderly parents, grandparents, and neighbors the wrong plan.

It's a rip-off, and it's got to stop. And that's why I have my investigators launching an inquiry into these slimy practices.

I want to share one last thought on strengthening the Medicare Advantage program—we've got to stamp out ghost networks. In May, our investigators looked at a cross section of mental health plans across America. They contacted these plans' providers and asked if they could get an appointment for a member. They could only get an appointment 18 percent of the time. Even if a senior can make an appointment with a provider, they may be exposed to extra costs if the provider is out of network.

Knowing if your doctor is in network is an essential piece of information when you enroll in a plan and when you are looking for health care. That's why I joined Senators Bennet and Tillis in introducing the REAL Health Providers Act to make sure provider directories in Medicare Advantage are up to date and accurate. This is something we should all be able to get behind.

In closing, I want to explain that this is part of an effort in this committee to reduce middlemen from health care. We spend $4 trillion a year on health care, and sleazy middlemen need to be rooted out. We've already begun with PBMs.

I want to thank our witnesses for testifying today at this Finance Committee hearing. I look forward to our discussion.

COMMUNICATIONS

AARP

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AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the Senate Committee on Finance's effort to examine deceptive marketing practices of Medicare Advantage (MA) plans during Medicare Open Enrollment and how to improve the overall consumer experience of enrollment in a Medicare Advantage plan.

With enrollment in MA plans eclipsing that in traditional Medicare, it is increasingly important for Congress to ensure that beneficiaries are adequately served in both MA and traditional Medicare in terms of costs, benefits, quality of care, and patient outcomes. AARP has long supported efforts to improve the quality and affordability of all Medicare plans while working to ensure that consumers maintain a robust choice of both MA and traditional Medicare options.

Plan marketing directly affects the consumer experience and ability to make informed choices in enrollment. In many cases, deceptive marketing practices have led individuals to enroll in a plan that does meet their needs. AARP has repeatedly raised concerns about marketing abuses around MA plans and advocated for greater oversight, enforcement, and regulation of marketing materials and marketing standards for MA plans.

We were pleased that the Administration has finalized regulations aimed at strengthening consumer protections from deceptive and abusive marketing practices, including a prohibition on the use of the Medicare name, logo and Medicare card in advertising, and a prohibition on the marketing of supplemental benefits in a service area where those benefits are not available. Beyond the insurance carriers that offer MA plans, we also supported [1] new requirements on how agents, brokers, and third-party marketing organizations can engage with prospective enrollees, such as the requirement that they disclose when they do not contract with all carriers offering plans in a given service area. Perhaps most importantly, agents and brokers are now required to explain to consumers the effect of a Medicare coverage option or plan choice prior to enrollment. This is especially important because a voluntary choice to leave an MA plan and return to traditional Medicare may expose consumers to medical underwriting—and subsequent higher premium costs—if they attempt to enroll in a Medicare supplement policy (Medigap).

Although the new rules discussed above are a significant step in the right direction, both Congress and the Administration must do more to ensure that MA marketing efforts are not misleading or harmful to consumers. The new guidelines will only help consumers if they are followed. Effective monitoring and enforcement mechanisms must be developed so that the appropriate federal agencies are empowered to use their authority to hold insurers and other entities accountable for inappropriate marketing of their plans. Coordination between the federal government—which regulates MA plan—and state governments—which regulate agents, brokers, and receive the bulk of Medicare-related marketing complaints—is critical to ensure adherence to marketing guidelines.

[1] *https://www.aarp.org/content/dam/aarp/politics/advocacy/2023/02/final-aarp-2024-ma-part-d-comment-21323.pdf.*

Despite the progress made by these new consumer protections, additional policy improvements continue to be needed. For example, improved transparency about agent, broker, and third-party organizations' compensation and financial incentives could help better inform consumer decision making. Also critical is equipping consumers with clearer information about available options to lodge a complaint about problematic marketing practices. In addition, given widespread confusion among consumers evaluating their Medicare coverage options, increasing access to unbiased sources of information—including through greater promotion of and funding for State Health Insurance Assistance Programs—is essential to helping consumers navigate Medicare marketing information.[2]

As enrollment in MA continues to outpace traditional Medicare, increased vigilance to protect consumers from troubling marketing practices will become even more important to help ensure that older adults are best equipped to make informed decisions about the coverage that will best meet their needs.

Thank you for the opportunity to provide AARP's perspective on deceptive marketing practices in MA and steps to protect consumers. We look forward to working with you to address this important issue and improve the experience of Medicare enrollment for older Americans.

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On behalf of the American College of Physicians (ACP), we are grateful for this opportunity to share our views regarding the recent Senate Finance Committee hearing, "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences." We urge you to adopt the following recommendations outlined in this statement to ensure that if seniors enroll in Medicare Advantage (MA) they: receive accurate information regarding the coverage, cost, and benefits of their plan; are not subject to fraudulent activity and deceptive marketing tactics; obtain access to updated accurate clinician directories; receive timely access to treatment that is not inappropriately denied through the prior authorization process; find accurate information regarding the cost of their prescription medication.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

Improve Transparency Regarding Coverage, Cost, and Benefits in MA Plans

MA plans should provide beneficiaries with a clear and understandable means to compare benefits and options when deciding between an MA plan and traditional Medicare. The process of "seamless conversion" into these plans should be stopped entirely and reevaluated so that newly eligible Medicare beneficiaries are not automatically enrolled in their commercial insurer's MA plan without their knowledge or understanding that they may opt out of the plan.

MA program transparency at the consumer level is also very important. The enrollment process, details regarding available benefits, cost-sharing arrangements and premium costs, and clinician (or "provider") directories should be readily available to all Medicare beneficiaries and presented in a clear and understandable manner. Comparing MA plan networks and available benefits still remains a challenge for beneficiaries due to the lack of readily available plan information. Beneficiaries and clinicians need to be fully aware of any differences in coverage that could result in delays to appropriate care, such as limits on prescription drug coverage and any access to criteria used by the plan for making prior authorization determinations. MA plans can also make significant changes to benefit options, cost sharing arrangements, clinician networks, and other details from year to year, making comparison

[2] *https://blog.aarp.org/thinking-policy/new-medicare-advantage-marketing-and-sales-rules-will-help-better-protect-consumers.*

even more difficult.[1] ACP supports the MA Program and its ability to provide beneficiaries with a choice of health coverage as long as benefit requirements and essential consumer protections are ensured, including providing valid and reliable information to facilitate informed decision-making.

Reduce Fraudulent Activity in MA Plans

ACP calls on the Senate Finance Committee, the Centers for Medicare and Medicaid Services (CMS), Office of Inspector General (OIG), and external independent bodies to investigate potentially fraudulent activity and the misuse of risk stratification by MA plans. Further, when any fraudulent activity is identified, the responsible Medicare Advantage Organization (MAO) or MA plan should be held liable for that activity and not the physicians participating in the MA plan.

CMS must also address issues of fraud and abuse in the MA Program. Reports[2] from such organizations as The Center for Public Integrity discuss allegations that some MA plans over bill CMS by exaggerating illness severity in some of their patient populations. Requiring transparency and specifically requiring publication of how the plan captures illness severity through use of the Health and Human Services-Hierarchical Condition Categories (HHS–HCC) risk adjustment methodology could help in identifying areas of potential fraud and promote a more cohesive method of capturing severity across all MA plans. To further promote and maintain program integrity, the CMS's Center for Program Integrity, the OIG, and such external independent organizations such as MedPAC and the GAO should take the lead in investigating potential situations of fraud or "gaming the system"[3] by MA plans to increase profitability by misusing the risk-stratification process.

Protect MA Beneficiaries from Deceptive Marketing Tactics During MA Enrollment

We urge the Senate Finance Committee to investigate and prohibit fraudulent marketing tactics used by some MA plans to enroll seniors in their plans. ACP strongly supports[4] CMS's proposal to increase the transparency of MA plans and their respective marketing policies. The College also supports the Agency's goal of ensuring that MA enrollees receive the same access to medically necessary care they would receive in traditional Medicare. To that end, we believe the Agency's proposal to require agents to explain the effect of a beneficiary's enrollment choice on their current coverage whenever the beneficiary makes an enrollment decision is a great safeguard of traditional Medicare and protection against current abusive marketing tactics.

ACP also appreciates the Agency tightening MA marketing rules to protect beneficiaries from misleading advertisements and pressure campaigns. Prohibiting advertisements that do not mention a specific plan name and that use words, imagery, and logos in a confusing way is a critical step in ensuring information disseminated to beneficiaries is accurate and not misleading. Due to the predatory nature and increasing role of third parties in the marketplace, it is imperative that CMS addresses the increasing number of beneficiaries misled into believing an entity is the federal government or a product is endorsed by Medicare. While CMS is simultaneously building a health system to support health equity, trust in the federal government and the health system is of utmost importance. ACP greatly appreciates the Agency's recognition of this relationship and the impact that revising its own Medicare-related marketing requirements may have on fostering trust across all populations but particularly those most vulnerable.

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[1] *https://www.kff.org/report-section/medicare-advantage-plans-in-2017-issue-brief/.*

[2] *https://publicintegrity.org/health/why-medicare-advantage-costs-taxpayers-billions-more-than-it-should/.*

[3] *https://www.nytimes.com/2017/05/15/business/dealbook/a-whistle-blower-tells-of-health-insurers-bilking-medicare.html?smprod=nytcore-iphone&smid=nytcore-iphone-share&referer=https://t.co/qX8GYze4pW%3famp=1.*

[4] https://assets.acponline.org/acp_*policy/letters/acp_comments_on_cms_proposed_changes_to_medicare_advantage_and_part_d_2023.pdf?_gl=1*1t3y4st*_ga*MTM0NTkwMzIxNC4xNjgxNDkzMzc4*_ga_PM4F5HBGFQ*MTY5ODMzNDM0Mi4xMDAuMS4xNjk4MzM0Nzk2LjUzLjAuMA..&_ga=2.144903348.1807582808.1698246081-931781502.1649951016.*

Ensure Accurate and Updated Clinician Directories in Medicare Advantage Plans

We support draft legislation [5] that was released last year by the Finance Committee that would codify existing requirements that MA plans maintain accurate clinician directories that include contact information and whether a clinician is accepting new patients. This legislation would require MA plans to update a clinician's in-network status changes within two days and post the clinician directories on a public website.

It is imperative that federal and state regulators [6] enact laws that require health plans to ensure access to behavioral health clinicians and primary care physicians, accurate directories [7] and transparent processes for selection of a clinician. Error-ridden clinician directories may give patients a false impression [8] that their plan's "provider" network is comprehensive and that their preferred physician is in network. Evidence shows that patients who use inaccurate mental health directories are more likely to receive a surprise bill [9] from an out-of-network behavioral health clinician than patients who use an accurate directory. MA directories often include incorrect [10] information and a recent study [11] found that additional measures were needed to ensure a sufficient number of clinicians within MA networks. **We suggest requiring MA provider directories include additional information,**[12] **such as the health care professional's gender, medical group and facility affiliations if applicable.**

Additionally, we urge you to require MA plans to maintain regularly updated directories that include information on whether listed clinicians are accepting new patients. Information published in MA provider directories is often inaccurate. We support robust requirements to ensure provider directories from MA provider directories are searchable, accurate, current, and accessible. **We urge the Senate to require MA plans to update their provider directories on a monthly basis to ensure that our patients may have access to accurate directories when they choose a plan or health professional.**

Remove Barriers to Care for Medicare Advantage Beneficiaries

We remain deeply concerned that some seniors that enroll in MA plans may be denied care covered by their plans through the prior authorization process. Prior authorization involves paperwork and phone calls, as well as varying data elements and submission mechanisms that may force physicians to enter unnecessary data in electronic health records (EHRs) or perform duplicative tasks outside of the clinical workflow. This inhibits clinical decision-making at the point of care and may be an unnecessary burden for physicians and barrier to medical care for patients.

HHS issued a report [13] in 2022 that detailed abuse in the prior authorization process in which "Medicare Advantage insurers sometimes delayed or denied beneficiaries' access to services, even though the requests met Medicare coverage rules." A survey [14] of more than 600 medical groups in March 2023 showed that 84 percent reported an increase in their prior authorization requirements for Medicare Advantage plans.

We urge the Senate to improve the process for prior authorization approval through the passage of the Improving Seniors Timely Access to Care Act of 2023. This legislation would help protect patients from unnecessary delays in care and reduce administrative burdens on physicians by standardizing and streamlining the prior authorization approval process in Medicare Advantage. We are pleased that this legis-

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[5] *https://assets.acponline.org/acp_policy/letters/acp_letter_to_sfc_regarding_mental_health_parity_discussion_draft_legislation_2022.pdf?_gl=1*1xw0a4c*_ga*MTM0NTkwMzIxNC4xNjgxNDkzMzc4*_ga_PM4F5HBGFQ*MTY5ODM0NTgyNy4xMDMuMS4xNjk4MzQ1OTc1LjQ0LjAuMA..&_ga=2.145948724.1807582808.1698246081-931781502.1649951016.*

[6] *https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4983.pdf.*

[7] *https://www.cms.gov/medicare/health-plans/managedcaremarketing/downloads/provider_directory_review_industry_report_round_2_updated_1-31-18.pdf.*

[8] *https://www.gao.gov/assets/gao-22-104597.pdf.*

[9] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7497897/.*

[10] *https://www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf?token=kx9rkgqJ.*

[11] *https://www.gao.gov/assets/gao-15-710.pdf.*

[12] *https://content.naic.org/sites/default/files/inline-files/MDL-074_0.pdf.*

[13] *https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.*

[14] *https://www.mgma.com/federal-policy-resources/spotlight-prior-authorization-in-medicare-advantage.*

lation has been approved by the House Ways and Means Committee and the House Energy and Commerce Committee has slated this bill for approval.

It would require that all MA plans establish an electronic prior authorization process to streamline approvals and denials and the Department of Health and Human Services to establish a process for MA plans to provide "real-time decisions" for prior authorization requests of items and services that are routinely approved. Further, we appreciate the provision that would require MA plans that are unable to meet these real-time prior authorization decisions due to "extenuating circumstances" to issue final prior authorization decisions within a 72-hour and 24-hour time frame for regular and urgent services, respectively. We also support the transparency requirements in the bill, which would require MA plans to report on how often they use prior authorization and their rates for approvals or denials.

We are pleased[15] that CMS has announced changes to MA program, including many provisions in the Improving Seniors Timely Access to Act of 2023 that would streamline prior authorization approval process. We urge you to approve the Improving Seniors Timely Access to Care Act to ensure that these improvements to prior authorization are codified into law.

Behavioral Health Cost Sharing and Utilization Management in Medicare Advantage

We continue to be concerned that prior authorization is often required[16] for mental health and substance use emergency services but is not mandatory for analogous medical or surgical hospitalization events; in addition, prior authorizations for generic medications for substance use disorder are often required when generics for chronic physical diseases are not. Concerns about burdensome step therapy and utilization review requirements and disproportionately low reimbursement rates for mental health and substance use disorder treatment have also been reported[17] to the U.S. Preventive Services Task Force. Such stipulations add to administrative burden and patient frustration.

We urge the Senate to mandate a U.S. Government Accountability Office (GAO) study on understanding differences in enrollee cost-sharing and utilization management in Medicare Advantage between mental health/substance use disorder benefits and non-mental health/substance use disorder benefits, and in comparison, to Medicare fee-for-service. This study shall require an analysis of how the utilization of prior authorization and other utilization management tools are used to determine coverage of mental health and substance use disorders in Medicare Advantage. This provision was included in draft legislation[18] released by the Senate Finance Committee last year to improve mental health parity.

Reform Step Therapy Protocols

Pharmacy benefit managers (PBMs) used by MA plans to administer prescription drug benefits have developed a series of price management tactics to curb the rising cost of prescription drugs. Among these, step therapy policies, commonly called "fail-first" policies, require patients to be initiated on lower-priced medications before being approved for originally prescribed medications. Carriers can also change coverage in an attempt to force patients off their current therapies for cost reasons, a practice known as nonmedical drug switching.

Step therapy, nonmedical drug switching, and other cost-curbing formulary designs can also undermine the medical expertise of physicians and fail to adequately account for the individual characteristics and needs of patients, including comorbid conditions, concurrent medications, and demographic factors, all of which can impact a medication's effectiveness and side effects. Step therapy and nonmedical drug switching have been shown to delay or inhibit access to effective treatments[19] and

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[15] *https://www.acponline.org/acp-newsroom/internal-medicine-physicians-say-changes-to-medicare-advantage-program-will-help-seniors-access-care.*

[16] *https://www.hhs.gov/programs/health-insurance/mental-health-substance-use-insurance-help/index.html.*

[17] *https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf.*

[18] *https://www.finance.senate.gov/chairmans-news/wyden-crapo-bennet-burr-release-mental-health-parity-discussion-draft.*

[19] *https://www.patientaccesscollaborative.org/videos/2019/3/19/non-medical-switching-hurts-patients.*

put patient safety at risk by increasing the risk for hospitalizations and other adverse health events.

We urge the adoption of S. 652, the Safe Step Act of 2023, to ensure seniors in MA plans have access to medications they need. This legislation would amend the Employee Retirement Income Security Act (ERISA) to require group health plans to provide an exception process for the administering of prescription drugs in their step therapy protocols. While the Safe Step Act does not ban step therapy protocols, it places reasonable limits on their use and creates a clear process for patients and doctors to seek exceptions to the step therapy requirements and accelerates approval, when necessary, for needed medications. Patients and their physicians would benefit greatly from requiring insurers to implement a clear and transparent process for when either party requests an exception to a step therapy protocol.

Ensure Transparency Regarding Drug Prices in Medicare Part D Plans

We also support efforts by Chairman Wyden and Ranking Member Crapo to ensure that seniors that enroll in MA plans have accurate information regarding the price and cost of their prescription drugs. **ACP supports S. 2973, the Modernizing and Ensuring PBM Accountability (MEPA) Act.** This legislation would set out new requirements for PBMs to annually report drug prices and other information to Part D plan sponsors and to the Secretary of Health and Human Services (HHS). PBMs would be required to include information related to several categories, such as information related to covered Part D drugs, drug dispensing, drug costs and pricing, generic and biosimilar formulary placement, PBM affiliates, financial arrangements with consultants, and potential PBM conflicts of interest.

S. 2973 would also require PBMs or their affiliates to provide Part D plans with a written explanation of contracts or arrangements with a drug manufacturer (or affiliate) that makes rebates, discounts, payments, or other financial incentives related the drug manufacturer's drug(s) contingent upon coverage, formulary placement, or utilization management conditions on other prescription drugs.

ACP supports the availability of accurate, understandable, and actionable information on the price of prescription medication. ACP urges health plans to make this information available to physicians and patients at the point of prescribing to facilitate informed decision making about clinically appropriate and cost-conscious care.

Conclusion

We urge the Senate Finance Committee to enact the reforms outlined in our statement to prevent waste, fraud, and abuse in MA plans and ensure that seniors who enroll in these plans have access to high quality care. We encourage CMS to finalize proposals to prevent these abuses and look forward to working with you to improve this program for our physicians and patients. Should you have any questions regarding this statement please contact Brian Buckley, our Senior Associate for Legislative Affairs at bbuckley@acponline.org.

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Statement of Everett E. Vokes, M.D., FASCO, Board Chair

The Association for Clinical Oncology (ASCO) is pleased to submit this statement for the record of the hearing entitled, "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences." ASCO appreciates that the Committee is holding today's hearing and has provided this opportunity to address the deceptive practices that threaten oncologists' ability to deliver high-quality cancer care that our patients, including those enrolled in Medicare Advantage (MA) plans, deserve.

ASCO is a national organization representing nearly 50,000 physicians and other health care professionals who care for people with cancer. ASCO members are dedicated to conducting research that leads to improved patient outcomes and are also committed to ensuring that evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans.

Prior Authorization

An ongoing source of frustration across the oncology care team is overly burdensome prior authorization requirements. ASCO recently published the results of a survey of our members in the United States to assess the impact of prior authorization on cancer care.

Nearly all survey participants reported a patient has experienced harm because of prior authorization mandates, including significant impacts on patient health such as disease progression (80%) and loss of life (36%). The most widely cited harms to patients reported were delays in treatment (96%) and diagnostic imaging (94%); patients being forced onto a second-choice therapy (93%) or denied therapy (87%); and increased patient out-of-pocket costs (88%).

The survey responses also reflected the difficulties of the prior authorization mandates. Nearly all respondents report experiencing burdensome administrative requirements, delayed payer responses, and a lack of clinical validity in the process. The survey also found that, on average:

- It takes a payer 5 business days to respond to a prior authorization request.
- A prior authorization request is escalated beyond the staff member who initiates it 34% of the time.
- Prior authorizations are perceived as leading to a serious adverse event for a patient with cancer 14% of the time.
- Prior authorizations are "significantly" delayed (by more than one business day) 42% of the time.

Over the past several years, Members of Congress have become increasingly concerned about the use of prior authorization in MA plans. The House of Representatives unanimously passed the *Improving Seniors' Timely Access to Care Act* (S. 3018/H.R. 3173) in September 2022. This bipartisan legislation, developed with input from ASCO, finished the 117th Congress with 380 combined cosponsors—53 Senators and 327 Representatives—supporting the legislation. Importantly, more than 500 organizations representing patients, health care providers, the medical technology and biopharmaceutical industry, health plans, and others endorsed the legislation.

While the legislation did not pass the Senate last Congress, ASCO is optimistic that the CMS Electronic Prior Authorization proposed rule, which was published in the Federal Register on December 13, 2022, takes steps to improve the prior authorization requirements that will improve beneficiary access to necessary and lifesaving services and ease the administrative burden on physicians and payers. This rule aligns with many of the provisions included in the legislation, which, if passed, would have gone into effect in 2024.

Both this proposed rule and the legislation:

- Establish an electronic prior authorization program.
- Standardize and streamline the prior authorization process.
- Increase transparency around MA prior authorization requirements and their use.

We strongly urge CMS to address two overarching concerns with the proposed rule to maintain current regulatory and legislative momentum to address prior authorization:

1. Expedite the implementation timeline of provisions finalized in this rule for all plans and require compliance with finalized proposals in contract year 2024.
2. Include drugs—which are currently excluded—in the electronic prior authorization program and application programming interface (API) requirements.

ASCO appreciates the 233 Representatives and 61 Senators who signed letters to CMS urging the agency to finalize and implement the proposed rule, as well as urges CMS to expand on the rule to allow for some real-time electronic prior authorization decisions, require a response within 24 hours for urgently needed care, and increase transparency.

Thank you for your attention to this important issue. ASCO is pleased to serve as a resource for you and your colleagues as you continue to investigate deceptive practices within Medicare Advantage that are impacting ASCO members and their practices. Should you have any follow-up questions or concerns, please do not hesitate to contact Kristine Rufener at kristine.rufener@asco.org.

ASSOCIATION OF WEB-BASED HEALTH INSURANCE BROKERS

The Association of Web-Based Health Insurance Brokers (AWHIB) appreciates the opportunity to share its perspective on Medicare Advantage marketing practices and agent compensation. While we share the Committee's concerns around deceptive marketing practices that mislead seniors, we want to make sure that the Committee recognizes the value that agents and brokers bring in helping Medicare beneficiaries understand their options. In particular, we want to ensure that the Committee is aware of and properly distinguishing between agents and brokers and the "middlemen" that are responsible for the behaviors about which the Committee is rightfully concerned. Although no one is questioning that agents and brokers should be fairly compensated for assisting beneficiaries, we want to resolve apparent confusion regarding administrative payments. Non-commission administrative payments are often an essential part of the fair compensation to agents and brokers when those agents and brokers perform services beyond the enrollment of beneficiaries. Commissions alone do not adequately compensate agents and brokers who provide those services, and indeed the first-year commissions from insurance carriers alone do not cover the cost of acquiring and enrolling the beneficiary.

I. AGENTS AND BROKERS ARE CRITICAL TO THE MEDICARE ADVANTAGE ECOSYSTEM AND ARE NOT THE MIDDLEMEN

A. Beneficiaries Rely on Agents and Brokers for Help

Agents and brokers serve a critical role in educating beneficiaries about the Medicare Advantage and Prescription Drug programs. Each year, new beneficiaries become eligible for Medicare, there are annual programmatic changes to Medicare, and insurers update and offer new Medicare Advantage plans. As Christina Reeg, Ohio senior health insurance information program director for the Ohio Department of Insurance, explained, there are so many options that "most Medicare beneficiaries won't review or change plans, because the task of comparing is too daunting to help narrow the field."

Agents and brokers help beneficiaries with this daunting task by educating them on their choices while taking into consideration their specific healthcare needs and the specific benefits offered by the available plans, including network participation and prescription drug coverage that is critical to their coverage. Importantly, agents and brokers provide a valuable service that is not available from any other source, including the Centers for Medicare and Medicaid Services ("CMS"), State Health Insurance Assistance Program ("SHIPS") or even the insurance carriers themselves. Specifically, each of the three witnesses agreed that neither of CMS nor SHIPS have adequate resources to help the 60 million beneficiaries that are eligible for Medicare Advantage. Among other things, they rely on the CMS Medicare plan finder, which is not always up to date and does not provide critical information, such as doctor network participation and drug coverage. While insurance carriers may be able to provide this information, they can only provide it for their own plans. In order to compare plans from multiple carriers, the beneficiary would need to contact each carrier separately; whereas a broker can simplify the process by presenting and advising on plans from several carriers in a single interaction. As a result, many beneficiaries prefer to work with brokers instead of separately contacting each insurance carrier to find the plan that is the better match for their personal needs.

Medicare beneficiaries value the role of the agent and broker—according to the Commonwealth Fund, agents and brokers assist over 30 percent of Medicare beneficiaries in selecting a Medicare Advantage plan or traditional Medicare, which is a greater share than *Medicare.gov,* state health insurance assistance programs, advertisements or friends and family.[1] According to the Commonwealth Fund's most recent report, 96 percent of beneficiaries said they feel like there are too many plan options and that they are more likely to stick with their current plan than to seek out a new plan. More than 1 in 3 beneficiaries said they would like to know more about benefits outside of their coverage options, and 1 in 4 would like one-on-one help. By providing this assistance as licensed professionals, agents and brokers alleviate the burden on CMS, which is not currently resourced to provide the manner or volume of assistance demanded by Medicare beneficiaries in selecting coverage options.

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[1] *https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.*

B. Agents and Brokers are Distinct from Lead Generators

Agents and brokers are highly regulated state licensed and registered entities that educate, solicit and enroll beneficiaries into Medicare Advantage plans and other insurance products. The role of the agent or broker is fundamentally different than the lead generator, which serves a "middleman" role in identifying and acquiring potential leads and selling them to another entity, which could be another lead generator, an agent/broker or an insurance carrier.

AWHIB members are concerned about the continual reselling of personal beneficiary data by multiple parties and have advocated for reasonable limits that would prevent continual reselling. AWHIB supports limits that prevent multiple transfers of beneficiary information. At the same time, the ability of independent agents and brokers to receive referrals for Medicare Advantage plans for which that agent is licensed to offer should be preserved. Otherwise, only insurance carriers would be able to receive those referrals, which would lead all beneficiaries who are referred through lead generators to carriers, which can only offer their own plans and do not allow easy comparisons between carriers.

II. AGENT/BROKER COMPENSATION AND ADMINISTRATIVE PAYMENTS ARE ALREADY REGULATED BY CMS

A. Agent and Broker Compensation is Tied Directly to Beneficiary Satisfaction

Agents and brokers are not incentivized to engage in unscrupulous activities. Rather, they are directly contracted with the carriers and their goals are naturally aligned with the insurance carriers, which is to enroll beneficiaries in a plan that best meets their needs. According to Krista Hoglund, CEO of Security Health Plan, brokers are responsible for "85 percent of Security's health plan enrollment . . . we need to partner with brokers to help put consumers in the plan that is best for them."

While agents and brokers receive enrollment-based commissions from insurance carriers, agents and brokers rely on beneficiary satisfaction for long-term sustainability. Agents and brokers are incentivized to help Medicare beneficiaries select *the plan which best suits their needs,* as they benefit most when beneficiaries stay with their selected plan for as long as possible.

Pursuant to existing CMS regulation, agents and brokers do not get paid any initial compensation for an enrollment if the beneficiary disenrolls from the plan within the first 90 days. They also only receive renewal compensation if the beneficiary renews the plan year after year. All of this incentivizes agents and brokers to recommend a plan that is in the beneficiary's best interests. Moreover, this compensation is capped at a specific dollar amount by CMS regulations.

CMS sets the maximum commission payable for enrollment into MA and PDP plans at a predetermined fair market value (FMV) amount that is adjusted annually to reflect growth in Medicare costs.[2] The current commission amounts are:

For Medicare Advantage:

- $611/enrollee in most states
- $689/enrollee in CT, PA, DC
- $762/enrollee in CA, NJ

For PDP:

- $100/enrollee

Federal spending per Medicare Advantage enrollee is over $13,000 per year; commissions are capped at less than 5 percent of the average cost of the plan being sold.[3] The June 2023 increase in commissions was approximately 1.67% in most states, about half the CPI inflation rate for the year.

Commission payments for each year that a beneficiary enrolls in the same or a "like" plan are also strictly regulated, at up to 50 percent of FMV, as defined by

[2] "Fair market value (FMV) means, for purposes of evaluating agent or broker compensation under the requirements of this section only, the amount that CMS determines could reasonably be expected to be paid for an enrollment or continued enrollment into an MA plan." 42 CFR § 422.2274(a), (d)(2).

[3] *https://aspe.hhs.gov/sites/default/files/documents/14a262cfc2979b8cc1a9dffaee06b022/medicare-advantage-enrollment-spending-overview.pdf.*

CMS.[4] The commissions paid by each carrier for each plan are publicly reported by CMS each year.[5]

B. Agents and Brokers Should be Fairly Compensated for the Additional Services They Provide

Insurance carriers may also pay brokers and agents for "services other than enrollment of beneficiaries."[6] Examples of such services include: "training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments."[7] These are payments for specific services that agents/brokers provide.

Payments for these services must not exceed "the value of those services in the marketplace."[8] Unlike enrollment services, these services, and the cost of providing them, varies depending upon the services that are provided and their value in the marketplace.

These administrative payments can be for services such as:

- Telephonic equipment required by CMS to record all sales calls and to retain them for 10 years;
- Tools to support plan comparison and enrollment;
- Other equipment and services required to support agent/broker services;
- Health risk assessments, in which a customer service representative obtains information from a beneficiary to properly assess the beneficiary's health risks for the insurance carrier;
- Licensing and appointment fees;[9]
- Product, sales and compliance training;
- Outreach to plan members to provide information about, and assistance with, how to use and access plan benefits after enrollment;
- Quality and compliance oversight activities; and
- Marketing, advertising and lead generation activities.

Marketing, advertising and lead generation activities may include, but may not be limited to, the costs associated with printing and mailing marketing and educational materials, producing television and radio commercials and purchasing media placements, building and operating websites, paid digital marketing, social media marketing, purchasing leads, etc. As with all marketing of MA and PDP products, such marketing services must meet CMS' stringent marketing requirements, including the extensive regulations imposed each year on filing, review, and approval of marketing materials.[10, 11] Such marketing may highlight the broker as a platform for choosing among multiple carriers, rather than focus on the plans of only a single carrier.

Administrative payments are essential to ensuring fair compensation of agents and brokers, as commissions from insurance carriers do not fully cover the cost of acquiring, enrolling and servicing the beneficiary. Beneficiary acquisition costs reflect overall staffing, training and personnel costs. They also cover cost of complying with the extensive regulatory marketing requirements, as well as the cost of providing any additional services required by carriers. As noted previously, while the current MA maximum commission ranges from $611 per enrollee to $762 per enrollee depending on the state, agent and broker acquisition costs according to publicly reported customer acquisition costs for publicly traded insurance agencies ranged from $888 per enrollee to over $1,200 per enrollee.[12] Consequently, administrative pay-

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[4] 42 CFR § 422.2274(d)(3).

[5] *https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/medicare-marketing-guidelines/agent-broker-compensation.*

[6] 42 CFR § 422.2274(e)(1).

[7] *Id.*

[8] 42 CFR § 422.2274(e)(1).

[9] Insurance carriers may pay brokers and agents the costs of becoming licensed and appointed to sell the carriers' plans. Licensing and appointment are state-based requirements for the sale of health insurance, including MA and PDP products.

[10] 42 CFR § 422.2274(c)(7).

[11] 42 CFR § 422.2261.

[12] eHealth, Inc. (EHTH) data from 2022 Form 10–K filing, page 55. SelectQuote, Inc. (SLQT) data from 2023 Form 10–K filing, page 51. GoHealth, Inc. (GOCO) data derived from 2022 Form 10–K filing as: $589,985,000 cost of submission (10–K p. 54) divided by 862,656 Medicare submissions (10–K p. 53). Each public company calculates and reports this type of information differently, so numbers are not directly comparable among the companies. One of the differences is that GoHealth's Customer Acquisition Cost ("CAC") is calculated on a submitted application basis whereas eHealth and SelectQuote calculate CAC on an approved application basis. The

ments from carriers are critical to helping agents and brokers assist beneficiaries and meet insurance carrier expectations in terms of additional services.

In addition to the fact that CMS regulations require that payments made for administrative payments must not exceed the value of those services in the marketplace, carriers are incentivized not to overpay for services funded by administrative payments because overall payments to brokers are constrained by medical loss ratio (MLR) limits. The Affordable Care Act (ACA) established an 85% MLR for MA and PDP plans. Under CMS regulations, this 85% does not include commissions, marketing fees, or other non-patient-care fees paid to brokers and agents, which must instead fit within the remaining 15% administrative side of the MLR ratio.[13] For clarity, this 15% of plan revenue under the contract with CMS also includes all carrier administrative overhead and carrier profits as well, so only a small amount of this 15% of plan revenue is ever potentially paid to agents and brokers.

Furthermore, payments to agents and brokers do not reduce the resources available to pay for Medicare enrollees' health care because 85% of plan revenue under the contract with CMS must be used for patient care, rather than for such other items as administrative expenses or profit. MLR regulations provide an upper bound on the amount of spending that may go from the Medicare Trust Funds and Medicare beneficiary premiums to carrier profit and carrier administrative overhead (such as compliance and general operational oversight, information systems, customer service, accounting, as well as commissions, marketing fees, or other non-patient-care fees paid to brokers and agents).

Agents and brokers play an essential role in the Medicare marketplace, and they should be fairly compensated for the services that they provide in support of beneficiaries and carriers.

About the Association of Web-Based Health Insurance Brokers (AWHIB)

AWHIB is a trade association of web-broker entities (WBEs) that work in collaboration with the Center for Medicare & Medicaid Services to enroll consumers in qualified health plan coverage offered on the Federally-facilitated Exchanges (FFE) and state-based exchanges on the Federal Platform (SBE–FP). Several of AWHIB's members also actively assist Medicare beneficiaries with selection of, and enrollment into, Medicare Advantage plan and Part D prescription drug benefit plan coverage that best meet their needs. AWHIB collaborates with consumers, issuers, regulators, lawmakers, and other industry groups to continually develop technologies and enrollment strategies that provide Americans with access to health insurance products and services.

STATEMENT SUBMITTED BY LAURA AVANT

MEDICARE ADVANTAGE SCAMS

I am still getting several mailed and called invitations to join a Medicare DisAdvantage plan every day. I enjoy calling them and telling them that their happy days of lying to consumers are nearly over because the Senate will put some restrictions on this fraudulent practice.

I watched the meeting on Zoom yesterday with several other members and volunteers of Be a Hero. We met with Senator Bennet's staff health and gave her some relevant information on Monday, then met on Zoom with his DC staff and repeated many of our points. Our hope was that Senator Bennet would take a strong stance regarding the many lies, deceptions and failure to treat patients that define these plans and he did.

I was also pleased to hear Senator Warren talk about the whole Advantage program and its consistent failure to provide care for U.S. citizens while robbing the Medicare Trust Fund to the tune of about $200 billion a year.

I was not so pleased to hear the general tone of pro-insurance companies that was prevalent in this hearing. They even heard repeatedly from an insurance executive

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$611 first-year MA commission is on a paid application basis. Only a certain percentage of submitted applications become approved applications, and then paid applications, for which the brokers actually receive commission payments.

[13] 42 CFR §§ 422.2410 and 423.2410.

and gave her numerous times to justify her company's recruitment and up-coding practices as though her company really had the interests of constituents at heart.

My hope is that this will be the first of several meetings to address not only dishonesty and lack of transparency in advertising these plans but the entire gamut of patient harm and treasury robbery that is going on. Be a Hero will press on until a true solution is reached.

Thank you for inviting us to join.

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Statement of Mary Beth Donahue, President and CEO

Better Medicare Alliance, on behalf of our Alliance and the 31 million beneficiaries enrolled in Medicare Advantage, is pleased to submit the following statement for the record related to the October 18, 2023 Senate Finance Committee Hearing titled *Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences.*

Better Medicare Alliance (BMA) is a community of over 200 Ally organizations and more than 1 million grassroots beneficiary advocates who value Medicare Advantage and the affordable, high-quality, coordinated care it provides to over 31 million beneficiaries. Together, our diverse Alliance of community organizations, providers, aging service organizations, health plans, and beneficiaries share a deep commitment to ensuring Medicare Advantage is a high-quality, cost-effective option for current and future Medicare beneficiaries.

Seniors and individuals with disabilities eligible for Medicare actively choose and trust the value-driven, affordable, quality, and innovative health care available in Medicare Advantage. Through value-based payment design and care coordination and management that results in improved health outcomes, extra benefits, and lower costs for beneficiaries and the Federal Government, Medicare Advantage addresses the needs of today's beneficiaries. With growing and high consumer satisfaction, Medicare Advantage is building the future of Medicare.

Over the past 5 months, BMA has engaged its Allies through a series of roundtable conversations to discuss recommendations for policymakers to further maintain and modernize the Medicare Advantage program. One of the overarching recommendation is to establish marketing guidance that supports beneficiaries in making informed choices. Recognizing Congress, and in particular this Committee's commitment to ensuring beneficiaries receive complete, accurate, and unbiased information about their health care choices, and the recent actions taken by the Centers for Medicare and Medicaid Services (CMS) in the CY 2024 Medicare Advantage Final Rule (Final Rule), BMA puts forth these recommendations as additional measures to further enable beneficiaries to make informed choices.

CMS responded to an increase in beneficiary complaints about marketing practices conducted by private sector agents, brokers, or third-party marketing organizations (TPMOs). In the CY 2024 Final Rule, CMS finalized restrictions to ensure that beneficiaries are not misled by inaccurate marketing materials. The rule includes provisions to (1) limit the use of the Medicare name, logo, and products or information in health plan marketing materials, (2) increase CMS's authority to review marketing materials, develop marketing standards, and prohibit certain marketing activities, (3) prohibit marketing potential savings to enrollees in certain circumstances, and (4) prohibit marketing events from occurring within 12 hours of an educational event. The Final Rule also includes provisions for TPMOs, such as requiring that they disclose the number of health plans they represent in an area, BMA has supported such steps to ensure transparency and accountability within Medicare Advantage.[1] Congress has also responded to complaints surrounding marketing practices. In 2022, this Committee released a report on misleading marketing

[1] CMS. CY 2024 Part C & D Rule. April 2023. Available at *https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.*

practices and potential policy recommendations to address Medicare Advantage marketing.[2]

Below are additional policies that will further support beneficiaries in making informed health care choices including:

- **Enhance enforcement of misleading marketing practices.** CMS's Medicare Communications and Marketing Guidelines states "plans are responsible for ensuring compliance with applicable federal laws and regulations, including CMS's marketing and communications regulations."[3] According to a 2022 Senate Finance Committee inquiry on deceptive marketing practices in Medicare Advantage, between 2017 to 2022, only one enforcement decision was related to deceptive marketing practices. CMS should increase consequences for health plans and their marketing partners that engage in misleading marketing practices.[4] CMS should consider levying the following enforcement actions, if warranted, on health plans to ensure compliance with its marketing and communication regulations: (1) monetary penalties, (2) suspension of enrollment, (3) immediate suspension of enrollment, (4) immediate suspension of enrollment and marketing, and (5) termination.
- **Enhance oversight of companies engaging in misleading marketing practices.** CMS should consider increasing funding to organizations that help monitor and report on marketing practices. State Health Insurance Assistance Programs (SHIPs), the Senior Medicare Patrol program (SMP), and Departments of Insurance are independent organizations that provide free, objective information on plan selection and benefits to all Medicare beneficiaries.[5] The Senate Finance Committee's 2022 inquiry identified these organizations as valuable partners in identifying local and national companies who are engaging in misleading or deceiving practices.[6]
- **Establish a code of conduct and/or best practices for TPMOs with continued oversight from health plans and CMS.** While CMS prohibits various marketing practices for health plans (*e.g.,* reference to statistical data), it does not offer a set of guidelines for TPMOs.[7]
- **Prohibit TPMOs from distributing beneficiary contact information.** TPMOs are currently permitted to collect personal beneficiary data and sell this information to other TPMOs. When beneficiaries place a call or click on a weblink related to an advertisement for a Medicare Advantage plan, they are often unaware they are providing consent for their contact information to be shared with other TPMOs for future marketing activities. CMS proposed to prohibit such activity in the CY 2024 Medicare Advantage and Part D Proposed Rule, but the agency did not finalize the policy.[8] However, CMS noted that it may address this provision in a future final rule.

In conclusion, BMA appreciates your interest and work on this important topic and share your commitment to strengthening the program and better informing beneficiaries of their Medicare choices. We welcome the opportunity to discuss these important issues with the Committee working in partnership with our Allies and partners. We appreciate being able to continue working together and ensuring that all

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[2] Senate Finance Committee. Deceptive Marketing Practices Flourish in Medicare Advantage. Available at *https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.*

[3] CMS. Medicare Communications and Marketing Guidelines (MCMG). Available at *https://www.cms.gov/files/document/medicare-communications-marketing-guidelines-2-9-2022.pdf.*

[4] United States Senate Committee on Finance. Wyden Reports Deceptive Marketing Practices in Medicare Advantage that Harm Seniors. Available at *https://www.finance.senate.gov/chairmans-news/wyden-reports-deceptive-marketing-practices-in-medicare-advantage-that-harm-seniors.*

[5] CMS. CMS/AOA Data Reporting Guidance: Joint SHIP/SMP Programs. Available at *https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/SMPSHIPGuidance.pdf.*

[6] Senate Finance Committee. Deceptive Marketing Practices Flourish in Medicare Advantage. Available at *https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.*

[7] CMS. Chapter 3—Medicare Marketing Guidelines. Available at *https://www.cms.gov/medicare/health-plans/managedcaremarketing/downloads/finalmmg051509.pdf.*

[8] CMS. Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS–4201–P). Available at *https://www.cms.gov/newsroom/fact-sheets/contract-year-2024-policy-and-technical-changes-medicare-advantage-and-medicare-prescription-drug.*

Medicare Advantage beneficiaries have the tools and resources necessary to attain optimal health and well-being.

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Statement of David Merritt, Senior Vice President of Policy and Advocacy

Blue Cross and Blue Shield (BCBS) companies want everyone to have access to high-quality, affordable and equitable health care. This is especially critical for the nearly 32 million seniors and Americans with disabilities who choose Medicare Advantage (MA)—an increasingly popular program that provides affordable, coordinated, patient-centered care and offers additional benefits that original Medicare does not, such as meal support and transportation. Medicare Advantage has a proven track record of reducing costs and improving care. As more and more beneficiaries choose MA over the traditional fee-for-service Medicare (FFS) program, the Blue Cross Blue Shield Association (BCBSA) commends Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee for holding this important hearing to examine MA annual enrollment.

BCBSA is a national federation of 34 independent, community-based and locally operated BCBS companies (Plans) that collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

Medicare Advantage Enrollment, Satisfaction and Quality

Medicare Advantage beneficiaries are extremely satisfied[1] with their health care coverage with 98% of beneficiaries saying they are satisfied with their MA plan, and 97% expressing satisfaction with their network of physicians, hospitals and specialists. BCBS companies collectively cover 4.5 million people in MA plans, which represents about 14% of the market. Enrollment in MA plans more than doubled between 2011–2021 with BCBS MA enrollment experiencing an 8% annual growth rate from the end of 2018 to September 2023.

Looking forward to 2024, BCBS will have a considerable geographic presence with individual MA plan offerings in 48 states and Puerto Rico, including new expansion to Mississippi. Additionally, for the third straight year, BCBS Plans lead all MA carriers in the number of eligible beneficiaries with access to individual MA products, reaching approximately 800,000 more Medicare eligibles than the next highest competitor in 2024.

This growth in enrollment is not surprising because the evidence shows MA delivers better services, better access to care, and better value. Studies show[2] that MA plans outperform original Medicare on leading quality measures, including reduced hospital admissions, lower inpatient care utilization and fewer emergency room visits. Compared to original Medicare, MA plans offer significant initiatives in primary care and preventive services, care coordination and case management designed to improve quality, with an emphasis on members with chronic conditions. MA beneficiaries report spending nearly $2,000 less on out-of-pocket costs and premiums annually. MA covers all Medicare-covered services like hospital and physician services for 24% less than original Medicare.

Third Party Marketing Organizations (TPMOs)

With the Medicare open enrollment period now underway, BCBS companies are committed to working with policymakers to build on the success of the MA program to ensure it continues to meet the diverse needs of beneficiaries. This commitment includes ensuring that marketing materials provide beneficiaries with accurate, easy-to-understand information about their coverage options. BCBSA is supportive of the Centers for Medicare and Medicaid Services' (CMS) new marketing guidelines which provide greater transparency and support to beneficiaries in making informed

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[1] *https://bettermedicarealliance.org/medicare-advantage-explained/*.
[2] *https://bettermedicarealliance.org/publication/avalere-medicare-advantage-outcomes-among-beneficiaries-with-chronic-conditions/*.

decisions about their health benefits. We appreciate the efforts of lawmakers and the Administration to protect beneficiaries from misleading marketing and reduce rapid disenrollment rates. We share these concerns and fully support recent regulatory changes to curb deceptive marketing practices and protect beneficiary information, including:

- Revisions to disclaimer and material submission requirements for TPMOs;
- Prohibiting the use of superlatives in marketing materials;
- Limitations on the use of the Medicare name and logo; and
- Limiting call recordings between TPMOs and beneficiaries to marketing and enrollment calls.

Overall, the actions taken to address marketing in the MA program are a much-needed step in the right direction. We look forward to working with Congress to ensure beneficiaries are protected from deceptive marketing practices and have the information they need to make health coverage decisions that meet their needs.

Increasing Transparency and Improving Senior Experiences on Medicare Plan Finder

Increasing transparency around supplemental benefit offerings empowers beneficiaries to make more informed choices about their benefit options. Making changes to the Medicare Plan Finder is an important way to educate beneficiaries about the availability of supplemental benefits.

We recommend Congress support regulatory action to modify the Plan Finder to ensure comprehensive summaries of available supplemental benefits in plan compare. We recommend CMS conduct working sessions with the health plans to assist with creating and testing the web-based version of the software so that stakeholders can provide suggestions on how to file some of the more complex benefits.

Conclusion

We applaud today's Senate Finance Committee hearing to help advance our shared goal of ensuring Medicare beneficiaries receive unbiased, actionable, and easy-to-navigate information to make informed decisions about their coverage and care. We look forward to working with Congress to build on the solid foundation of the MA program to ensure stability, preserve access to care and increase competition.

STATEMENT SUBMITTED BY LUCILLE CELESTINO

We don't need more competition amongst Medicare Advantage Plans.

We need to overhaul the Medicare system to stop MA plans from abusing lower income individuals who cannot afford Supplement plans and have no real choice but the Medicare Advantage Plans.

We need to get rid of the built in bigotry of Original Medicare which mandated the 20 percent rule based on the demands of racist southern politicians of the past. This is 2023.

We need to respect health-care providers and not support a private enterprise that seeks to come between them and their patients.

Claims of added benefits by MA plans must be countered by at least making those minimal benefits available to all Medicare recipients without the exaggerated fraudulent marketing of the MA plans.

Rules that allow health-care dollars of Medicare to be offered instead as food or income support need to be revised and eliminated.

We must stop Medicare Advantage from raiding our Medicare Fund for profit at the expense of our most vulnerable Seniors.

What is going on is craven and obscene.

The time to act is now.

Respectfully,

Lucille Celestino

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Statement of Brandon Novick

I am Brandon Novick, Domestic Program Outreach Assistant at the Center for Economic and Policy Research (CEPR), and I am pleased to submit this statement on behalf of CEPR.

Deceptive and fraudulent advertising for MA plans cost taxpayers $6 billion in 2022 alone; however, this symptom only constitutes between 4% and 7% of the larger issue: MA itself.[1] In 2022, the privatization of Medicare through MA cost taxpayers between $88 billion and $140 billion.[2]

The federal government will have given over $450 billion in 2023 to insurance companies running MA plans, who now provide coverage to 51% of Medicare beneficiaries.[3] Thus, it is only natural that plans, marketers, and brokers will utilize wide-ranging strategies, however misleading, to get as much taxpayer money as possible. Ultimately, much of these taxpayer dollars are going to the largest, for-profit insurance companies; UnitedHealthcare and Humana account for 46% of MA enrollment in 2022.[4]

While MA plans advertise comprehensive, inexpensive coverage, they fail to make clear the realities of poor coverage through restricted networks, prior authorizations and denials of care, and high costs for their supplemental benefits. This statement delves into what MA plans don't tell the American people in their advertisements.

Overall, MA costs taxpayers billions more than Traditional Medicare (TM), enriches large insurance companies, and provides less reliable coverage. Thus, CEPR urges Congress to save money and increase quality coverage by bolstering TM and clamping down on misleading advertising and overpayments to MA plans.

Poor Coverage in MA

Last year's report on deceptive marketing practices in MA by the Majority Staff of the U.S. Senate Committee on Finance highlights how a principal way marketers mislead Medicare beneficiaries is by suggesting that their preferred providers are in network.[5] While this deception is fraudulent on its face, it highlights the larger problem of restrictive networks in MA.

Medicare beneficiaries in TM can see nearly any provider they prefer, while those in MA plans have access to a significantly more limited network of providers. An all too common story for beneficiaries choosing to enroll in Medicare Advantage is losing their doctor whom they like because they are not in network.[6] A 2017 analysis of 391 MA plans' physician networks found that only 22% offered broad networks while 35% and 43% offered narrow and medium networks, respectively.[7] On average, MA plans' networks included less than half (46%) of all physicians in a county. Restricted networks are especially problematic in MA, as 58% of plans in

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[1] David Lipschutz, "Senate Finance Committee Holds Hearing on Medicare Advantage Marketing Misconduct," Center for Medicare Advocacy, October 19, 2023, *https://medicareadvocacy.org/senate-finance-committee-holds-hearing-on-medicare-advantage-marketing-misconduct/*.

[2] Physicians for a National Health Program, "Our Payments Their Profits: Quantifying Overpayments in the Medicare Advantage Program" (Physicians for a National Health Program, October 4, 2023), *https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf*.

[3] Nancy Ochieng et al., "Medicare Advantage in 2023: Enrollment Update and Key Trends," Kaiser Family Foundation, August 9, 2023, *https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/*.

[4] Meredith Freed et al., "Medicare Advantage 2023 Spotlight: First Look," Kaiser Family Foundation, November 10, 2022, *https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/*.

[5] Majority Staff of the U.S. Senate Committee on Finance, "Deceptive Marketing Practices Flourish in Medicare Advantage" (U.S. Senate, November 2, 2022), *https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf*.

[6] Philip Moeller, "My Physician Isn't in My Medicare Advantage Network. What Can I Do?," PBS NewsHour, September 6, 2017, *https://www.pbs.org/newshour/economy/physician-isnt-medicare-advantage-network-can*.

[7] Gretchen Jacobson et al., "Medicare Advantage: How Robust Are Plans' Physician Networks?," Kaiser Family Foundation, October 5, 2017, *https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/*.

2023 are Health Maintenance Organizations (HMOs), which require patients to fully pay out-of-pocket (OOP) for using any provider that is out of network.[8]

In addition to restricted networks, some physicians opt out of serving MA beneficiaries while still serving TM patients due to low reimbursement rates. Around a month ago, two major health groups with Scripps Health—a San Diego-based nonprofit healthcare system—dropped their contracts with MA plans entirely.[9] According to a 2022 Government Accountability Office (GAO) report, MA plans improperly rejected 18% of payment denials to providers.[10] While a growing number of hospitals and health systems are ending their relationships with MA plans; in comparison, only 1.1% of non-pediatric physicians have opted out of the TM program.[11, 12]

Additionally, MA plans are more likely to direct patients to lower quality providers. A 2018 study in PubMed Central (PMC) shows that MA enrollees were more likely to be enrolled in lower quality skilled nursing facilities compared to TM based on 32 unique quality measures gathered by the Centers for Medicare and Medicaid Services (CMS).[13] Similarly, a 2023 study published in *JAMA* found that MA enrollees are significantly less likely to go to high quality home health agencies (HHAs) than TM beneficiaries.[14]

Unlike TM, MA also hurts beneficiaries through prior authorizations and improper denials of care. Prior authorizations deny and delay medical care if the MA plan has not pre-approved the treatment. Thus, providers must submit requests for approval from the MA plan, showing that the treatment is medically necessary before helping their patient. In 2021, providers submitted over 35 million prior authorization requests to MA plans.[15]

MA plans fully or partially denied roughly 2 million or 6% of these requests in 2021.[16] When the denials were appealed, patients had an 82% success rate; however, only 11% of appeals were appealed in the first place. However, the 2022 GAO report found that 13% of MA plan denials of care met Medicare coverage rules and would have likely been covered under TM.[17] Therefore, while 13% of denials are improper, only 9% of the denials are successfully appealed, meaning that Medicare beneficiaries were denied 80,000 treatment requests they were entitled to in 2021.

These prior authorizations and denials of care lead not only to heightened anxiety for Medicare beneficiaries but it directly harms the ability for physicians to care for their patients. A 2022 survey by the American Medical Association found that 94% of physicians reported experiencing prior authorizations caused delays to necessary care with 56% reporting this occurring always or often.[18] 80% of physicians reported that prior authorizations caused the abandonment of recommended treatment. Consequently, 33% reported that prior authorizations caused a serious adverse event for their patients.

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[8] Freed et al., "Medicare Advantage 2023 Spotlight."

[9] Cheryl Clark, "Two Large Medical Groups Shun Medicare Advantage Plans," MedPage Today, September 25, 2023, *https://www.medpagetoday.com/special-reports/exclusives/106483.*

[10] Christi Grimm, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (U.S. Department of Health and Human Services Office of Inspector General, April 2022), *https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.*

[11] Jakob Emerson, "Hospitals Are Dropping Medicare Advantage Left and Right," Becker's Hospital Review, October 9, 2023, *https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html.*

[12] Nancy Ochieng and Gabrielle Clerveau, "How Many Physicians Have Opted Out of the Medicare Program?," Kaiser Family Foundation, September 11, 2023, *https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/.*

[13] David J. Meyers, Vincent Mor, and Momotazur Rahman, "Medicare Advantage Enrollees More Likely to Enter Lower-Quality Nursing Homes Compared to Fee-for-Service Enrollees," *Health Affairs* 37, no. 1 (2018): 78–85, *https://doi.org/10.1377/hlthaff.2017.0714.*

[14] Margot L. Schwartz et al., "Quality of Home Health Agencies Serving Traditional Medicare vs Medicare Advantage Beneficiaries," *JAMA Network Open* 2, no. 9 (September 4, 2019): e1910622, *https://doi.org/10.1001/jamanetworkopen.2019.10622.*

[15] Jeannie Fuglesten Biniek and Nolan Sroczynski, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021," Kaiser Family Foundation, February 2, 2023, *https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/.*

[16] *Ibid.*

[17] Grimm, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care."

[18] American Medical Association, "2022 AMA Prior Authorization (PA) Physician Survey" (American Medical Association, February 10, 2022), *https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.*

One of the primary benefits marketers present to Medicare beneficiaries about MA is the inclusion of dental, hearing, and vision benefits that don't exist in TM. However, the general quality of care is quite poor. For example, while around 96% of MA enrollees are in a plan that offers some kind of dental coverage, these enrollees do not utilize dental services more so than those in TM.[19] This reality is likely due to high costs. The majority of plans have very high coinsurance rates outside of routine check-up and cleaning appointments, as the average is around 50%, along with cost sharing for preventative care.[20]

Additionally, the majority of MA plans with dental coverage have an annual cap on how much they will spend on coverage; 59% of MA patients were in plans that would not spend more than $1,000 or less in 2021. Similarly, most MA plans have an annual vision care limit of just $160, and they covered only 30% of overall vision spending for MA enrollees in 2020.[21] For hearing care, 99% of MA enrollees are in plans with annual dollar limits on coverage, frequency of use limits for covered services, or both.[22] While TM does not currently offer dental or vision coverage, a 2022 study found that there was no significant difference in how many MA and TM patients delayed dental and vision care due to cost.[23]

Ultimately, while it is very problematic that shady marketers mislead Medicare beneficiaries about network and quality issues with specific MA plans, the existence of restricted networks, prior authorizations, denials of care, and other methods to reduce spending on patient care are features not bugs of MA.

MA has Never Saved Money and Rips Off Taxpayers

While one of the central tenets of MA proponents is that introducing market competition would increase efficiency and lower costs, MA has never yielded savings for taxpayers in comparison to TM according to MedPAC. Thus, the privatization of Medicare MA is accelerating the depletion of the Medicare Trust Fund rather than slowing or stopping it.

Insurance companies are currently gaming the "value-based" payment system that MA operates within.[24] CMS uses a "capitated" payment model (that is, flat, individual, per person payments) to pay for services provided by MA. CMS claims that the capitated payments are "value-based," improving the quality and cost of patient care by incentivizing MA plans to invest in preventative care and increase the health of patients. Whatever money they don't spend raises their profit margins. However, this theory presupposes that the MA plans are mission-driven and principally care about patient well-being.

While there are good stories of mission-driven nonprofits succeeding within a value-based system, most beneficiaries use plans run by large, for-profit insurers. Thus, the central aim of the for-profit insurers behind the most-utilized, major MA plans is to make money. The preponderance of the evidence shows just that: privatized senior care has led to higher costs for Medicare, a drain on the Medicare trust fund, and less reliable care for patients that need it.

In fact, a recent report from Physicians for a National Health Program (PNHP), found that MA plans overcharged taxpayers between $88 billion and $140 billion in

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[19] Lisa Simon, Zirui Song, and Michael L. Barnett, "Dental Services Use: Medicare Beneficiaries Experience Immediate and Long-Term Reductions After Enrollment: Study Examines Dental Services Use by Medicare Beneficiaries," *Health Affairs* 42, no. 2 (February 1, 2023): 286–95, *https://doi.org/10.1377/hlthaff.2021.01899*.

[20] Meredith Freed et al., "Medicare and Dental Coverage: A Closer Look," Kaiser Family Foundation, July 28, 2021, *https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/*.

[21] Anuj Gangopadhyaya et al., "Are Vision and Hearing Benefits Needed in Medicare?" (Urban Institute, November 19, 2021), *https://www.urban.org/sites/default/files/publication/105115/are-vision-and-hearing-benefits-needed-in-medicare_1.pdf*.

[22] Meredith Freed et al., "Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage," Kaiser Family Foundation, September 21, 2021, *https://www.kff.org/health-costs/issue-brief/dental-hearing-and-vision-costs-and-coverage-among-medicare-beneficiaries-in-traditional-medicare-and-medicare-advantage/*.

[23] Rahul Aggarwal, Suhas Gondi, and Rishi K. Wadhera, "Comparison of Medicare Advantage vs Traditional Medicare for Health Care Access, Affordability, and Use of Preventive Services Among Adults With Low Income," *JAMA Network Open* 5, no. 6 (June 7, 2022): e2215227, *https://doi.org/10.1001/jamanetworkopen.2022.15227*.

[24] Eileen Appelbaum, Rosemary Batt, and Emma Curchin, "Profiting at the Expense of Seniors: The Financialization of Home Health Care" (Center for Economic and Policy Research, September 26, 2023), *https://cepr.net/report/profiting-at-the-expense-of-seniors-the-financialization-of-home-health-care/*.

2022 alone.[25] PNHP estimates that the real figure is actually higher, as their estimate did not include various illegal activities like outright fraud.

According to the report, overpayments come from five principal sources: favorable selection, favorable deselection, upcoding, benchmarks and bonuses, and induced utilization. First, CMS pays MA plans from a benchmark based on TM; however, MA plans target beneficiaries who are already healthier and less costly. This resulted in $44–$56 billion in overpayments.[26]

Favorable deselection refers to the phenomenon where MA patients who get sick, have high needs, and/or also qualify for Medicaid have to switch out of MA back to TM due to unreliable coverage. However, further highlighting how MA enrollees are generally healthier than those in TM, Medicare spent $1,253 less per beneficiary in 2016 for those who switched from MA back to TM compared to those who remained in TM.[27]

While targeting healthier individuals, since CMS increases the size of capitated payments per individual based on how sick they are which is measured by a risk score, MA plans also engage in upcoding.[28] More specifically, MA plans have their patients receive false or irrelevant diagnoses to increase their risk score, thus, increasing how much taxpayer money they receive. In 2019, MA risk scores were 20% higher than they would have been in TM. Upcoding results in around $20 billion in overpayments according to PNHP.[29]

When the federal government ordered payers to return $4.7 billion in overpayments due to upcoding, Humana sued, alleging that the Department of Health and Human Services (HHS) had no legal right to audit them.[30] The $4.7 billion actually only accounted for a portion of total overpayments due to upcoding, as the government is letting insurers keep fraudulently acquired taxpayer funds from before 2018.[31]

MA plans also increase the amount of taxpayer money they collect by gaming the benchmark and bonus systems created by the Affordable Care Act. CMS uses county benchmarks to reward MA plans with rebates depending on how much they spend relative to TM. The purpose of this system is to incentivize and reward MA plans to expand coverage to underserved communities; however, it currently overpays MA plans to the tune of $8–$12 billion in 2022.[32] Moreover, CMS also rewards MA plans with quality bonuses through a star-rating system. However, due to significant flaws in the quality measures, MA plans have inflated their star ratings to receive higher rebates, leading to $16 billion in 2022 overpayments.[33]

Another flaw in how CMS pays MA plans regards how MA benchmarks are not only based on beneficiaries in TM, but they include Medicare beneficiaries who have purchased supplemental, Medigap plans. Medigap plans fill in the holes in coverage that TM currently does not; thus, beneficiaries with supplemental coverage are more likely to use more care. Including them raises the benchmark and increases the amount of money CMS pays to MA plans; therefore, taxpayers are subsidizing supplemental coverage for private insurers while those in TM have to pay for it themselves. In 2022, this resulted in $36 billion in overpayments.[34]

Ultimately, MA is a massive boon to the profits of private insurers by allowing them to further drain the Medicare Trust Fund and take taxpayer dollars while not actu-

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[25] Physicians for a National Health Program, "Our Payments Their Profits: Quantifying Overpayments in the Medicare Advantage Program."
[26] *Ibid.*
[27] Gretchen Jacobson, Tricia Neuman, and Anthony Damico, "Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?," Kaiser Family Foundation (blog), May 7, 2019, *https://www.kff.org/medicare/issue-brief/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending/*.
[28] Appelbaum, Batt, and Curchin, "Profiting at the Expense of Seniors: The Financialization of Home Health Care."
[29] Physicians for a National Health Program, "Our Payments Their Profits: Quantifying Overpayments in the Medicare Advantage Program."
[30] Rebecca Pifer, "Humana Sues HHS over Medicare Advantage Audits," Healthcare Dive, September 5, 2023, *https://www.healthcaredive.com/news/humana-sues-hhs-ma-risk-adjustment-audits/692665/*.
[31] Center for Medicare Advocacy, "Center for Medicare Advocacy Statement on Recent Medicare Advantage Payment Policies and Proposals," Center for Medicare Advocacy, February 3, 2023, *https://medicareadvocacy.org/center-for-medicare-advocacy-statement-on-recent-medicare-advantage-payment-policies-and-proposals/*.
[32] Physicians for a National Health Program, "Our Payments Their Profits: Quantifying Overpayments in the Medicare Advantage Program."
[33] *Ibid.*
[34] *Ibid.*

ally improving the quality of coverage for Medicare beneficiaries. MA is so profitable for insurers that Humana, the fifth-largest health insurance company in the United States, announced earlier this year that it will stop all of its commercial insurance activities to solely focus its business on MA plans.[35, 36]

In a healthcare environment where the federal government significantly over subsidizes private insurers who offer MA plans, it is inevitable that these companies and marketers would employ every strategy possible to get in on the massive profits. While we appreciate that Congress is investigating fraudulent and deceitful marketing strategies, we ask that Congress not only scrutinize the symptoms but the cause of worsening healthcare coverage for seniors.

The Need to Strengthen Medicare

While MA overcharges taxpayers and offers insufficient coverage, Medicare beneficiaries have increasingly chosen to enroll in MA plans so that now over half take part in MA.[37] Americans are not irrational when making this decision, as both deficiencies in TM and CMS overpayments to MA plans contribute to this growing reality.

The cost of healthcare in the United States is extremely expensive and continuously rising at the same time as Americans do not have significant savings, especially the senior and disabled people who make up the Medicare beneficiary population. In 2021, the US spent $4.3 trillion on healthcare or $12,914 per person while the average cost of healthcare in other wealthy countries is roughly half as much.[38, 39] At the same time, 37% and 57% of Americans are not able to cover $400 and $1000 emergencies, respectively, with cash or its equivalent.[40, 41]

Thus, having sufficient health insurance that does not result in high OOP costs is vital for millions of Americans, yet TM only covers 80% of outpatient healthcare costs with no limit on OOP expenses.[42] Consequently, many individuals purchase a supplemental Medigap plan to cover the remaining 20%; but, Medigap plans can cost anywhere from $600 to over $3600 per year, which many people cannot afford.[43]

Comparatively, MA plans advertise full coverage with an average of $18.50 in monthly premiums, and some plans have no premium at all.[44] In addition, many MA plans include supplemental benefits not covered by TM, such as dental, hearing, and eye care. MA plans are able to offer such low costs due to significant subsidies and overpayments from CMS and American taxpayers.

In addition to cracking down on deceptive marketing for MA, we urge Congress to strengthen TM to improve coverage, save money, and force MA plans to increase their coverage quality rather than profiteer off taxpayer money. While CMS overpaid MA plans $88–$140 billion (and likely even more due to illegal, fraudulent behavior), Congress can cap OOP costs at $5,000 for $39 billion and provide dental,

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[35] Stephanie Guinan, "Largest Health Insurance Companies for 2024," ValuePenguin, October 2, 2023, *https://www.valuepenguin.com/largest-health-insurance-companies.*

[36] Laura Joszt, "Humana Leaving Commercial Business, Will Focus on Government-Funded Programs," AJMC, February 23, 2023, *https://www.ajmc.com/view/humana-leaving-commercial-business-will-focus-on-government-funded-programs.*

[37] Ochieng et al., "Medicare Advantage in 2023."

[38] Centers for Medicare and Medicaid Services, "National Health Expenditure Data: Historical," *CMS.gov,* 2023, *https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2018.3%20percent.*

[39] Peter G. Peterson Foundation, "Why Are Americans Paying More for Healthcare?," Peter G. Peterson Foundation (blog), July 14, 2023, *https://www.pgpf.org/blog/2023/07/why-are-americans-paying-more-for-healthcare.*

[40] The Federal Reserve, "The Fed—Report on the Economic Well-Being of U.S. Households in 2022—May 2023," Board of Governors of the Federal Reserve System, 2023, *https://www.federalreserve.gov/consumerscommunities/sheddataviz/unexpectedexpenses.html.*

[41] Ivana Pino, "57% of Americans Can't Afford a $1,000 Emergency Expense, Says New Report. A Look at Why Americans Are Saving Less and How You Can Boost Your Emergency Fund," Fortune Recommends, January 25, 2023, *https://fortune.com/recommends/banking/57-percent-of-americans-cant-afford-a-1000-emergency-expense/.*

[42] Medicare Rights Center, "Outpatient Therapy: Medicare Coverage and Costs," Medicare Interactive (blog), accessed October 27, 2023, *https://www.medicareinteractive.org/get-answers/medicare-covered-services/rehabilitation-therapy-services/outpatient-therapy-costs.*

[43] Lindsay Malzone, "Average Cost of Medigap Insurance Plans," *Medigap.com,* October 5, 2023, *https://www.medigap.com/faqs/average-cost-of-medigap-insurance-plans/.*

[44] The National Council on Aging, "What Are the Costs of Medicare Advantage?," NCOA, October 18, 2023, *https://www.ncoa.org/article/what-are-the-costs-of-medicare-advantage-part-c.*

hearing, and vision coverage for $84 billion.[45, 46, 47] Unlike MA enrollees, people in TM would be able to access these benefits without restricted networks, prior authorizations, and other methods to limit and worsen care.

Furthermore, Congress can save billions of dollars by simultaneously reining in overpayments to MA plans. According to the Committee for a Responsible Budget, CMS could implement coding intensity adjustments to limit overpayments, saving $198–$355 billion in Medicare spending, $32–$57 billion in Medicare premiums, and $207–$372 billion in the federal budget deficit all over 10 years.[48]

Conclusion

Medicare beneficiaries deserve to choose the best plan for them without getting misled by deceptive, fraudulent advertisements by marketers on behalf of MA plans. CEPR applauds Congress for any efforts to crack down on this illegal and harmful behavior; however, we urge consideration of the deeper, systemic issues within the MA program itself. American taxpayers subsidize and overpay large, profitable insurance companies to the tune of billions of dollars to provide limited, restrictive health coverage that is unreliable when Medicare beneficiaries need it most. At the same time, Congress could reallocate funds, save money, and improve coverage for senior and disabled Americans by improving TM and reducing overpayments to MA plans.

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[46] Anuj Gangopadhyaya et al., "Adding an Out-of-Pocket Spending Limit to Traditional Medicare" (Urban Institute, June 6, 2022), *https://www.urban.org/research/publication/adding-out-pocket-spending-limit-traditional-medicare.*

[47] Hannah Katch and Paul Van De Water, "Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits," Center on Budget and Policy Priorities, December 8, 2020, *https://www.cbpp.org/research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits.*

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Overview

The Center for Medicare Advocacy (the Center) is a national, non-profit law organization that works to ensure access to comprehensive Medicare, health equity, and quality healthcare. The organization provides education, legal assistance, research and analysis on behalf of older people and people with disabilities, particularly those with long-term conditions. The Center's policy positions are based on its experience assisting thousands of individuals and their families with Medicare coverage and appeal issues. Additionally, the Center provides individual legal assistance and, when necessary, challenges patterns and practices that inappropriately deny access to Medicare and necessary care. We appreciate the opportunity to submit this written testimony for the record.

The Center applauds the Senate Finance Committee for holding a hearing focusing on marketing abuses surrounding the sale of Medicare Advantage (MA) plans. In November 2022, the Senate Finance Committee issued a report[1] titled "Deceptive Marketing Practices Flourish in Medicare Advantage" which "found evidence that beneficiaries are being inundated with aggressive marketing tactics as well as false and misleading information." More recently, reports by KFF[2] and Commonwealth Fund[3] show that during last year's open enrollment period, 85% of Medicare-related ads focused on MA plans, three-quarters of Medicare beneficiaries faced daily TV or online ads, and 1 in 3 reported receiving 7 or more unsolicited phone calls per week. Lower income individuals were more likely be to subject to "advertising information that was later found to be untrue" and a larger share of Black adults than White adults reported unsolicited calls.

Amidst this onslaught of marketing promoting enrollment into MA plans, most people with Medicare are not making informed decisions about their health care coverage. According to KFF 's analysis[4] of MA marketing:

> Ads rarely mentioned traditional Medicare, or potential limitations with plan coverage, such as provider networks or prior authorization requirements, leaving beneficiaries with an incomplete view of their coverage options and the tradeoffs among them.

There are many things that Congress and the Centers for Medicare & Medicaid Services (CMS) can and should do to address Medicare Advantage problems, including marketing misconduct. The Center supports all of recommendations from November 2022 Committee report, in particular shoring up the State Health Insurance Assistance (SHIPs) and addressing agent/broker commissions, as discussed below. But larger systemic issues plaguing Medicare Advantage also demand broad, systemic solutions.

Policy Suggestions to Address Medicare Advantage Marketing Misconduct

Rein in Wasteful Overpayments to MA Plans

One of the major drivers of marketing misconduct is the massive financial incentives for insurance companies to maximize enrollment in their most profitable products and, in turn, the corresponding incentives of those who sell these products. As mentioned by Senators Stabenow and Warren at the hearing, MA plans are paid at a higher rate than the traditional Medicare program spends on a given bene-

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[1] *https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.*

[2] *https://www.kff.org/medicare/report/how-health-insurers-and-brokers-are-marketing-medicare/.*

[3] *https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/private-plan-pitch-seniors-experiences-medicare-marketing-advertising.*

[4] *https://www.kff.org/medicare/press-release/kff-research-shows-that-medicare-open-enrollment-tv-ads-are-dominated-by-medicare-advantage-plans-featuring-celebrities-active-and-fit-seniors-and-promises-of-savings-and-extra-benefits-without-fund/.*

ficiary. While estimates of the extent of MA overpayments vary, such wasteful payment is receiving more attention from both the media and policymakers. While the Medicare Payment Advisory Commission (MedPAC) estimates wasteful overpayments to be almost $27 billion in 2023,[5] as noted in a *CMA Alert* (August 3, 2023),[6] in July 2023 the Committee for a Responsible Federal Budget (CRFB) posted research suggesting that MA plans might be overpaid by between $180 billion and $1.6 trillion over the next decade. More recently, as discussed in another *CMA Alert* (October 5, 2023),[7] Physicians for a National Health Program (PNHP) released a report stating that MA plans are overpaid by as much as $140 billion a year.

Strengthening Traditional Medicare

These wasteful overpayments allow MA plans to offer extra benefits that are used to entice people while distracting from more important considerations. Not only do such wasteful overpayments put strain on Medicare's finances, they crowd out coverage expansion in traditional Medicare program. Congress should rein in wasteful MA overpayments and use them to both shore up Medicare's finances and add benefits to traditional Medicare—such as dental, hearing and vision coverage—which would accrue to all Medicare beneficiaries, including those who choose to enroll in MA plans. Adding these benefits, as well as an out-of-pocket cap, would help level the playing field between MA and traditional Medicare, and allow for a true choice of coverage options. Due to extra money to offer extra benefits, and massive insurance company marketing budgets aimed to maximizing enrollment into MA plans, today, the deck is stacked in favor of enrollment into Medicare Advantage. This disparity is exacerbated by the lack of freedom of movement between coverage options. Free movement between types of Medicare coverage must be made more fair and equitable. This includes expanding federal Medigap rights beyond the current rules, which generally do not require Medigap companies to sell a policy to someone who disenrolls from an MA plan after a year of being in such a plan.

Similarly, there are unequal rights to move in and out of MA plans vs. stand-alone Part D plans (PDPs). The Medicare Advantage Open Enrollment Period (MA–OEP) allows someone to make changes to their coverage during the first 3 months of the calendar year if they began the year with MA coverage. No similar right exists for individuals in traditional Medicare and PDPs. As Senator Grassley suggested during the hearing, there should be a corresponding right for enrollment in PDPs.

Strengthen Oversight and Enforcement

With more than half of the Medicare population now enrolled in MA plans, it is unclear if CMS' resources and staff have been allocated accordingly in order to provide necessary regulatory oversight and enforcement. Congress should invest additional funding in the agency's oversight, and provide CMS with additional tools to hold plans accountable, including enhanced enforcement measures such as higher civil monetary penalties and more meaningful sanctions, including the ability to terminate plan contracts due to misconduct. Further, CMS should work more closely with state departments of insurance and the National Association of Insurance Commissioners (NAIC) to ensure that agents, brokers, and plan sponsors are held accountable for misconduct.

Foster Informed Decision-Making

In order to assist Medicare beneficiaries to make fully informed decisions about their coverage options in a more consumer-friendly manner and without undue pressure from agents and brokers, Congress and CMS should work to reform agent/broker commissions, standardize and limit plan offerings, and better support the SHIP network.

Reform Commissions Paid to Agents and Brokers

During the hearing, Ms. Hogland, CEO of Security Health Plan, testified about how the lure of "add-on payments" available to agents and brokers can negatively impact enrollment in small, regional health plans. The Center agrees that additional payments to agents and brokers beyond commissions are problematic and further skew enrollment towards certain MA plans. For example, we discussed plan sponsor incentive payments, health assessments and the sale of ancillary health products in

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[5] *https://www.medpac.gov/wp-content/uploads/2023/03/ExecutiveSummary_Mar23_MedPAC_Report_To_Congress_SEC.pdf.*

[6] *https://medicareadvocacy.org/policymakers-must-address-medicare-advantage-abuses/.*

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CMA Alerts last fall.[8] Add-on payments to agents/brokers should be prohibited. MA plans should not be able to provide additional compensation to agents and brokers to complete health risk assessments, which further incentivizes agents and brokers to sell MA over other products.

As noted in our *CMA Alert* summarizing the hearing, what was *not* discussed, however, was the disparate commission rates paid for MA enrollments vs. other Medicare products, such as Part D plans and Medigaps. As noted in a February 2023 Commonwealth Fund report,[9] agents and brokers report being paid more to enroll people in MA than in traditional Medicare, by some reports three times as much. Payments are also higher for new enrollments as opposed to renewals, which incentivizes churning of enrollment. When it comes to Part D, agents report that a lot of carriers don't pay at all for Part D enrollments. Overall, "[c]ommissions for stand-alone Part D plans were viewed as too low and not worth the time." Further, "[a]ll brokers and agents who have served people dually eligible for Medicare and Medicaid said they enroll them in Special Needs Plans only." The report also highlighted extra income that agents can earn from conducting beneficiary health risk assessments and bonus payments for reaching enrollment benchmarks.

In addition to the financial incentives insurance companies have to maximize profitable enrollment in MA plans, skewed commissions and other payment incentives drive agents and brokers to push people towards MA plans and away from traditional Medicare. Thus, we urge that agent and broker commissions for MA and Part D plans be equalized. Further, agents and brokers should be required to disclose any and all commissions they receive for the sale of a Medicare product to prospective enrollees.

Standardize MA Benefits and Limit Plan Offerings

In order to make it easier to make meaningful choices among plans, Congress should explore standardizing MA plan benefits, and should limit the number of plans offered per sponsor in a given area. Further, CMS should reinstate meaningful difference requirements with respect to multiple plans offered by the same sponsor.

Invest Further in SHIPs

The nationwide State Health Insurance and Assistance Program (SHIP) is a critical source of unbiased information about the Medicare program and coverage options, yet the SHIP network cannot compete for attention with MA marketing and agents and brokers seeking commissions. As suggested in the Committee's November 2022 report, the SHIP network must be strengthened. More recently, Senator Menendez suggested at the hearing that proving more resources to SHIPs might help; similarly, Senator Casey noted that SHIPs might not have the resources they need.

Close Current Loopholes in Medicare Marketing Rules

CMS has made significant improvements in marketing rules in recent regulatory updates. Notably, the final Part C & D rule for 2024 brings some needed consumer protections.[10] But this work is not done—more is needed in order to adequately protect Medicare beneficiaries from unwanted, often misinforming, and sometimes harassing sales pitches. Among other things, CMS should:

- Prohibit contacts due to pre-existing relationships (from both agents/brokers and insurance plans—*e.g.,* Part D plan sponsor calling a current enrollee to convince them to enroll in same sponsor's MA product)
  - CMS did tighten rules re: opt-out from contact but didn't go far enough—We often hear about individuals enrolled in a stand-alone Part D plan being contacted by the plan sponsor in an attempt to get the individual to switch to one of the sponsor's Medicare Advantage products. This is not a solicited contact, rather it is a cold call, and has nothing to do with the provision of care or benefits of an individuals' current coverage, and therefore should be prohibited. In other words, CMS should prohibit plan sponsors from calling current members to discuss Medicare products. At the very least, members should be able to opt-in to receiving such contact rather than having to ac-

[8] *See https://medicareadvocacy.org/ma-misconduct/* and *https://medicareadvocacy.org/ma-and-selling-extra-products/*.

[9] *https://www.commonwealthfund.org/publications/2023/feb/challenges-choosing-medicare-coverage-views-insurance-brokers-agents.*

[10] *See, e.g.,* a summary of these rules in a CMA Special Report: *https://medicareadvocacy.org/c-and-d-rule-2023/*.

tively opt-out under current rules (even if they are notified at least annually under CMS' proposal).
    - CMS proposed 6 month time period limit for contact after Scope of Appointment (SOA) or Business Reply Card (BRC) filled out, they finalized a 12 month period—this should be shorted to 3 months, or the current enrollment period.
- Prohibit cross-selling of other health related products during the sale of MA and Part D plans
    - In marked contrast to the proclamations of the insurance industry, many of the same people selling Medicare Advantage products both highlight and rely upon MA products' shortcomings in order to promote the sale of ancillary products.[11]
    - Under current Medicare marketing rules, MA organizations may not "Market non-health care related products to prospective enrollees during any MA sales activity or presentation. This is considered cross-selling and is prohibited." 42 CFR §422.2263 (b)(4). This limited regulation has such a limited definition of "cross-selling" that it allows a broad range of exploitative behavior, including the sale of ancillary health products during MA sales.
- Prohibit collection of Business Reply Cards (BRCs) or other information during educational events
- Direct CMS to revisit distinction between "marketing" and "communications" and corresponding requirements—we disagree with the agency's assertion that documents which may impact an enrollment decision, but are not intended to do so, don't qualify as marketing documents. If a beneficiary uses a plan-issued document to make enrollment choices, the sponsor's intent is irrelevant. Plan- and agent/broker-issued content should be subject to stringent oversight by CMS to ensure accuracy and readability.
- Address Marketing of supplemental benefits, particularly SSBCI that might not be available to everyone in a given plan
    - We have heard from SHIP programs that in some areas, the top issue that drove people to seek SHIP counseling during the last annual enrollment period were plan-issued debit cards, or flex card benefits—people demanded to be enrolled in the plan that offered the most money, without regard to any other considerations. One example provided by a SHIP counselor concerned a client who was convinced to look at issues in addition to debit card she wanted, and discovered that none of the five providers she was currently seeing were in network of the plan that offered the highest value debit card she sought. At the beginning of the year, the same SHIP programs report that one of the top issues they have heard about concern how such debit or flex cards don't, in fact, work as the beneficiary was led to believe by the plan or agent/broker.
- Further strengthen new requirements re: explaining the effect of an individual's enrollment choice on current coverage
    - Pre-Enrollment Checklist (PECL)—needs to address prior authorization; needs to inform bene that providers can leave/be terminated from network mid-year; should be an articulation of right to seek care outside of a plan's network when an in-network providers or benefits is unavailable or inadequate to meet an enrollees' medical needs.
- Require that agents and brokers sign an attestation form that whatever product is being sold is appropriate for that beneficiary. Such an attestation is currently required for the sale of Medigap (Medicare supplemental insurance policies).
- Finalize the rule (proposed, but not finalized in the 2024 C&D rule) that personal beneficiary data collected by a TPMO may not be distributed to other TPMOs.

Increase Transparency and Strengthen Reporting Requirements

Require Medicare to collect and publicly report more information about how people access their MA benefits, including denials and delays in care. As Senator Bennet suggested during the hearing, access to information about plan denial rates would help with beneficiary decision-making.

KFF issued a report[12] in 2023 that highlights data gaps—both in information that CMS collects but does not report, as well as information that is not required to be reported by MA plans. This report should be used as a roadmap for additional, re-

[11] *See, e.g.,* CMA Alert: *https://medicareadvocacy.org/ma-and-selling-extra-products/*.

[12] *https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/*.

quired reporting requirements by plans relating to information that should be publicly available, including:

- What share of Medicare Advantage enrollees use supplemental benefits offered by their plan and how does use vary by race/ethnicity, income, or health condition?
- What services and subgroups of enrollees, such as those with specific health conditions, have the highest prior authorization denial rates?
- Reason for prior authorization denials—Do certain insurers attribute denials of prior authorization requests to medical necessity more often than others?
- Do certain insurers respond to prior authorization requests more quickly?
- How often do Medicare Advantage insurers deny payments for Medicare-covered services?

We appreciate the opportunity to submit this written testimony. For additional information, please contact David Lipschutz, Senior Policy Attorney, dlipschutz@MedicareAdvocacy.org at 202–293–5760.

COMMONWEALTH CARE ALLIANCE
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Chairman Wyden, Ranking Member Crapo, and members of the Committee, thank you for the opportunity to submit testimony for the Senate Finance Committee's recent hearing on October 18, 2023 entitled "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences."

Commonwealth Care Alliance (CCA) is a mission-driven healthcare services organization that offers high-quality Medicare Advantage health plans and care delivery programs designed for individuals with significant needs. With offerings in Massachusetts, Rhode Island, Michigan, and California, CCA delivers comprehensive, integrated, and person-centered care by coordinating the services of local staff, provider partners, and community organizations. CCA's model is consistently recognized as one of the best in the country at managing whole-person care across the continuum, including full integration of primary and acute care, behavioral health, long-term services and supports (LTSS), and services that address health-related social needs. We advocate for equitable and cost-effective policies that lead to high-quality health care for individuals who need it most.

CCA strongly supports efforts to improve oversight, ensure that beneficiaries have the best information available and limit dishonest plan marketing practices (*e.g.,* prohibiting certain deceptive marketing activities, ensuring third party marketing organizations (TPMOs) provide more complete information and modifying the TPMO disclaimer).

As we explained in our response to the proposals set forth in CMS' Contract Year 2024 Medicare Advantage and Part D proposed rule (87 FR 79452), we applauded steps taken to meaningfully improve beneficiary protections, such as prohibiting misleading advertising that causes enrollee confusion and abrasion, disallowing contact at home unless an appointment at the time and place was previously scheduled and making improvements to the pre-enrollment checklist (PECL).

However, we also urged caution, as certain policies could inadvertently hinder beneficiaries' ability to make informed decisions about their coverage, as well as disproportionally impact smaller plans committed to and focused on serving those beneficiaries. For example, we recommended CMS not finalize their proposal to require an agent or broker obtain a Scope of Appointment (SOA) form at least 48 hours prior to a personal marketing appointment as it could create an additional, unnecessary barrier to enrollment for some higher-need members who may have mobility or transportation issues, require assistance from caregivers who may have other priorities and other obstacles such as inflexible work schedules. These challenges can make scheduling future appointments particularly burdensome. Additionally, individuals who elected to sign a paper SOA, due to either low digital health literacy or discomfort with signing an electronic SOA, would have been required to wait an additional 48 hours before having a conversation with the agent or broker who might already be at the person's home.

Further, while we agree that appropriate monitoring and oversight is critical to ensure agent and broker compliance, we believe such activities should be the shared responsibility of the TPMO, Medicare Advantage organization and CMS collectively.

Requiring Medicare Advantage plans alone to bear the burden of implementing such a program for each entity with which they work is prohibitively burdensome, especially for smaller, community-based plans like CCA.

We look forward to working with the Committee to ensure the bill addresses potentially deceptive marketing practices while also preserving beneficiary access to necessary education and enrollment support as well as protecting small, not-for-profit plans such as CAA.

Finally, as the Committee explores oversight of the Medicare Advantage program as a whole, we encourage you to continue to keep in mind the needs and resource availability of smaller, not-for-profit health plans like CCA. It is critical to examine the potential consequences of policy changes that could limit community-based plans' ability to provide robust, person-centered coverage or prohibit them from competing in the Medicare Advantage market. Smaller, safety-net plans such as CCA work every day to provide a high-quality product for some of the most vulnerable Medicare beneficiaries, and we thank the Committee for drafting policies that support this important work.

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Statement of Gretchen Jacobson, Ph.D.,
Vice President, Medicare

Chair Wyden and Ranking Member Crapo,

Thank you for the opportunity to submit a statement for the record regarding your October 18th hearing on Medicare Advantage annual enrollment and marketing practices.

The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most underserved communities.

My comments draw from Commonwealth Fund-supported research on consumers' experiences with Medicare marketing, advertising, and enrollment, the information used to make coverage choices, and perspectives of brokers and agents.

Views from Insurance Brokers and Agents on the Challenges of Choosing Medicare Coverage

Insurance brokers and agents are prominent sources of help for beneficiaries making coverage decisions. However, beneficiaries lack information about how brokers and agents winnow down plan options and what role financial incentives might play in the advice they give.

In September 2022, the Commonwealth Fund supported PerryUndem to hold four focus groups with more than 2 dozen brokers and agents who sell Medicare Advantage plans, Medigap supplemental coverage plans, and Part D prescription drug plans with representation in a variety of U.S. states. We sought to learn their perspectives on the state of coverage choices, the challenges their clients face in choosing an option, and the ways in which their financial incentives align or conflict with beneficiaries' interests. The following insights emerged from those discussions.

Medicare Brokers' and Agents' Financial Incentives

- **Most brokers and agents said they are compensated more to enroll people in Medicare Advantage plans than Medigap plans for traditional Medicare.** In focus group interviews, brokers and agents shared that Medicare Advantage plans generally provide more compensation than Medigap plans, and that compensation for selling Part D plans (PDPs) is relatively low or not provided at all. However, the brokers and agents said that relative compensation can differ for new enrollments versus renewals.
- **Brokers and agents said the commission structure of Medigap plans incentivizes the sale of plans charging high premiums.** This may result in some beneficiaries paying more for coverage than they need or want to.

- **Commissions for standalone Part D plans were viewed as too low and not worth the time—creating some problems for beneficiaries and unique issues for people dually eligible for Medicare and Medicaid.** CMS sets a maximum for Part D commissions but not a minimum. Low compensation—or even none—deters brokers from initiating or reevaluating Part D coverage for clients. The low commissions for Part D plans also mean that the only way brokers and agents are compensated for discussions with people dually eligible for Medicare and Medicaid is if the broker enrolls them into a Medicare Advantage plan since people dually eligible typically cannot afford to purchase a Medigap plan.
- **Brokers and agents said they can earn extra income from conducting beneficiary health risk assessments during the Medicare Advantage enrollment process.** The brokers and agents did not know how the risk assessments were used. It is unclear if the assessment is provided to beneficiaries' primary care physicians or used to inform beneficiaries' care management or receipt of additional resources and benefits.
- **Brokers and agents said insurers commonly provide them bonus payments for reaching enrollment benchmarks,** which can create incentives for brokers and agents to steer clients to a certain plan, even if it may not be the best one for their needs.

Challenges Faced by Beneficiaries

- **Some brokers and agents said clients have trouble getting Medigap plans when trying to switch from Medicare Advantage to traditional Medicare.** Extensive underwriting was noted by brokers and agents as a frequent barrier to purchasing a Medigap plan among beneficiaries looking to switch from Medicare Advantage to traditional Medicare outside of the "guaranteed issue" period. Older or sicker beneficiaries may face higher rates or be denied coverage altogether by a Medigap plan.
- **All brokers and agents who have served people dually eligible for Medicare and Medicaid said they only enroll them in Special Needs Plans for people dually eligible (D–SNPs).** Dually eligible beneficiaries have a range of coverage options available to them, including other types of SNPs, other Medicare Advantage plans, traditional Medicare, PACE plans, and Medicare-Medicaid plans. Funneling all clients to D–SNPs raises questions about whether brokers and agents are incentivized to offer other coverage options that may be a better fit for some dually eligible people, a population with diverse and significant health needs. Are they equipped with the information to help their clients weigh those options? Are they incentivized to do so?
- **Brokers generally don't sell all plans in their geographic area. They said that they choose which plans to offer based on how quickly insurers answer their questions, the feedback they receive from clients, and sometimes on plan benefits.** Brokers and agents are not required to contract with all available plans in an area, nor are they required to offer all plans to beneficiaries. Beginning in 2022, brokers and agents who don't offer all plans in an area are required to disclose that fact to their clients—though they are not required to disclose what proportion of plans in the area they sell, or how their compensation differs across plans.
- **Most brokers and agents said they personally would choose traditional Medicare and Medigap over a Medicare Advantage plan.** A few thought that Medicare Advantage would be fine for their needs, but most said that traditional Medicare with Medigap would offer better health care coverage and choices—particularly as people age.

Drivers of Growth in Medicare Advantage Enrollment

- According to brokers and agents, **rising Medigap premiums are driving some beneficiaries to choose Medicare Advantage.** Brokers noted more significant increases in Medigap plan premiums in recent years, compared to historical trends.
- **Marketing efforts have led to beneficiary confusion and helped drive enrollment in Medicare Advantage,** according to brokers and agents. In some instances, ads led some clients to enroll in plans that excluded their doctors from the provider network and others to unknowingly change plans. Brokers and agents said Medicare plan advertising requires them to spend a lot

of time resetting client expectations. In some cases, they even lose clients who don't believe them or want everything the ads promise.

- Some brokers and agents said that, **based on relative commission rates and information from CMS, it seemed to them as if the federal government wants more people to be in Medicare Advantage plans.**

To better align brokers' incentives with beneficiaries' interests, policymakers could consider:

Setting commissions to ensure that agents are not financially motivated to favor a particular type of coverage and can provide beneficiaries unconflicted advice.

Ensuring that brokers and agents are compensated for helping beneficiaries with their Part D coverage. Providing higher Part D commissions would help to balance the total compensation from helping beneficiaries in traditional Medicare versus Medicare Advantage, would compensate brokers and agents for helping traditional Medicare beneficiaries to switch their drug coverage, and would provide compensation for helping dually eligible beneficiaries who want to enroll in coverage options other than a Medicare Advantage plan.

Defining a minimum level of service required to earn the renewal or switching commission.[1] While ensuring commissions even if beneficiaries stay with their original plans may help prevent unnecessary switching, it also runs the risk of giving agents limited incentive to revisit plan fit or routinely check in with beneficiaries. Adding minimum standards for receiving these commissions could mitigate these risks.

Ensuring that brokers and agents are knowledgeable about and compensated for discussing all Medicare coverage options with people dually eligible for Medicare and Medicaid. Brokers and agents are currently only compensated for their discussions with dually eligible people if they enroll this population into Medicare Advantage plans.

Educating Medicare beneficiaries about when they can change their source of coverage. This enhanced education could include informing beneficiaries about the windows in which they have "guaranteed issue rights" to Medigap coverage and possibly allowing for more opportunities to purchase a Medigap plan without underwriting. The education could also include information about existing Special Election Periods that allow beneficiaries to change their source of coverage outside of the Open Enrollment Period.

Increasing transparency and reporting on insurance carriers' actual compensation payments across MA, Part D, and Medigap.[2] Through commissions and administrative payments, insurers can align agents' financial incentives around their business priorities (*e.g.,* growth of a particular MA product over another, or growth of MA business over Medigap). Requiring more information on overrides and payment for other services (*e.g.,* health risk assessments), as well as more transparency into the relationships between health care providers, third-party marketing organizations (TPMOs), and insurers, could help CMS assess whether compensation and other financial arrangements are aligned with beneficiaries' interests.[3]

Seniors' Experiences with Medicare Marketing and Advertising

During the annual Medicare open enrollment period, beneficiaries can reassess their coverage options to decide which one best meets their health needs and budget. Throughout this period, marketing pitches from private plans are seemingly everywhere. The proliferation has coincided with an increase in complaints in recent years, with beneficiaries and brokers reporting confusing and misleading sales tactics.

Through two nationally represented surveys in 2022 and 2023, the Commonwealth Fund sought to understand (1) how people aged 65 and older went about choosing between traditional Medicare and Medicare Advantage and (2) the experiences of

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[1] Riaz Ali and Lesley Hellow, "Agent Commissions in Medicare and the Impact on Beneficiary Choice," To the Point (blog), Commonwealth Fund, October 12, 2021. *https://doi.org/10.26099/kwgc-8k34.*

[2] Riaz Ali and Lesley Hellow.

[3] Steven Findlay, Gretchen Jacobson, and Faith Leonard, "The Role of Marketing in Medicare Beneficiaries' Coverage Choices" (explainer), Commonwealth Fund, January 5, 2023. *https://doi.org/10.26099/6qnb-fa27.*

people aged 65 and older with plan marketing and advertising efforts—and how those efforts may have informed their coverage decisions.[4,5]

Source of Information for Coverage Decision-Making

- **About one in three Medicare beneficiaries ages 65 and older, regardless of whether they had traditional Medicare or a Medicare Advantage plan, said they used insurance brokers or agents to choose their coverage.** The next most reported source of information was friends and family (18%). Relatively small shares of people used the federal *Medicare.gov* website and hotline and State Health Insurance Assistance Programs, or SHIPs. More than one in three said they did not receive any help in picking their coverage.
- **A larger share of Black and low-income seniors than White or higher income seniors said that they used advertising and marketing to help make their coverage choices.** The sharp increase in complaints about misleading or false marketing by Medicare plans and contractors in recent years raises concerns over who is disproportionately disadvantaged by a lack of access to unbiased help.

Quantity of Marketing Information

- **During Medicare open enrollment, Americans aged 65 and older receive many phone calls, mailings, emails, and advertisements about plan choices each week.** In our survey, nearly all reported receiving at least one phone call, mailing, or email per week. Two in five reported receiving at least seven marketing appeals weekly.

Reports of Fraud and False Advertising

- **Some people reported experiences with Medicare plan marketing that were misleading, violated federal rules, or were possibly fraud—including more than 1 in 5 people with low incomes.** This included being asked by marketers for Medicare or Social Security numbers outside the formal plan enrollment process, as well as being offered time-limited, special discounts on Medicare plans, which do not exist. Some seniors also reported experiences with false advertising or misleading marketing information. About one in 10 said they had enrolled in a plan under the impression that their doctor was covered, only to learn later that there were limitations on seeing that doctor or the doctor was not in the plan's network.
- **About 1 in 5 seniors said they didn't know how to file a complaint about Medicare marketing and didn't think they could figure out how.** While formal complaints about marketing have been on the rise, the complaints likely undercount the number of beneficiaries who are encountering misleading, fraudulent, or prohibited marketing tactics.

Marketing's Effects on Older Adults

- **Nearly 1 in 3 seniors with low incomes reported staying on the line when getting unsolicited marketing phone calls about Medicare coverage choices.** In contrast, less than one in 10 seniors with household incomes above $50,000 stayed on the line.
- **When it seems like they have too many Medicare plan options, nearly all seniors (96%) said they stick with their current plan.** As a result of this "stickiness," beneficiaries can end up paying higher out-of-pocket costs than they would have otherwise under a different plan.

Policy Options for Consideration:

Devoting more resources to unbiased sources of information and decision-making support for consumers, such as State Health Insurance Assistance Programs (SHIPs), *Medicare.gov,* and the Medicare hotline. Our survey of beneficiaries found that one in four people ages 65 and older said they would like more one-on-one help in making their coverage decisions. Investing in resources and not-for-profit educational organizations that have no financial stake in plan decisions is crucial, given the consequential decisions that beneficiaries are making with imperfect

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[4] Faith Leonard et al., "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why" (Commonwealth Fund, October 2022). *https://doi.org/10.26099/2rfq-z770.*

[5] Gretchen Jacobson et al., "The Private Plan Pitch: Seniors' Experiences with Medicare Marketing and Advertising" (Commonwealth Fund, August 2023). *https://doi.org/10.26099/a9bz-by48.*

information.[6] These entities also serve as important educational resources on navigating Medicare and understanding the program more broadly.

Educating beneficiaries on how to file complaints about fraudulent marketing and advertising practices. This support could be especially helpful for older adults with lower incomes, who, as shown in our survey, are more likely than those with higher incomes to report negative experiences with marketers.

Thank you again for the opportunity to provide comments for the record. Please contact Rachel Nuzum, Senior Vice President of Policy at the Commonwealth Fund, at rn@cmwf.org, and myself at gj@cmwf.org, if we can be of further assistance.

STATEMENT SUBMITTED BY LISA DEKKER

U.S. Senate, Committee on Finance

Thank you for the opportunity to add to the record and for holding a hearing about Medicare, especially during this open enrollment period. I am a volunteer with PSARA Puget Sound Advocates for Retirement Action but this my personal statement.

For over a year, I have been following the ever-more alarming news about what was created as a public good, Medicare, being taken over and exploited by the private insurance industry to the detriment of the very people it was intended to serve, our seniors and people with disabilities. The deceptive advertising and misinformation coming from for-profit private insurers in Medicare Advantage (MA) via television and social media is the tip of the iceberg. The massive fraud and abuse by these insurers in the billions of dollars, documented by both media and government investigations, plus the failure of CMS to exert real oversight and to put beneficiaries' health and welfare first, cannot be overstated.

I am already enrolled in Traditional Medicare, but have seen many examples of the deceptive (and obviously costly) advertising from so-called Medicare Advantage plans (private insurance). In addition, I have read about how the on-the-ground experiences of Medicare Advantage beneficiaries are very different from those of us on Traditional Medicare (TM).

This situation appears to be way past simply making small adjustments. Action from our elected leaders is necessary and urgent. Since this is the Senate Finance Committee please add this recently released report from PNHP Physicians for a National Health Program to the record: Our Patients Their Profits, *https://default.salsalabs.org/Tf70ffaa1-4264-4e55-b795-8e37d961c33a/e22a406d-0e4a-4abf-9f6f-fffc96d789f4.* The data there shows that the amount of overpayments to MA insurers for just the past year totals between $88 and $140 billion. If you are looking for why the Medical Trust Fund is losing money, and how to recover it, please start here.

On the human experience side, I've learned that Medicare Advantage insurers have caused undue harm and even deaths due to prior authorizations, delays and denials of care. In Medicare Advantage's capitated system, it is obvious that the built-in incentive for them to contradict a beneficiary's own provider's recommended treatment or drug is greater profit.

Also regarding finances: There is a gross inequity problem for individuals just signing up when they must choose between the 2 options. While those with limited incomes, many of them people of color, likely are *not* informed of the limited networks plus the delays and denials they will experience in Medicare Advantage, the lower upfront costs virtually force them to choose an Medicare Advantage plan.

After months of looking at the situation, I conclude, along with PSARA, that the only solution is to immediately "level the playing field" between the 2 options, Traditional Medicare and Medicare Advantage, being offered.

The 3 fixes necessary to "level the playing field are:

1. Adding benefits to Traditional Medicare including vision, dental and hearing.
2. Eliminating the 20% co-pays in Traditional Medicare and capping out-of-pocket expenses.

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[6] Riaz Ali et al., "How Agents Influence Medicare Beneficiaries' Plan Choices" (Commonwealth Fund, April 2021). *https://doi.org/10.26099/32d2-pz96.*

3. Paying for improvements to Traditional Medicare by eliminating excessive administration costs and profits in private insurance plans; and returning funds to the Medicare Trust Fund that were lost to the fraud and abuse by insurance companies.

I urge you to stop the crimes and malfeasance from the private Medicare Advantage insurers, and honor the trust that Americans still have in true Medicare and in the ability of you, our elected representatives, to fix it.

Working across generations for social justice, economic security, dignity, and a healthy planet for all of us.

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eHealth is pleased to offer our viewpoints and observations related to the Medicare Annual Enrollment Period (AEP), and in particular our insights regarding Medicare marketing practices and recommendations to improve Medicare beneficiaries' experiences. eHealth is a licensed insurance agency. We serve customers who seek individual, family and small business health plan solutions, as well as the full complement of Medicare options, including Part D Plans, Medicare supplemental insurance, and Medicare Advantage. We make it easy to compare and enroll in the healthcare plans that best fit a person's needs. As a leading independent insurance advisor, our user-friendly platform offers access to over 180 health insurers, including national, regional and local companies. For more than 25 years, we've helped millions of Americans find the healthcare plan that fits their needs at a price they can afford.

Our licensed agents are instructed to treat eHealth Medicare customers as if they were their own parents and grandparents: with patience and compassion. Every employee abides by our Medicare Beneficiary Pledge and is dedicated to performing their responsibilities with the highest degree of ethics and integrity while meeting government regulations and insurer standards to protect the rights and interests of those we serve. eHealth benefit advisors are commission-blind and paid the same no matter which MA or Medicare supplement plan the customers select, and they are rewarded when customers are so satisfied with their coverage that they retain their plan for a longer period. Additionally, eHealth benefit advisors' compensation is the same regardless of which PDP plan a customer selects.

The term "third-party marketing organization" (TPMO) encompasses a wide range of actors in the continuum of Medicare marketing, sales and enrollment. Some TPMOS are licensed, and some are not. eHealth, a private health insurance marketplace, is licensed, and our company name is tarnished with the mischaracterization of TPMO entities throughout the industry as a whole. In the unfortunate cases where customers are dissatisfied, eHealth has created an extensive process for investigating and remedying every single complaint, grievance and CTM received. Our compliance team of more than 40 professionals engage in a process which includes research, investigation, identification of root cause, and implementation of corrective action, up to and including termination. In the end, our business depends on keeping satisfied long-term customers, and this is only possible when we provide superior service in helping beneficiaries find and enroll in the best available plan for their circumstances.

1. Brokers Help Beneficiaries Find the Right Plan for Their Needs Without Increasing Enrollee Costs

Brokers are an essential component to helping beneficiaries find the best plan for their specific needs. They are required to have state-issued licenses, and then they must be appointed by a carrier and pass carriers' exams [1] for CMS regulatory compliance as well as content knowledge of carrier-specific product offerings. Local brokers can be helpful when a beneficiary has narrowed the decision to a single carrier or a small subset of carriers. However, local brokers may not work with as many carriers as a regional or national broker, which limits the ability of beneficiaries to explore all their options when a beneficiary is undecided. Local plans can be a great

[1] 42 CFR § 422.2274(b)(1) and (2).

choice for some beneficiaries, while regional and national plans with different provider networks and benefit offerings may be a better match for others.

Licensed brokers help beneficiaries determine whether the smaller local plans or the larger regional or national plans are the better fit for their particular circumstances. The larger brokers like eHealth have developed sophisticated, proprietary plan-matching tools that can consider a person's preferred medical providers, nearest pharmacies, and prescribed drugs. These information elements can then be taken into consideration in combination with plan information such as Star Ratings, plan benefits, and budget considerations to identify which carriers and plans provide better coverage for an enrollee's unique situation. Moreover, brokers' specific knowledge of a carrier's supplemental benefit offerings in combination with familiarity of the beneficiary's social determinants of health (SDOH) can help with a plan selection which achieves optimal health outcomes. Larger brokers, like eHealth with its omnichannel choice platform featuring over 40 Medicare Advantage carriers, can often provide beneficiaries with more options than local brokers so that the beneficiaries can make the best-informed choices.

2. Marketing Fees Support Beneficiary Education, Comparison and Selection

Whether a broker is local or national, every broker business needs to market its services to be a viable entity. Commissions and marketing fees make this economically feasible. Approaches to advertising and beneficiary education reflect the variations from one market to another and are dictated by the goals of partner carriers. It is simplistic to assume that enrollment activity tied to "commission" is always preferable to non-commission "marketing fee" activity. Both payments are used to help connect beneficiaries with the right plans. For example, marketing fees may help fund more expensive marketing campaigns that reach traditionally underserved or isolated communities. In all cases, marketing fees, like all other administrative fees, are tied to a fair market value by current CMS regulations, which specify such services as training, customer service, agent recruitment, operational overhead, as well as other services designed to improve the health of the beneficiary and quality of healthcare service, such as assistance with completion of health risk assessments (HRAs or HRA).[2]

All administrative fees permitted by CMS regulations, including marketing fees, are paid by carriers to brokers for specific services a carrier would otherwise purchase from a discrete entity or perform on their own. Unlike commissions, marketing and other administrative fees are not paid at a fixed-dollar amount set by CMS because the services for which carriers pay for vary greatly. Such fees can pay for items necessary to provide the best possible experience for beneficiaries. One such service eHealth performs is HRA completion for a limited number of carriers, as well as first-appointment scheduling services for select carriers. Because we have an existing relationship with the beneficiary and are at the front line of the engagement process, we can carry out these services much better than a third party without an existing prior relationship. HRAs serve as a "first alert" to the carrier's care management team enabling immediate coordination of a beneficiary's chronic condition before it manifests into multiple emergency room visits. These services are mandated for Special Needs Plans (SNPs) and are an established best practice for Quality Programs of standard Medicare Advantage Plans.[3] Together with immediate scheduling for a first appointment with a provider of the beneficiary's choosing, HRAs facilitate care management and enhance the enrollee's quality of life. Some HRAs include components of SDOH assessments offering a level of care that extends into supports for daily living. The notion that such assessments are conducted solely to gain risk adjustment payments is without merit as any such payment does not factor in until the end of an enrollee's first year in the plan.[4]

Administrative fees also partially offset the growing compliance costs associated with increasingly burdensome and complex regulation of the industry as a whole. Examples range from recording equipment required to create and maintain call recordings for the 10 years required by CMS regulation, to training, licensing, marketing material development and the administrative responsibilities tied to general oversight, carrier review and approval, and submission to CMS and monitoring agents to provide beneficiaries with professional, legally compliant service. Because the costs of such items vary depending on the situation and scope of services, it

[2] 42 CFR § 422.2274(e)(1).
[3] 42 CFR § 422.152(g)(2)(iv).
[4] 42 CFR § 422.310(g).

would be administratively prohibitive, if not impossible, to establish for each plan year and each geographic region the exact dollar amount for every possible permutation of service.

Commissions and fees do not reduce the funds available for patient care in the Medicare program. The Affordable Care Act established an 85% medical loss ratio (MLR) for MA and PDP plans.[5] Broker compensation and administrative fees do not reduce the resources available to pay for Medicare enrollees' health care expenses because 85% of premium revenues must be used for patient care. The remaining 15% covers everything else, including carrier profit; carrier distribution costs like marketing, advertising, and commissions; and carrier overhead, like rent, call centers, information systems, etc. As CMS itself explains, there are "several levels of sanctions for failure to meet the minimum MLR requirement, including remittance of funds to CMS, a prohibition on enrolling new members, and ultimately contract termination. The minimum MLR requirement creates incentives for MA organizations and Part D sponsors to reduce administrative costs and helps to ensure that taxpayers and enrolled beneficiaries receive value from Medicare health plans."[6]

MLR regulations therefore already provide an upper bound on the amount of spending that may go from the Medicare Trust Funds and Medicare beneficiary premiums for non-patient care. A reduction in broker compensation would most likely lead to more money being spent on other administrative activities or being allocated to profit by carriers—not an increase in funding for actual patient care.

Finally, taxpayer-funded CMS television and paid search advertising which direct enrollees to CMS's Medicare Plan Finder are nothing more than a publicly funded competitor to a private sector partner. When beneficiaries are enrolled into Medicare Advantage plans utilizing substantial, and growing, public dollars, carriers are the ones who benefit by not paying a broker commission. Such taxpayer funding is not subject to the same MLR limitations that broker commissions are. Thus, taxpayers ultimately are funding the overhead operations of private carriers and doing so despite the well-identified limitations of CMS's Medicare Plan Finder and without the benefit of state licensure and carrier-specific training on plan options to ensure the best fit for a beneficiary.

3. eHealth Helps Beneficiaries Find the Right Plans for Their Circumstances

eHealth's platform allows beneficiaries to easily compare available plan features, including the use of proprietary tools for comparing provider networks, prescription drug coverage, and other plan benefits. Because of these significant investments to help beneficiaries with plan selection, eHealth is able to provide beneficiaries with an easy way to search for preferred doctors and pharmacies both online and telephonically. The convenience eHealth's search tools provide contrasts with the difficult process hearing witnesses described using public tools such as CMS's Medicare Plan Finder to search up to 100 plans when trying to find the plans which cover certain providers. We believe eHealth's best-in-class, easy-to-use search and plan matching capabilities are a good example of the innovation the private sector brings to the public-private partnership which makes Medicare Advantage possible.

We share the Committee's concern with "ghost networks" full of providers that either do not exist or have no availability to see new patients, and we fully support efforts to increase applicable enforcement efforts and transparency regarding the availability of providers. Our overarching goal at eHealth is to assist our beneficiaries in finding the best available plans for their needs and preferences. This goal is greatly hampered when the provider network data from carriers is incomplete, outdated, or otherwise does not reflect the availability of providers in a carrier's network. eHealth receives weekly feeds from our carrier partners with updated provider network information, yet we still do not have complete assurance of provider network data quality even with these frequent, active updates to our carrier-supplied information.

4. Discrete Regulatory Guidance and Transparency Will Help Vulnerable Medicare Beneficiaries

Along with members of the Committee, eHealth wants to avoid enrolling individuals with cognitive impairment and continues to work on screening out such individuals

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[5] 42 CFR §§ 422.2410 and 423.2410.

[6] Medical Loss Ratio. Centers for Medicaid and Medicare Services, last modified September 6, 2023 4:57 pm, *https://www.cms.gov/medicare/health-drug-plans/medical-loss-ratio.* Accessed October 28, 2023.

whenever possible within the bounds of existing regulations and upon best available guidance from carriers and CMS. It would be helpful for CMS to provide clarification or regulatory change to facilitate screening individuals with cognitive issues. Current regulations do not allow health status to be used when marketing or enrolling beneficiaries as doing so violates the anti-discrimination statute.[7]

Just as carriers and marketing organizations are required to provide far more data to CMS, it is vital that business partners in turn receive data from CMS for assessment and continuous improvement benefiting the entire industry. Greater transparency on the following topics is essential to ensuring beneficiary needs for information are being met:

- *Complaint Tracking Module (CTM) rates (2020–2022).* This information would allow partners and regulators to measure progress going forward from the point when new CMS guidance went into effect for 2022.
- *Performance metrics.* Service levels are a key factor in measuring quality. As taxpayer-funded contracts are awarded to serve a rapidly growing Medicare population, transparency about rates of cancellation, disenrollment and overall satisfaction and complaints for 1–800–MEDICARE and CMS's Plan Finder could pinpoint issues to address. Providing data for 1–800–MEDICARE average hold time, the percentage of calls answered within 30 seconds, and the average disconnect rate especially during high volume periods is vital to understanding the beneficiary experience.
- *SHIPs.* Data about the effectiveness of State Health Insurance Programs, including elements to measure performance, are a further window at a more local level into satisfaction and complaints, particularly when the data is compared with other channels such as CMS or carriers.

We noted with interest the discussion and subsequent recommendations to CMS by majority members of the Committee regarding the addition of broker data to CTM reporting. eHealth offers the following considerations to ensure any new data is accurate and not misleading:µ

- Individual agents move among carriers and brokerages/agencies frequently, which would likely make it difficult to track the carrier or insurance agency tied to the complaint in an accurate manner for any length of time beyond the snapshot timeline of the CTM receipt date. Additionally, if an individual agent is identified by its insurance agency as having compliance issues before a CTM is a filed, the insurance agency's remedy is discipline, including termination. Since CTMs are lagging indicators, they may be filed after the agent has been terminated. This would create a "black mark" despite the insurance agency having taken appropriate steps even before a CTM is filed.
- Detailed reporting by CMS on CTMs, including accuracy of reported broker information, investigation timelines, and dispositions, will be necessary to ensure brokers are not unfairly maligned by inaccurate reporting, unfounded CTMs, or CTMs that have not been researched to resolution. In other words, CTMs incorrectly associated with a broker or determined to be unfounded or not investigated ought not remain on the record as a "black mark" which cannot be expunged.
- Large agencies/brokerages will have more enrollments, and therefore more CTMs. Further, the continuing rapid growth of the Medicare population translates to an increased number of complaints, hence the need to examine complaint rates and not absolute numbers. We suggest that CTM data be reported as percentage of enrollment, similar to the reporting required by Stars that reflects the actual complaint rate rather than absolute number of complaints, which simply indicate an entity does a large volume of business.
- Moreover, a beneficiary can lodge a complaint with both the carrier as well as CMS, and so a single issue counts as two separate categories of complaints, one being an internal carrier complaint and the other a CTM, both of which remain on the carrier record and count against performance. It is also important to note that CTMs often include complaints which are outside the scope of a broker's control, such as a mid-year formulary change.

[7] 42 CFR §§ 422.110 and 45 CFR Part 92.

5. eHealth Supports Eliminating Abusive Marketing Practices

As a responsible participant in the market, eHealth supports the Committee's desire to eliminate unscrupulous and disruptive marketing practices which harm beneficiaries. Such marketing abuses also harm the reputation of eHealth and other respected brokers. The marketing abuses on which the Committee is focusing are generally from non-licensed lead generators, and not from credible, licensed brokers such as eHealth.

The worst actors within the lead generator community tend to be smaller, unestablished outfits which are typically not licensed to sell insurance products and do not focus on Medicare marketing. Such lead generators are not constrained by the requirements of insurance licensing and often do not follow the strict compliance standards required for Medicare marketing. Indeed, the most unscrupulous among them purposely avoid regulations which interfere with their profits. eHealth seeks to avoid working with such lead generators because they are not only harmful to beneficiaries in general, but also harmful to eHealth's customers and reputation. eHealth requires all of its lead generation partners to submit their marketing materials for approval and filing in accordance with the regulatory requirements established by CMS and enforced by the carriers. eHealth refuses to do business with lead generators that cannot comply with eHealth's requirements and the CMS-mandated regulatory framework for Medicare marketing, and we terminate contracts when we identify abuses.

6. CMS Marketing Regulations Have Room for Improvement

CMS regulations regarding Medicare marketing are already quite extensive and complex. Compliant brokers must file materials with each carrier with which they partner, as well as CMS. For a licensed insurance agency operating nationwide like eHealth, doing so requires obtaining approval from each of over 40 different Medicare Advantage carriers for a single postcard, banner ad, or other piece of marketing material before it can be used. Once those approvals are obtained, all materials must then be filed with CMS. CMS currently requires 45 days to approve video and television marketing materials, and a five-day file and use process for direct mail pieces.

In practice, it takes months of preparation and an eHealth staff of dozens to prepare and use compliant marketing materials at all. Furthermore, carriers and CMS staff must review the same piece potentially dozens of times as each TPMO submits the identical piece for duplicative reviews as the current regulations require. Reducing this duplicated effort would allow carriers and CMS to better allocate their resources and funding without reducing any safeguards on the materials presented to beneficiaries. A viable example would be the more streamlined approach previously in place as a part of the Lead Plan review process, prior to implementation of the Third-Party Marketing Module.

CMS has issued new rules each year for the last several years, often with confusing and contradictory guidance, making good-faith compliance difficult. For example, this year's rule requiring a scope of appointment be obtained from a beneficiary 48 hours before speaking with the individual has resulted in a number of conflicting interpretations from the various Medicare Advantage carriers due to unclear or inconsistent guidance from CMS. The result is widespread industry confusion that increases the likelihood that beneficiaries will have inconsistent and unsatisfactory experiences when seeking advice on their Medicare Advantage options.

7. Conclusion

Along with members of the Committee, eHealth leaders are deeply invested in the well-being of Medicare beneficiaries and their caregivers, together with all who utilize our services to secure health coverage that not only allows them to live healthier lives, but also brings peace of mind. Member satisfaction with Medicare Advantage plans remains very high, and eHealth's CTM rates on average have declined since 2021. We stand ready to partner with lawmakers and regulators to ensure the Medicare program as a whole delivers on its promise to meet the vastly diverse needs and preferences of those we serve in public-private partnership.

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Statement of Charles N. Kahn III, President and CEO

The Federation of American Hospitals (FAH) submits the following Statement for the Record in response to the Senate Finance Committee (Committee) hearing on *Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences.* The FAH commends the Committee's leadership in providing oversight of the Medicare Advantage (MA) program as an increasing number of America's seniors receive their Medicare benefits through Medicare Part C health plans instead of the traditional fee-for-service program.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

We welcome the opportunity to work with the Senate Finance Committee on its oversight of the MA program to ensure Medicare beneficiaries enrolling and enrolled in MA plans are treated fairly, provided accurate and timely information, and have access to the same benefits and healthcare services as Medicare beneficiaries in traditional Medicare.

As an organization representing tax-paying hospitals that provide 24/7 care to patients, including MA enrollees, we understand the extensive and inappropriate practices of prior authorization abuses and patient care delay and denial. MA plans systematically limit, delay, and deny access to care for MA enrollees, and problems with deceptive marketing practices and unclear benefit descriptions are only the tip of the iceberg. Every day our members experience patients' confusion and frustration when they realize their MA plan does not cover or will not pay for the Medicare services they expect.

Further, MA plans often offer and publicize attractive benefits to Medicare beneficiaries who struggle to afford supplemental services such as Medicare Part D, dental, club memberships, or other similar benefits. However, severely ill or injured patients who need access to specialized medical and hospital services may find these additional benefits do not outweigh limited provider networks and overly aggressive utilization control practices.

The FAH believes that greater information on an MA plan's utilization management practices should be made available to beneficiaries and potential enrollees during the enrollment process. For example, being better informed about the services that require prior authorization and the approval/denial rates for each plan could help beneficiaries with chronic illnesses or known medical conditions assess how easy it will be for them to access care in a particular plan. Additionally, all beneficiaries would benefit by being able to compare plans on the extensiveness of their utilization management practices and potential abuses. The FAH urges the Committee to pursue legislation that would accomplish this level of transparency and we believe the *Improving Seniors' Timely Access to Care Act of 2023* would provide the needed information to require this type of transparency.

Many of our concerns related to MA plan utilization management abuses were included in a 2022 HHS OIG Report.[1] The report showed that MA plans systemically apply problematic operating policies, procedures and protocols that limit care for MA enrollees. The OIG Report also identifies a pattern by which MA plans apply utilization controls to improperly withhold coverage or care from MA enrollees. Specifically:

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[1] Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General ("OIG"), OEI09–18–00260, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022), *https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.*

- *Improper prior authorization denials.* The OIG found that 13 percent of prior authorization requests denied by MA plans would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation.* The OIG found that in many cases beneficiary medical records were sufficient to support the medical necessity of the services provided.
- *Improper payment request denials.* The OIG found that 18 percent of payment requests denied by MA plans actually met Medicare coverage rules and MA plan billing rules.

These OIG findings reflect a broader pattern of MA plan practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care for MA beneficiaries. CMS also recently acknowledged many of these concerns in a December 2022 proposed rule regarding improving prior authorization processes and an April 2023 final regulation with MA policy changes[2] that would constrain some of the bad behaviors MA plans regularly employ related to prior authorization and non-coverage of items and services that would be covered for beneficiaries under the traditional Medicare fee-for-service program.

We commend the Committee's leadership and focus today to ensure Medicare beneficiaries have reliable access to care and meaningful information during the MA enrollment process and urge passage of the *Improving Seniors' Timely Access to Care Act of 2023* which will provide needed information and transparency on utilization management practices. Further we urge you to investigate the utilization management practices and exercise oversight authority to help protect patients against harmful MA plan behaviors through, for example, prior authorization reforms and comprehensive provider networks.

We look forward to working with you and your colleagues in Congress as you evaluate these important issues. If you have any questions or would like to discuss these comments further, please do not hesitate to contact me or a member of my staff at (202) 624–1534.

Sincerely,

Charles N. Kahn III

LETTER SUBMITTED BY PATRICIA GALLEGOS

October 23, 2023

U.S. Senate
Committee on Finance

I am sending this Statement about Medicare Advantage for the Record. The official hearing was held on October 18, 2023 by the Senate Finance Committee. I would like this statement to be entered into the official record. I would also appreciate it if a copy of my comments are sent to each member of the Senate Finance Committee.

I am writing to voice my opposition to Medicare Advantage plans. My reasons include the following:

Medicare Advantage has always cost the government more money than Traditional Medicare. The Medicare Advantage plans have been getting more money than Traditional Medicare through fraudulent billing, mostly related to falsified diagnoses. Medicare Advantage plans have received billions of dollars in overpayments from excessive subsidies, among other items.

Information from a top government official stated that In 2020 Medicare Advantage companies received more than $25 billion In overpayments. The University of Southern California's research warns that overpayments to Medicare Advantage plans will exceed $75 billion in 2023. Other studies and reports put the level of overpayment at more than $88 billion.

At the rate these fraudulent overpayments are being made, combined with the aging of the population, the Medicare Trust Fund will be bankrupt very soon. Medicare will then be privatized and health-care costs will increase

[2] *https://www.cms.gov/newsroom/press-releases/cms-proposes-rule-expand-access-health-information-and-improve-prior-authorization-process; https://www.cms.gov/newsroom/fact-sheets/2024-Medicare-advantage-and-part-d-final-rule-cms-4201-f.*

even more and millions of people will lose there health care. This would indeed be a disaster.

Medicare Advantage charges more to the government and to the patients than what Traditional Medicare charges. The fact is that Medicare Advantage plans have been over billing for services, tests, medicine, surgeries, etc. since the start of the program. In addition, all the policies put in place by Medicare Advantage plans have increased the cost of providing medical care.

Equally important, patients on Medicare Advantage ultimately pay higher costs for needed healthcare than those on Traditional Medicare. Given the evidence of delays and denials of necessary care, Medicare Advantage patients often suffer higher overall costs.

Medicare Advantage was authorized in 1982 and expanded in 2003, with very little Input from Medicare patients. This Is one reason why Medicare Advantage companies financially benefit at such a huge rate and are draining the Medicare Trust Fund.

Also, ample data shows that Medicare Advantage has not yielded any savings, while also not providing better care than Traditional Medicare.

There are numerous studies, research and evidence that have found additional, ongoing problems with Medicare Advantage which include limiting access to plans for patients deemed not healthy enough, limiting the network of doctors and providers, restricting prior authorization procedures, patients having longer wait times to see doctors and receive medical services, and patients receiving more denials for coverage.

Medicare Advantage should not be extended until a thorough review can be made of the current program. The review should require an in-depth review of the billions of dollars of overpayment to Medicare Advantage companies. It should also look at why patient costs are increasing at such a fast rate under Medicare Advantage. In addition, it should look at quality of care, accessibility, billing practices, fraudulent practices and any other issues that affect patient care provided by Medicare Advantage plans.

Most importantly, the review and recommendation process must include people who are themselves Medicare patients. The decision about Medicare Advantage shouldn't be made by business managers, underwriters, insurance managers or any person with a profit motive. Medicare should be run by professionals, advocates and people who are knowledgeable about what is the best care for the patients and how to make it affordable for everyone.

Thank you very much.

Patricia Gallegos

STATEMENT SUBMITTED BY VIRGINIA GEBHART

Volunteer with Be a Hero Foundation

https://beaherofund.com/

To Whom It May Concern:

I was surprised that a broker for a Medicare DisAdvantage company was presented as an expert when there was nobody representing those who have been harmed by Medicare DisAdvantage plans.

Examples of those who have been harmed by Medicare DisAdvantage include seniors who were influenced by deceptive advertising to choose these inferior for-profit commercial insurance plans. Examples include the many hospitals and medical clinics who are now refusing to take Medicare DisAdvantage plans because their "delay, deny, don't pay" business practices are harming patient care and harming the bottom line. Examples include those who have been forced into Medicare DisAdvantage plans via the corrupt ACO REACH program. Examples include those individuals who have faced "delay, deny, don't pay" business practices that have caused unnecessary extended pain and suffering. Examples include individuals whose loved ones died prematurely due to the "delay, deny, don't pay" business practices of Medicare DisAdvantage plans.

I was surprised that the Senators seem to accept that corrupt organizations (*i.e.,* corporate-run for profit Medicare DisAdvantage) should continue to have the opportunity to raid the Medicare Trust Fund. I was surprised that the Senators would

not direct CMS to enforce existing rules and penalize or expel those corrupt organizations who are victimizing seniors and health care providers.

It's clear to me that corporate-run Medicare DisAdvantage is elder fraud and financial exploitation. I'm surprised that the Senators seem to accept that these corrupt organizations have a role to play in providing health care to Seniors. It's clear to me that Medicare DisAdvantage plans prioritize profits over patient care and/payments to providers. Corporate-run Medicare DisAdvantage plans are the quintessential corporate pigs feeding at the trough.

We the people are your constituents. The corporate pigs are not.

LETTER SUBMITTED BY BRIAN GRAD

U.S. Senate
Committee on Finance

The *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*[1] concludes that the Hospital Insurance Fund will be depleted by 2028.

While it is true that the number of beneficiaries continues to grow, that indicator alone is not the main cause of this projection. Medicare Advantage is causing the Trust Fund to run a deficit because of the overpayments made to insurance companies.

The Federal Government is losing as much as $140 billion per year by subsidizing private Medicare Advantage plans.

What can be done to prevent Medicare from going bankrupt?

Sincerely,

Brian Grad

LETTER SUBMITTED BY PATTY HARVEY

October 18, 2023

U.S. Senate
Committee on Finance

Dear Senators,

It is laudable that in today's hearing you looked into the outrageous practices of fraud and abuse by MA companies (and it was good to see Senator Warren include the execrable practice of upcoding) that are draining the Medicare Trust Fund. But you did not address an overarching reality; namely, that these plans are unnecessary to begin with.

Why are we taxpayers being forced to subsidize the additional perks and expenses of these middlemen (not to mention fraud and abuse that nets MA from $88 to over $100 billion/yr from the Medicare Trust Fund)? *Why not just improve our original Medicare* to include dental, vision, hearing, long-term care and elimination of the need for Medigap plans and add any other perks offered at a much higher cost to us by MA?

The fraud and abuse of MA, if recouped, could pay for all these perks and improvements to be added to real Medicare and extend those benefits to all residents from birth to death. This has been well-documented and verified by even the most conservative estimates. Where is the political will to do something that actually will work? People are frustrated and angry and need health care—like in other industrialized democracies! Senators, stop luxuriating in the bribes you enjoy from corporate interests and do something for the people!

Patty Harvey
Co-chair
HCA/PNHP-Humboldt

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[1] *https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.*

INSURANCE MARKETING COALITION
19580 W. Indian School Rd., Suite 105, PMB 141
Buckeye, AZ 85396

Dear Members of the Committee:

The Insurance Marketing Coalition (IMC) submits this statement for inclusion in the record of the October 18, 2023, hearing "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences." Although IMC shares the Committee's concerns around unscrupulous companies that use deceptive marketing practices to mislead seniors and other Medicare beneficiaries, care should be taken to avoid measures that would hurt consumer choice and competition with the collateral effect of punishing law-abiding businesses and their employees. More specifically, IMC seeks to emphasize the following points, which are explained in greater detail below:

I. Insurance agents, brokers, and marketers serve a critical role in making consumers aware of Medicare Advantage and Prescription Drug programs and helping them compare their coverage options.

II. Insurance marketers play a critical role in helping insurance agents and interested consumers connect with each other, and allow small agencies to compete with dominant players, thereby promoting consumer choice and competition.

III. It is unfair to malign an entire industry based on the deceptive and illegal acts of some dishonest actors. Most industry participants are honest, hard-working, and strive to be transparent with their customers.

IV. Legislators should encourage regulatory agencies and law enforcement to crack down on deceptive practices under existing laws, while avoiding reactionary measures that would hurt consumer choice and competition while punishing law-abiding industry participants.

OVERVIEW OF IMC

The IMC is a consortium of more than forty companies representing a cross section of insurance industry stakeholders. Our members employ Americans in all fifty states and include large and small companies. The mission of IMC is to help protect the best interests of consumers by, among other things, promoting compliant and best practices in insurance marketing and services. Each year, we interact, collectively, with millions of consumers by providing information, education and meaningful choices related to their insurance coverage options. Some of our members are licensed agencies and brokers that represent multiple MA organizations and collectively enrolled more than a million beneficiaries in Medicare Advantage plans in 2022. These companies are currently working to assist the more than 60 million Americans currently eligible to make changes to their Medicare coverage during the Annual Enrollment Period (AEP) that is now underway. Other members are marketing and advertising companies that assist millions of beneficiaries to connect with licensed agents and brokers each year. Some of our members are technology companies that provide platforms and services to support brokers, agents, and marketers. Among other things, our members are dedicated to providing transparency in their efforts to help beneficiaries become aware of and understand their Medicare coverage options and select plans that meet their needs.

I. Insurance agents, brokers, and marketers serve a critical role in making consumers aware of Medicare Advantage and Prescription Drug programs and helping them compare their coverage options.

Insurance agents, brokers, and marketing companies serve a critical role in raising awareness with consumers and educating them about Medicare coverage options. For consumers who are new to Medicare, coverage options can be overwhelming. Indeed, many consumers who become eligible for Medicare are unaware of Medicare Advantage and Prescription Drug options, which are a better fit for some consumers than Original Medicare. For consumers who already have Medicare, plan benefits, networks, and costs can change each year. Although the broad variety of plans and options available to beneficiaries is good for consumer choice and competition, some consumers find the task of comparing plan options and benefits as daunting. As Christina Reeg, Ohio senior health insurance information program director for the Ohio Department of Insurance, explained at the October 18 hearing, there are so many options that "most Medicare beneficiaries won't review

or change plans, because the task of comparing is too daunting to help narrow the field."

In addition to plan options and choices that consumers may not be aware of, there are also crucial deadlines and windows of opportunities during which choices must be made. For example, new Medicare beneficiaries may have to pay late enrollment penalties if they fail to sign up for Medicare coverage during their initial enrollment period. And for existing Medicare beneficiaries, changes to plans can only be made during a narrow open enrollment period, unless there are certain life changes that qualify a beneficiary for a special enrollment period.

So who can raise awareness among American consumers about their Medicare plan options? Who can raise awareness through relevant media channels, including social media, TV, radio, podcasts, etc. of critical deadlines, windows of opportunity, and potential eligibility for plan changes due to certain life events? Who can sit with consumers, one-on-one, during lengthy meetings to undertake an analysis of the consumers' needs, help review their medical networks and prescription drug coverage, and answer their individualized questions and concerns?

The answer to these questions is insurance agents, brokers, and marketers such as the members of IMC. The government does not have the resources or expertise to undertake this, and it cannot be done through technology or self-help services online. All three witnesses present at the October 18th hearing agreed that neither CMS nor SHIPS have adequate resources to help the 60 million beneficiaries who are eligible for Medicare Advantage. Among other things, they rely on the CMS Medicare plan finder, which they described as cumbersome, often out of date, and unable to provide critical information, such as doctor network participation and drug coverage. And while insurance carriers may be able to provide this information, they can only provide it for their own plans. A broker can help beneficiaries compare plans from multiple carriers, avoiding the need for the beneficiary to contact each insurance carrier separately in order to find the plan that best meets their personal needs.

Further, surveys show that consumers want and appreciate the services provided by insurance agents, brokers, and marketers. According to a 2023 Kaiser Family Foundation Study, many beneficiaries find selecting Medicare coverage "overwhelming" and rely on brokers to assist them when choosing their coverage and value their expertise. "Participants who use brokers to help select and enroll in a Medicare plan say brokers are a trusted resource."[1] Another survey reports that "[i]n Q2 2020, 41% of those surveyed said they believed it was essential or very important to interact with an agent, and that percentage increased to 49% in Q3 2021."[2] And as reported by Commonwealth Fund, more than 1 in 3 beneficiaries said they would like to know more about benefits outside of their coverage options, and 1 in 4 would like one-on-one help.[3] Agents and brokers help beneficiaries with this daunting task by educating them on their choices while taking into consideration their specific healthcare needs and the specific benefits offered by the available plans, including provider network participation and prescription drug coverage that is critical to their coverage.

II. Insurance marketers play a critical role in helping insurance agents and interested consumers connect with each other, and allow small agencies to compete with dominant players, thereby promoting consumer choice and competition.

Insurance marketers play a critical role in the marketing and sales process for Medicare Advantage and Prescription Drug insurance where consumers often seek one-on-one consultations with licensed professionals to understand options, terms, and pricing prior to purchase. Marketers help make consumers aware of the broad array of available product choices and where to get them. Rather than promoting a single product or service, many insurance marketers empower consumers to explore their coverage options easily and quickly from multiple licensed agents if they

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[1] Kaiser Family Foundation Study, September 15, 2023, What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage? Available at *https://www.kff.org/medicare/report/what-do-people-with-medicare-think-about-the-role-of-marketing-shopping-for-medicare-options-and-their-coverage/#:~:text=In%20general%2C%20many%20thought%20TV,role%20in%20their%20plan%20choices.*

[2] Insurance News Net, January 20, 2022, Consumers Shopping for Insurance in the Midst of The Pandemic. Available at *https://insurancenewsnet.com/innarticle/consumers-shopping-for-insurance-in-the-midst-of-the-pandemic.*

[3] *See https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/private-plan-pitch-seniors-experiences-medicare-marketing-advertising.*

choose. Many of these marketers rely on digital marketing, which requires a specialized skill set. Digital ad markets are extremely competitive and expensive to participate in, making it cost prohibitive for many companies to compete. Marketers use their expertise in digital advertising and ad buying to permit participation in digital ad markets by companies that otherwise would not have the expertise or resources to do so. For small businesses in particular, such as mom-and-pop insurance brokers, performance marketing is the lifeblood of their businesses as it allows them to reach new customers on equal footing as national companies that have multi-million-dollar marketing budgets. This, in turn, benefits consumers by providing them with significant additional choice from a variety of different businesses at a glance. This type of marketing also provides an alternative avenue for digital advertising to tech giants like Facebook and Google, thereby helping to promote competition more broadly in the digital world. Marketers thus play an important role in fostering consumer choice and market competition.

To understand further the benefits provided by marketers to consumers, we provide a typical example of how marketers help beneficiaries connect with licensed agents. For example, a beneficiary with original Medicare who is in search of dental care might be visiting a dentist and learn that original Medicare provides no coverage for these services. Frustrated, she may go online and type: "Why doesn't Medicare cover my dental care?" into her search engine and find a truthful and accurate website (operated by a marketer) explaining that dental benefits are not included in original Medicare, but that some Medicare Advantage plans do, in fact, offer certain dental benefits. Prior to visiting the website, the beneficiary in this example not only was unaware that some Medicare Advantage plans may offer certain dental benefits, but she was entirely unaware of the availability of certain alternatives to original Medicare. The website may provide the beneficiary with the option to request up to three licensed agents to call her and discuss the Medicare Advantage plans that they offer. The beneficiary doesn't need to search the yellow pages for an agent, make an appointment, get dressed, drive across town, and meet in person at an office (or invite an agent into her home). Instead, the beneficiary can submit the webform and shortly thereafter she can receive the calls she requested from the licensed agents, who present the beneficiary with the information that she desires. This allows the beneficiary to easily, and without cost or inconvenience, explore multiple available options and make an informed choice as to what coverage she wants.

The marketer operating the website in the example above not only helps the beneficiary to efficiently connect with licensed agents and compare plan options, but it also helps the licensed agents to compete in the marketplace against massive insurance carriers and dominant market players. Marketers who operate websites such as in the example may provide referrals to potentially thousands of different agents, with the actual referral dependent on variable factors such as the beneficiary's zip code, the licensed agent's availability to call the beneficiary at the requested time, etc. Because the marketer operates its website at scale, it is able to provide costly and complex digital advertising strategies at accessible prices for even the smallest insurance agency or broker. In other words, the most modest "mom and pop" insurance shop is able to affordably compete with the largest market players for the exact same customers, which promotes competition and consumer choice. As mentioned above, the services offered by marketers are the lifeblood for small insurance agents and brokers throughout the country who rely on these marketers for helping to reach consumers.

III. It is unfair to malign an entire industry based on the deceptive and illegal acts of some dishonest actors. Most industry participants are honest, hardworking, and strive to be transparent with their customers.

Although IMC recognizes that there are bad actors within the insurance industry, as is true with any industry, it is grossly unfair to assume that the vast majority of responsible, law-abiding industry participants are committing the same wrongs as those bad actors. The examples of deceptive marketing materials and tactics do not accurately reflect the practices of most industry participants. The members of IMC collectively interact with millions of consumers each year, either as marketers or as service providers. The overwhelming majority of consumers appreciate these experiences and find them valuable. Given the valuable services that marketers, agents and brokers provide to both consumers and businesses, the marketing industry should be commended, not maligned, and caution should be taken not to take actions that would hurt consumer choice and competition in favor of larger corporate organizations.

IMC members and others within the insurance industry take compliance seriously, care deeply about ensuring a positive consumer experience, and are highly incentivized to prevent consumers from receiving deceptive advertisements or unwanted contact. IMC's employees, managers, and leaders are real people, many with family members on Medicare, and who participate in civic and volunteer organizations. Insurance agents and brokers who retain the services of marketers do not want and find no value in referrals of customers who are upset or surprised about being called, or who have been misled by dodgy advertisements. Marketers that reliably deliver genuinely interested consumers are rewarded by the marketplace. Building relationships of trust with consumers is critical to success for many agents and brokers, who depend on reputation, referrals, and repeat customers, and it is grossly unfair to collectively portray them as money-grubbing scoundrels or crooks.

This is not to say that there are not bad actors. There are. Which is why IMC supports legal action against those who break the law. But the harm caused by bad actors cannot be fairly attributed to the industry as a whole, nor should it be used as a reason to abolish the services they provide. Indeed, as an example, a single bad actor can alone generate billions of unwanted calls to consumers.[4] There is thus no basis to assume from the volume of deceptive or unlawful practices that the cause is widespread.

IV. Legislators should encourage regulatory agencies and law enforcement to crack down on deceptive practices under existing laws, while avoiding reactionary measures that would hurt consumer choice and competition while punishing law-abiding industry participants.

The IMC is deeply concerned about potential regulatory overreach intended to address practices that are already illegal under existing law. Such overreach, although well intended, threatens consumer choice, competition, and the livelihood of law-abiding business owners. Deceptive advertising, for example, is already illegal under a multitude of statutes and regulations, such as Section 5 of the FTC Act, state UDAAP laws, and CMS marketing regulations. Unsolicited telemarketing calls are similarly illegal under a variety of statutes and regulations, such as the Telephone Consumer Protection Act, Telemarketing Sales Rule, CMS marketing regulations, and analogous state laws.

Recently, in a purported effort to address practices that are already illegal under current law, a variety of agencies have considered regulations that would strip consumers of their ability to make informed decisions for themselves, while stifling the ability of small businesses to compete in the marketplace. For example, the FCC is considering a proposal that would effectively put an end to efficient comparison shopping (such as the example set forth above in Section I of the beneficiary who was searching for information on dental coverage and was able to easily connect with multiple licensed agents to discuss options). CMS recently proposed to deprive beneficiaries of their ability to decide for themselves how their personal information is used by enacting a regulation that would prohibit the transfer of beneficiary data between TPMOs, even when the beneficiary requests that their data be transferred. We understand that the Committee supports implementing this regulation. However, it is a radical proposal that cuts directly against the grain of existing privacy law regimes, including HIPAA, all of which recognize consumer choice as a fundamental element to personal privacy rights. IMC has submitted comments in response to the above-mentioned FCC and CMS proceedings, which we encourage the Committee and lawmaker staff to review for further information on how these proposals miss their intended marks entirely and would do far more harm than good for American consumers and businesses.[5]

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[4] For example, government agencies have brought actions involving billions of illegal calls by a single bad actor. *See, e.g.,* "FTC Crackdown Stops Operations Responsible for Billions of Illegal Robocalls" at *https://www.ftc.gov/news-events/news/press-releases/2019/03/ftc-crackdown-stops-operations-responsible-billions-illegal-robocalls.*

[5] *See* IMC Initial Comments *(https://www.fcc.gov/ecfs/search/search-filings/filing/1050833302323)* and Reply Comments *(https://www.fcc.gov/ecfs/search/search-filings/filing/10606772724875)* filed in FCC CG Docket No. 21–402 (Targeting and Eliminating Unlawful Text Messages) and FCC CG Docket No. 02–278 (Rules and Regulations Implementing the Telephone Consumer Protection Act of 1991), and IMC Comments *(https://www.regulations.gov/comment/CMS-2022-0191-0669)* filed in CMS docket Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications.

Promulgating rules and regulations is relatively easy, but without enforcement, is ineffective. The unlawful acts and practices that the Committee seeks to eradicate are engaged in by bad actors that will simply ignore new rules and regulations and continue operating illegally unless and until they are caught and stopped. For example, the unwanted and annoying calls that bombard consumers are mostly made by foreign actors, not U.S. businesses.[6] Further, the bad acts carried out by few are magnified due to technology.[7] The same is true of deceptive advertising: a single scofflaw can easily target millions of consumers with deceptive mailers, TV ads, websites, etc. But the illegal acts of relatively few should not be the rationale for infringing consumer choice and hurting competition. In the quest to eradicate unwanted calls and deceptive advertising, care must be taken to avoid rules that would frustrate consumers' ability to receive desired calls and prohibit truthful advertising.

More enforcement, not more regulation, is the antidote. After all, no amount of traffic laws will change some drivers' behaviors, unless there is regular and consistent enforcement. IMC recognizes that enforcement is easier said than done. Federal and state regulators have limited resources, and those resources should be used where likely to have the greatest impact. IMC thus encourages the Committee to exercise restraint in promulgating new rules and regulations, and to encourage agencies (over which Congress controls funding) to similarly exercise restraint in promulgating ill-advised regulations while encouraging vigorous enforcement action under existing laws and regulations.

CONCLUSION

The IMC supports the Committee's effort to ensure transparency with consumers and protect them from deceptive and abusive practices. But the solution lies in enforcement of existing laws and regulations, not through other means. Thank you for your time and consideration of our coalition's statement.

LETTER SUBMITTED BY CAROLA GAY KNUTSON

October 18, 2023

U.S. Senate
Committee on Finance

Medicare Advantage Plans

I am a faithful, active, registered voter living in Port Angeles, Washington. It is my hope that my senators, Maria Cantwell and Patty Murray, along with my Congressman, Derek Kilmer, will take more serious notice of the alarming financial and personal issues created by the so-called "advantage" plans. So far, my representatives have shown little interest in this topic.

Though numbers may vary, it is clear that these plans are helping draw down millions and millions of dollars in precious Federal funds, depositing them into the accounts of insurance companies. This waste cannot be sustained. I know I need not catalog the many issues involving medical testing, coding, billing, fraud and so on as you likely have committed this list of issues to memory. I have personally heard healthcare providers as well as credible senior citizens' advocates speak numerous times on this subject. The Internet had recently experienced a ground swell of interest in this topic, also.

If the waste of resources was not enough, there are countless stories of patients whose health has been compromised by timing issues caused by referral problems.

We seniors have worked hard our entire lives and need to be assured that the Social Security and Medicare programs won't run out of funds in our lifetimes, as well as the lifetimes of our children. Something needs to be done immediately to stop this hemorrhaging of money.

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[6] *See, e.g.,* FCC December 23, 2022 Report to Congress (noting that "Foreign-originated calls are a significant portion, if not the majority, of illegal robocalls . . ." and referencing multiple enforcement actions involving billions of illegal calls made without consent), available at *https://docs.fcc.gov/public/attachments/DOC-390423A1.pdf. See also* "Who's Making All Those Scam Calls?", *NY Times,* available as of May 6, 2023 at *https://www.nytimes.com/2021/01/27/magazine/scam-call-centers.html.*

[7] Indeed, government agencies have brought actions involving billions of illegal calls by a single bad actor as noted above in FN 4.

I would ask that you seriously consider abolishing advantage programs as well as continuing to raise the rates/percentage of payment by high income earners. We are the only first world nation I know of that does not have its act together with regard to medical care and other services for its population. No wheels need to be re-invented . . . look to the Scandinavians, for example, and follow their lead. I have heard that we're actually paying less taxes (in today's dollars) than we were during the Eisenhower Era. Elected officials need the courage to buck the anti-tax contingent and big insurance companies.

For myself, I'd rather pay more taxes and get good services and infrastructure than pay fewer taxes and have a half-baked country.

Carola Gay Knutson

LETTER SUBMITTED BY GREGORY J. LAWSON

October 23, 2023

U.S. Senate
Committee on Finance

Most companies who offer Medicare Advantage (MA) programs require patients to pay excessively high co-payments for therapies (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Cardiac Rehabilitation (CR), and Pulmonary Rehabilitation (PR)). This fact is not clear to most potential enrollees, partly because most enrollees are not shopping for MA programs based on a potential need for therapy services.

Nevertheless, companies who contract with MA continue to restrict access to therapy services by often imposing "specialty" co-pays of $20 to $50 and sometimes as high as $75 per visit, limiting the frequency and duration of care a patient is able to afford. This practice unfairly treats these therapies, a routine health service, as a specialty service. Specialty copays are intended for specialized medical services or medical specialties, such as cardiology, orthopedics, neurology, and pulmonary.

Legislation appears to be the only way to prohibit a health payer from inappropriately shifting the cost of care onto consumers by limiting therapy co-payments to no greater than that of the co-pay of an office visit to a physician or osteopath.

The practice of treating therapy providers as "specialists" has allowed MA payers to require consumers to pay the entire or nearly the entire cost of therapy care. The excessive copay amounts often results in patients paying more out of pocket for therapy than they do any surgery, imaging, or pharmacy that they have had.

The financial implication of excessive co-pay amounts results in disincentives for patients to participate in therapy resulting in lack of compliance for their care. This can result in significant recurrence and downstream costs including further surgery, imaging, and pharmacy.

Since PT, OT, ST, CR, and PR frequently require multiple visits over an extended period of time as the practice of these therapies works in conjunction with the healing process, many consumers are forced to pay nearly $600 per month in out-of-pocket expenses to receive therapy services. This is in addition to the cost of health insurance paid by the consumer. Decisions to reduce the frequency or duration of their care or not to even initiate therapy has led to poor outcomes and complications which only lead to higher costs for health care in the future.

Fair co-pays lead to better outcomes and improved access. In these difficult economic times, it is a struggle for the average working patient to afford what they thought was a covered service.

I have contacted Senator Murray's office about this issue. I worked in Cardiac Rehab for 40 years, so I am well aware of how these high co-pays can limit a patient's recovery from a cardiac event.

Gregory J. Lawson

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The Medicare Rights Center (Medicare Rights) appreciates this opportunity to submit a statement for the record on the October 18, 2023, hearing of the U.S. Senate Committee on Finance, titled "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences." Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly 3 million people with Medicare, family caregivers, and professionals.

Medicare is a vital, life-saving program that protects the health and well-being of over 66 million older adults and people with disabilities.[1] As people join Medicare, and every year afterward, they have choices to make about how they will receive their coverage. A growing number select Medicare Advantage (MA), also known as a Medicare private health plan or Part C. Individual needs, preferences, and priorities typically guide these enrollment choices.

Unfortunately, there are other factors influencing these choices as well, including predatory marketing, widespread confusion, and a lack of sufficient tools and guardrails to ensure coverage choices are informed and optimized.

At Medicare Rights, we frequently hear from beneficiaries who need help understanding their Medicare coverage options and making enrollment decisions. The MA plan landscape is overwhelmingly cluttered. Recent statutory and regulatory changes, such as the elimination of meaningful difference and uniformity requirements, as well as reduced network adequacy standards and booming profits—in part due to MA overpayment—have led to an influx of plans, with single sponsors often offering multiple plans in any given area.[2]

During open enrollment for 2023, the average beneficiary had 43 different MA plans from which to choose. This is more than double the number in 2018 and does not even include employer-sponsored plans, Special Needs Plans (SNPs), cost plans, or Medicare-Medicaid integrated plans, all of which are additionally available to some beneficiaries,[3] or fully capture geographic differences. In 27 counties, more than 75 plans were offered.

Most beneficiaries (60%) had plans available from fewer than 10 companies. In 1,136 counties (accounting for 50% of beneficiaries), at least one company offered 10 or more plans. This is also reflected in the enrollment numbers. Two companies, UnitedHealthcare and Humana, accounted for 46% of MA enrollment in 2022.

Plans can vary on everything from costs to coverage, sometimes in subtle but important ways. For most beneficiaries, this makes close analysis both critical and unattainable. Indeed, identifying and simultaneously comparing each plan deviation, year after year, is a challenging, intimidating, and time-consuming task that few people with Medicare perform.[4] Instead, they may rely on heuristics like where their neighbors or friends get coverage. Worse, they may rely on marketing that is designed to lure them with promises of benefits they may not be eligible for or that may be so limited as to be essentially worthless.

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[1] Centers for Medicare and Medicaid Services, "Access to Health Coverage" (last visited October 31, 2023), *https://www.cms.gov/pillar/expand-access.*

[2] Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (March 2022), *https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.*

[3] Meredith Freed, et al., "Medicare Advantage 2023 Spotlight: First Look" (November 10, 2022), *https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/.*

[4] *See, e.g.,* Meredith Freed, et al., "More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually," Kaiser Family Foundation (October 29, 2020), *https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/;* Wyatt Korma, et al., "Seven in Ten Medicare Beneficiaries Did Not Compare Plans Past Open Enrollment Period," Kaiser Family Foundation (October 13, 2021), *https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/.*

Complex analyses of seemingly endless plan designs may be particularly burdensome for consumers with limited English proficiency, those who have cognitive impairments or other serious health needs, and people with inadequate Internet access. Despite the severe consequences of making a poor plan choice—such as high costs, restricted provider access, and delayed care—there are few remedies. If an enrollee makes a mistake, they may be stuck in a plan that does not meet their needs for up to a year, or could be locked into MA indefinitely because of the high cost of Medigap coverage.

In one series of KFF focus groups, consumers reported feeling overwhelmed and inundated by Medicare marketing.[5] They received unwelcome and unsolicited phone calls from brokers and plan representatives, sometimes with no clear information about who was calling. And they reported that TV ads were often misleading and deceptive, and that it was often unclear whether the government or a private company was behind the ad.

Research shows that marketing by MA plans is a major source of information for many consumers.[6] Such marketing is not objective; it only touts the benefits of MA, not the tradeoffs, and complaints about misleading marketing are on the rise as TV ads become more prevalent.[7] This points to the need to extend and improve information access about the pros and cons of Original Medicare and MA to ensure people are getting the full picture.

For example, there are no clear rules about how MA plans and brokers may market supplemental benefits to current or potential enrollees. According to a recent Commonwealth Fund analysis, 24% of those who opted for MA were drawn by the extra benefits.[8]

The KFF and Commonwealth findings echo what we often hear from beneficiaries about the challenges of enrolling in Medicare initially and the complexity of re-evaluating their coverage every year. In our experience, people find Medicare coverage choices overwhelming and are confused about how Medicare works. This includes confusion about the different parts of the program, what is included in an MA plan and any supplemental benefits, the tradeoffs of switching to MA, and what the differences are between MA and Medigap or other supplemental coverage.

Confused beneficiaries then may seek help, and research shows that most people who receive help choosing between their coverage options turn to brokers and agents rather than objective sources.[9] Agents and brokers receive commissions and will be paid more for enrolling people into MA plans than into supplemental coverage like Medigap.[10] This may create an incentive for agents and brokers to steer consumers into MA.

Once in MA, enrollees can encounter unexpected prior authorization and network limitations, as well as higher than anticipated co-pays.[11] To ensure people better understand the tradeoffs, we urge better government informational materials and decision-making tools that are complete and unbiased. If information about MA touts the potential for MA to decrease beneficiary costs, it must also alert the consumer to the potential that it will raise costs and the risk of losing access to valued providers. In addition, supplemental benefits need marketing guardrails to ensure

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[5] Meredith Freed, et al., "What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?" (September 15, 2023), *https://www.kff.org/medicare/report/what-do-people-with-medicare-think-about-the-role-of-marketing-shopping-for-medicare-options-and-their-coverage/*.

[6] Faith Leonard, et al., "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why" (October 17, 2022), *https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.*

[7] Victoria Knight, "Medicare Advantage has a marketing problem" (September 8, 2022), *https://www.axios.com/2022/09/08/medicare-advantage-marketing-problem.*

[8] Faith Leonard, et al., "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why" (October 17, 2022), *https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.*

[9] Faith Leonard, et al., "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why" (October 17, 2022), *https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.*

[10] Riz Ali and Lesley Hellow, "Agent Commissions in Medicare and the Impact on Beneficiary Choice" (October 12, 2021), *https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice.*

[11] Meredith Freed, et al., "What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?" (September 15, 2023), *https://www.kff.org/medicare/report/what-do-people-with-medicare-think-about-the-role-of-marketing-shopping-for-medicare-options-and-their-coverage/*.

any communications about them include information about their limitations. Without such guardrails, nothing prevents supplemental benefits from being used merely or primarily as a sales tool.

Although Medicare Plan Finder has information about specific plans, it is limited, especially when it comes to cost comparisons and supplemental benefits. Plan Finder can also be confusing to use due to the number of plan choices and the complexity of MA and Part D structures. In addition, people are not able to search by network providers. Even outside of Plan Finder, provider directories are wholly inadequate and riddled with errors.

We suggest improving Medicare Plan Finder by integrating plan network data, individual claims history, and more realistic and predictive estimated costs. We also support including more information about supplemental benefits, like coverage and eligibility limits. Medicare Plan Finder must not be a marketing tool for MA plans to bolster enrollment.

We also ask Congress to provide increased funding for State Health Insurance Assistance Programs (SHIPs) like Ohio Senior Health Insurance Information Program (OSHIIP) so ably represented by Christina Reeg. Despite being a primary, trusted source of unbiased enrollment counseling, SHIP funding is unable to keep pace with growing demands, driven by an aging population, MA enrollment increases, and an ever more complex plan selection process.

As always, we also note that many people struggle to enroll in Medicare in the first place. Among the most frequent calls to Medicare Rights' National Helpline are from or on behalf of people trying to understand their options and navigate enrollment.[12] For many, including those who must actively enroll, this can be a confusing and overwhelming time.

Most people new to Medicare are automatically enrolled because they are receiving Social Security when they become eligible—but a growing number are not.[13] These individuals must enroll on their own, taking into consideration specific timelines, intricate Medicare rules, and any existing coverage. Mistakes are common and carry serious consequences, including lifelong financial penalties, high out-of-pocket health care costs, disruptions in care continuity, and gaps in coverage.

Conclusion

As MA enrollment, plan numbers, and costs grow,[14] it is increasingly important to ensure the program is working well for enrollees. It is clear there is ample room for reform. MA advertising is misleading and rampant. Plan selection is overly onerous, and official Medicare resources under-utilized. There are too many barriers to care and informed decision-making, and too few options for relief. People with Medicare need stronger consumer protections, more reliable coverage, and tougher plan oversight—without delay.

Thank you for your consideration and leadership. The Medicare Rights Center looks forward to continued collaboration.

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I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits

[12] Medicare Rights Center, "Medicare Trends and Recommendations: An Analysis of Call Data from the Medicare Rights Center's National Helpline, 2020–2021" (May 2022), *https://www.medicarerights.org/policy-documents/2020-2021-medicare-trends-and-recommendations.*

[13] *See, e.g.,* Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2019), *http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.*

[14] Medicare Rights Center, "Medicare Advantage 101" (July 2023), *https://www.medicarerights.org/policy-series/medicare-advantage-101.*

specialists. The members of NABIP help millions of individuals and employers of all sizes purchase, administer and utilize health plans of all types.

The health insurance agents and brokers that NABIP represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers with choosing the health plan or plans that are best for them. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees [1] and 84 percent of people shopping for individual exchange plans found brokers helpful—the highest rating for any group assisting consumers.[2] During the 2023 open enrollment period, agents and brokers assisted 71 percent of those who enrolled through *HealthCare.gov* or a private direct enrollment partner's website. Additionally, premiums are 13 percent lower in counties with the greatest concentration of brokers.[3]

Independent, licensed and certified agents and brokers also assist seniors with their plan options in the Medicare market. Many agents working with seniors are the most experienced agents in the business and are sometimes 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. Individuals qualifying for Medicare at age 65 typically have 3 months before their 65th birthday, their birthday month, and 3 months following their birthday month to explore their options and make choices. Thereafter, they can change their choice annually during the Annual Enrollment Period (AEP), which is underway now. Because of the complexity of the plan-selection process, many beneficiaries rely on licensed and certified insurance agents to help them identify the coverage and benefits options that best meets their needs. Independent agents assist Medicare beneficiaries with all of the options available to them, including Medicare supplements, Medicare Part D and Medicare Part C, known as Medicare Advantage.

As of August 2023, over 60 million individuals were enrolled in one or more parts of the Medicare program. Among that population, over 30.8 million Medicare beneficiaries were covered by Medicare Advantage (MA) coverage.[4] The broad availability of MA plan options means seniors have an array of plan choices for their health insurance coverage. MA plans also offer supplemental benefits that are often not covered by traditional fee-for-service Medicare. Most enrollees are in plans that provide access to eye exams or glasses, telehealth services, dental care, a fitness benefit and hearing aids. MA products provide other affordable, high-quality services as well, including care coordination, disease-management programs, access to community-based programs and out-of-pocket spending limits.

Medicare Advantage products also provide necessary coverage to some of the most underserved populations. Compared to beneficiaries enrolled in both Part A and Part B, beneficiaries enrolled in MA are more likely to report incomes below 100 percent of the Federal Poverty Level, with 52 percent of enrollees earning less than 200 percent of the FPL.[5] Nearly two-thirds of MA beneficiaries (60 percent) pay no premium for their plan other than the Medicare Part B premium.[6] MA beneficiaries are more likely to be 75 years of age or older and have educational attainment less than high school. Additionally, MA enrollees were more likely than fee-for-service Medicare enrollees to be dually enrolled and to have multiple health conditions.[7]

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[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013, *https://www.kff.org/wp-content/uploads/2012/09/8465-employer-health-benefits-2013.pdf.*

[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014, *https://hrms.urban.org/briefs/obtaining-information-on-marketplace.html.*

[3] Karaca-Mandic, Pinar, et al. The Role of Agents and Brokers in the Market for Health Insurance. National Bureau of Economic Research. August 2013, *https://www.nber.org/papers/w19342.*

[4] Ochieng, Nancy. Medicare Advantage in 2023: Enrollment Update and Key Trends. Kaiser Family Foundation. 9 August 2023, *https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.*

[5] Better Medicare Alliance. Medicare Advantage Outperforms Fee-for-Service Medicare on Cost Protections for Low-Income and Diverse Populations. April 2022, *https://bettermedicarealliance.org/wp-content/uploads/2022/04/BMA-Medicare-Advantage-Cost-Protections-Data-Brief_FINv2.pdf.*

[6] Freed, Meredith, et al. A Dozen Facts About Medicare Advantage in 2020. Kaiser Family Foundation. 13 January 2021, *https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/.*

[7] HHS Assistant Secretary for Planning and Evaluation Office of Health Policy. Medicare Beneficiary Enrollment Trends and Demographic Characteristics. 2 March 2022, *https://*

Medicare Advantage beneficiaries also include a higher percent of Black and Latino beneficiaries than in fee-for-service Parts A and B; 53 percent of Latino Medicare beneficiaries and 49 percent of Black Medicare beneficiaries are enrolled in MA. While approval of MA coverage is high across all populations, non-white beneficiaries report an even higher level of satisfaction, with 99 percent reporting that they were satisfied with their coverage.[8]

The share of the Medicare population enrolled in MA plans grew from 24 percent in 2013 to 51 percent in 2023—a 112 percent increase in enrollment over 10 years. Today, 96 percent of Medicare Advantage beneficiaries are satisfied with their quality of care.[9]

When consumers are considering their Medicare plan options or are looking for specific drugs and services to be covered, there is no greater resource than a licensed agent or broker. Brokers educate clients on how Medicare works (both broadly and in conjunction with other coverage options), research physician networks and prescription formularies for the plans to ensure a suitable health and drug plan is recommended, and review plan comparison and enrollment changes annually. The assistance that agents provide does not end with the AEP; agents provide ongoing support throughout the plan year (such as with billing problems or claims issues).

By taking the time to understand the unique requirements and preferences of each beneficiary, agents offer tailored solutions and answer any questions a beneficiary may have. This personalized interaction not only simplifies the decision-making process but also addresses individual concerns, making beneficiaries feel valued and understood. Independent agents are also almost always members of the same communities that their clients live in. Above all else, Medicare agents offer a human connection and empathetic understanding of a beneficiary's position, thus providing comfort during a time many seniors find stressful.

Medicare agents often obtain clients through referrals, which is a type of lead that can only be achieved by providing great service to a beneficiary. Personal referrals are the primary source of lead generation by independent agents. The beneficiary who is referred usually contacts the agent, who then follows up to provide detailed information about Medicare choices and guide them through the enrollment process. Many independent agents represent multiple carriers while others are considered "captive agents" and work for just one carrier. Agents are paid commissions from the carriers, with rates set by federal regulators.

Independent Medicare agents must be licensed, undergo several hours of training, and are required by law to be certified before selling MA plans. Agent marketing practices for Medicare Advantage are strictly regulated by CMS, along with carrier-specific oversight. Most states also require licensed insurance agents to complete continuing education courses to maintain their license, ensuring that agents are always informed about the ever-changing landscape of Medicare benefits.

Unfortunately, recent Medicare regulations have grouped independent agents and brokers with unscrupulous third-party marketing organizations, or TPMOs. Lead-generation and marketing entities have traditionally been defined as TPMOs. The call centers they control have engaged in bad-faith practices for several years, airing television commercials that leverage a celebrity's popularity and credibility to attract the attention of Medicare beneficiaries, with the goal of enrolling the beneficiary in supplemental plans they may not need—purely for the pursuit of profit.

TPMO call centers feature auto-dialers and other productivity tools that maximize the number of calls in a day, which prioritizes the quantity of consumers contacted over the quality of assistance provided. NABIP members report that it is not unusual for a call center representative to average over 40 enrollments in just one month, with calls lasting less than 20 minutes. In contrast, the average production of a successful traditional independent agent is between 10 and 15 enrollments in a month.

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aspe.hhs.gov/sites/default/files/documents/f81aafbba0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf.

[8] Better Medicare Alliance. Medicare Advantage Satisfaction Hits New High Amid COVID–19 Crisis. 21 January 2021, *https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/medicare-advantage-vs-traditional-medicare-beneficiaries-differ.*

[9] Jacobson, Gretchen, et al. Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? Commonwealth Fund. 14 October 2021, *https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/medicare-advantage-vs-traditional-medicare-beneficiaries-differ.*

Additionally, TPMOs can include ad agencies and lead-generation companies that are not regulated by CMS. Unlike the personal referrals that make up most independent agents' books of business, TPMO call centers commonly engage in other types of lead-generation activities. Outside of the "television leads" that a TPMO obtains when airing previously mentioned advertisements, vendors sell different types of leads—from shared leads (sold to multiple buyers at a low price) to exclusive leads (sold to one buyer at a high price before being repackaged and resold as a shared lead). These leads are sometimes sold as part of a larger financial package marketed as relatively easy profit. Such lead-generation practices result in multiple undesired cold calls to Medicare beneficiaries.

These call centers also commonly employ "fronters," which are unlicensed entities from call centers that are often (but not always) offshore. Fronters use an Internet lead to call a Medicare beneficiary and qualify the beneficiary's interest in the insurance consultation. Once that is done, the beneficiary is transferred by phone to the TPMO call center.

Independent agents should not, under any circumstances, be lumped into the same group as TPMO call centers. As previously mentioned, agents are state-licensed, certified by the plans they contract with, pay attention to clients' specific needs, and take care of their clients year-round. TPMOs, on the other hand, only have interest in enrolling beneficiaries in certain plans (regardless of whether it is the correct fit for the beneficiary) and have no interest in establishing a genuine relationship with the beneficiary as a servicing agent.

CMS stated in recent regulation that the government cannot determine which entities are contributing to the deceptive television commercials, who is buying certain leads, and more. While CMS may not be able to make that determination, a contracted entity, such as an insurance carrier, can. Carriers already process such information, such as tracking which entities are the agent of record for a specific beneficiary. Independents agents should not be regulated as TPMOs, but separately through the plans they contract with in their respective states.

Outside of independent agents and TPMO call centers, there are other actors in the Medicare space that the committee should have a comprehensive understanding of. Field marketing organizations (FMOs) play a unique role in the system, serving as an intermediary between agents and carriers that offer MA and MAPD plans. FMOs operate as variable cost sales offices working on a contracted basis with multiple carriers. The organizations provide a wide variety of services that empower agents and their clients, from handling contracting and credentialing processes to helping agents navigate the regulatory environment. For example, many small independent agencies would not be able to fully comply with recent call-recording requirements without FMO assistance, since they do not possess the proper technology to comply with the rule. Without an FMO to provide these services, many services would fall on the carrier to implement, which would likely lead to increased premiums. Overall, FMOs are a necessary piece of the Medicare system and make the enrollment process quicker and smoother for both the agent and consumer.

FMOs contract with an array of MA and MAPD plans of varying sizes. FMOs and insurance carriers choose which entities to work with based on a variety of reasons. For example, a regional FMO may not choose to contract with a small plan because the FMO seeks to represent all plans in its region. FMOs may also consider factors like a carrier's star rating or technology capabilities. Some carriers, on the other hand, choose not to contract with large national FMOs because they only want to work with local agencies.

FMOs may have their own call centers, but a distinction must be drawn between FMO call centers and the TPMO call centers. Unlike TPMO call centers, FMO call centers are required to follow CMS-approved scripts with set benchmarks and quality metrics such as retention and satisfaction. FMOs are the primary servicing point for agents who have issues concerning the status of an enrollment, commissions and post-enrollment issues. For these reasons, FMOs should not be equated with TPMOs that strictly generate leads or operate only as a call center.

Like the Senate Finance Committee, NABIP wants to protect the vulnerable senior population from the unscrupulous actors in our healthcare system. Independent agents serve beneficiaries across the country as trustworthy advocates who provide accurate and ethical guidance. Ultimately, without licensed and certified agents assisting in enrollments, Medicare beneficiaries will have few choices in finding accurate enrollment assistance and will be led directly to the bad actors that the federal government seeks to protect them from.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NABIP can be of assistance as you move forward, please do not hesitate to contact me at jgreene@nabip.org or (202) 595–3677.

Sincerely,

John Greene
Senior Vice President of Government Affairs

PEOPLE'S ACTION
1301 Connecticut Avenue, NW
Washington, DC 20036
https://peoplesaction.org/

Contact: Megan Essaheb, Director of Federal Affairs, m.essaheb@peoplesaction.org.

People's Action's Care Over Cost *(https://careovercost.org/)* campaign appreciates the opportunity to submit a written statement for the record of the hearing, "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences."

People's Action builds the power of poor and working people in urban, rural, and suburban areas to win change through issue fights and elections. We are a national network of 40 state and local grassroots power-building organizations in 29 states—united in the work of building a bigger "we."

Everyone should have access to the care they need, when they need it. Too often, private insurance corporations refuse to pay for health insurance claims submitted by health care providers in order to increase their profits. These care denials cause medical debt, bankruptcy, worse health outcomes, and in some cases even premature death due to care not received.

People's Action's Care Over Cost campaign is made up of grassroots groups organizing nationwide to address the systemic problem of care denials by private insurance corporations. The vast majority of Americans are affected by care denials, whether that looks like a prior authorization denial that prevents someone from getting the treatment they need or insurance's refusal to pay for treatment someone has already received via a claim denial. The Care Over Cost campaign is organizing people experiencing care denials and helping them file appeals and run public pressure campaigns on the insurance corporations to overturn the denials, and elevating these stories in traditional and digital media *(https://careovercost.org/ourstories/).* Through fighting individual claims, we publicly expose the injustice and build power and expertise as we build towards policy campaigns to reduce claims denials and profiteering and build public support for Medicare for All as we are campaigning.

Medicare Advantage Plans

At People's Action, we believe that health care is a human right and that it is the Federal Government's job to ensure that people's health and wellbeing is not negatively impacted by profiteering by corporations. We are very concerned by reports that the Medicare Advantage program ("MA") is draining the Medicare Trust fund to line the pockets of corporate CEOs and shareholders. Spending per beneficiary has grown faster in MA than in traditional Medicare, yet sicker people are more likely to switch back to traditional Medicare in order to get the care they need.

In recent years, reports have documented that MA is engaging in various practices of upcoding in order to pad its profits. *The New York Times* article, "How Insurers Exploited Medicare for Billions," illustrates that 9 of the 10 top Medicare Advantage private insurers are either accused of fraud or overcharging by the federal government.[1] Sometimes, the private insurance companies kick beneficiaries off of their plans and send them back to traditional Medicare when their expenses get too high. That way, they don't have to pay, which would cut into their profits. The Government Accountability Office (GAO) reported that MA beneficiaries in the last year of

[1] Reed Abelson and Margot Sanger-Katz, "'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions," *New York Times,* October 8, 2022, *https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html.*

life disenrolled to join traditional Medicare at more than twice the rate of all other MA beneficiaries.[2]

Delays and denials of care are a major concern in Medicare Advantage plans. Last year, the Department of Health and Human Services Office of the Inspector General released a report showing that MA plans wrongly denied 18 percent of payment claims.[3] This February, a KFF report found that MA insurers denied over two million prior authorization requests in 2021.

The Care Over Cost campaign has supported people on United Healthcare MA plans in fighting back against unjust denials. United Health Group is the largest provider of Medicare Advantage plans (27.1% market share) and is accused of fraud and overbilling by the federal government.[4]

United Healthcare denied Carly Morton life-saving surgery that would allow her to eat again.[5] Care Over Cost waged a public campaign and with assistance from thousands of people who signed her petition to United Healthcare and shared her story on social media and Senator Bob Casey's office who reached out, we won Carly's prior authorization request and she had her surgery in late July 2023.[6] After a rough couple of months of recovery, Carly says that she is eating and enjoying food for the first time without pain! However, Carly recently heard from her surgeon's office that United Healthcare is still trying to avoid paying part of the bill.

After two rounds of cancer treatment, side effects from a mastectomy and breast reconstruction surgery put former State Representative (R–NH) and emergency medical technician Jenn Coffey *(https://www.levernews.com/care-denied-the-dirty-secret-behind-medicare-advantage/)* in bed for years. Her Medicare Advantage plan through United Healthcare refused to pay for her treatments, forcing Jenn to sell her car and fundraise to pay for treatments. Care Over Cost campaigned to win Jenn approval for her first round of treatment, but Jenn is now navigating repeated prior-authorization processes that hinder her care. Care Over Cost and New Hampshire Senators Shaheen and Hassan continue to work with Jenn to help remove these and other obstacles to her life-saving care.[7]

Deceptive and Wrongful Practices in Advertising

CMS should crack down on MA advertising. A New Hampshire resident recently shared her experience with organizers from People's Action member group, Rights and Democracy. Miriam said, "A Medicare Advantage company, Wellcare, called my son on his cellphone and signed him up to switch to their insurance. My son has autism. He is 26 and verbal enough to talk on the phone. This makes him very vulnerable. He doesn't understand what the consequences of changing to Medicare Advantage might be. He can't make these kinds of decisions without help. This phone conversation messed up his insurance and I am fortunate that I found out the same day. I was able to undo the changes. It required a number of phone calls to Wellcare, Medicare and Cigna. All of this is beyond what my son can deal with." These stories are all too common.

More is Needed to Reign in Profiteering by Private Insurance Companies

More broadly CMS and Congress must increase regulation of and consumer transparency about MA plans and improve traditional Medicare. While we support CMS's recent efforts to reign in Medicare Advantage plans overcharging, more needs to be done to improve traditional Medicare and reign in abuse by Medicare Advantage plans.

Congress should improve traditional Medicare by expanding it to include dental, vision and hearing and lowering out of pocket costs. Within the MA program, Congress and CMS must do more to protect vulnerable older adults and people with disabilities from enrolling in Medicare Advantage plans that won't meet their needs

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[2] "Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight," GAO–22–106026, June 28, 2022, *https://www.gao.gov/products/gao-22-106026.*

[3] *https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.*

[4] Reed Abelson and Margot Sanger-Katz, "'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions," *New York Times,* October 8, 2022, *https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html.*

[5] Video of Carly sharing her win of getting the prior authorization, October 18, 2023, *https://www.youtube.com/watch?v=GBw2pUB8__A&t=122s.*

[6] Video of Carly Morton, People's Action, March 29, 2023, *https://twitter.com/PplsAction/status/1641136092081422340.*

[7] Video of Jenn Coffey, People's Action, April 14, 2023, *https://twitter.com/PplsAction/status/1646880876943355904.*

when they need care. The government must stop overpaying for Medicare services, especially when there is no good data to support their value.

- Publish claims denial data by plan, gender, race, ethnicity and other factors to identify inequities and offer people accurate information when choosing a plan.
- Set an appropriate limit on Medicare Advantage plan revenue, equal to or less than traditional Medicare per enrollee.
- Create a standardized claims processing system for all Medicare Advantage plans that ensures coverage of medically reasonable and necessary services, with a public—non-proprietary—prior authorization overlay.
- Require Medicare Advantage plans to cover care from all cancer centers of excellence and other Medicare providers to ensure people have good access to care.
- Collect and share de-identified patient encounter data so that "value" can be assessed and there is a robust system for identifying persisting and emerging health care needs, including the ability to detect a disease outbreak or the need for greater resources in a community as a result of a force majeure.
- Enact a "strict liability" punishment for Medicare Advantage plans that violate their legal and contractual obligations, including automatic plan termination for ongoing violators.

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM
29 E. Madison Street, Suite 1412
Chicago, IL 60602

PNHP applauds Senators Wyden and Crapo for holding a hearing on this timely issue. October 15, the start date for Open Enrollment, is a time when vulnerable senior citizens are subjected to a barrage of phone, print, billboard, and TV ads touting the benefits of various so-called Medicare Advantage (MA) plans. What these ads fail to mention is the significant coverage limitations in MA caused by **insufficient provider networks and abuse of prior authorization requirements.** This lack of transparency "leaves beneficiaries with an incomplete view of their coverage options and the tradeoffs among them," according to KFF's analysis [1] of MA marketing. Indeed, the Senate Finance Committee's own report [2] in November 2022 "found evidence that beneficiaries are being inundated with aggressive marketing tactics as well as false and misleading information."

Medicare Advantage plans came into being on the assumption, devoid of any evidence to support it, that private industry is more efficient than the Federal Government, and could both reduce costs and improve quality in the Medicare program. The evidence, gathered over the past 20 years and reported by government agencies, non-governmental organizations, academics, and journalists, is that these plans do just the opposite; they increase costs through rampant overpayments,[3] and decrease quality of care through insufficient networks and onerous prior authorization requirements.

Provider networks are required to demonstrate that they are adequate [4]—namely, that they contract with enough primary care providers and specialists to meet the health needs of beneficiaries. However, until the passage of the No Surprises Act in 2022, there were no regulations regarding the accuracy [5] of those networks. Experience has shown that published networks are notoriously inaccurate, resulting in endless confusion and frustration for patients as well as costly fragmentation of care, sometimes with deadly consequences. Medicare-eligible seniors and people with disabilities deserve to know that the MA plan they choose may inaccurately list their long-time provider as being in-network, only to find out later that their provider is not actually covered.

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[1] *https://www.kff.org/medicare/press-release/kff-research-shows-that-medicare-open-enrollment-tv-ads-are-dominated-by-medicare-advantage-plans-featuring-celebrities-active-and-fit-seniors-and-promises-of-savings-and-extra-benefits-without-fund/.*

[2] *https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.*

[3] *https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf.*

[4] *https://www.cms.gov/newsroom/fact-sheets/contract-year-2021-medicare-advantage-and-part-d-final-rule-cms-4190-f1-fact-sheet.*

[5] *https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf.*

Nearly all MA enrollees are in plans that require **prior authorization** for many services. Government reports in 2018[6] and 2022[7] found "widespread and persistent problems related to denials of care and payment of Medicare Advantage plans." These delays and denials can have catastrophic effects on patients. Medicare-eligible seniors and people with disabilities deserve to know that the MA plan they are considering requires prior authorization, and that many hospitals[8] and doctors[9] are refusing to contract with MA plans due to excessive delays and denials not only of care, but of payment for that care. As networks "collapse", patients are caught in the crossfire, having to wait longer for tests, treatments, and procedures that could mean the difference between life and death.

We urge the Committee to significantly improve transparency in the marketing of MA plans. Marketing for plans must be highly restricted and subject to stringent requirements for accuracy. Harsher penalties should be imposed on plans that list inaccurate information on their provider networks. Finally, there needs to be greater oversight of prior authorization processes to ensure that MA plans are not allowed to continue delaying and denying necessary care at the expense of patients. This should include more transparency in data on denials and penalties for plans that deny any services that would be covered under traditional Medicare.

STATEMENT SUBMITTED BY ELLEN A. REICHART, ESQ.

Dear Committee Members:

The following has been my experience with an Aetna Advantage plan:

The issue with Medicare Advantage plans is that they deny coverage for medical treatment covered by Original Medicare. For example, Original Medicare covers nerve ablation for pain management (Genicular Knee) under procedure code procedure code 64624. Original Medicare under CMS rules does not require the physician to submit pre-approval to Original Medicare in order to have most procedures covered. When Original Medicare pays for a procedure it has effectively deemed that procedure covered under either Part A or Part B. My doctor advised me that Original Medicare covers the procedure but Aetna Advantage does not and that if I wanted to have it done I would have to pay $7000 out of pocket. He said that most of the Advantage plans routinely deny coverage but Aetna was among the worst. I actually had the procedure done 2 years ago. It was very effective as I was pain free for 2 years. The doctor's practice was not paid by Aetna for that procedure—the practice never balance billed me and I was unaware that the practice was not paid until July 2023 when I tried to arrange to have it done. I have been appealing the denial since that time. Under CMS rules Advantage insured can be required to obtain pre-approval however because an Advantage plan must cover what Original Medicare covers the pre-approval is basically a notice requirement. The Advantage plan is limited to determining medical necessity which can be appealed and subject to CMS regulations regarding medical necessity.

Aetna Medicare Advantage however denies coverage for the Genicular Knee ablation because it states that the procedure is investigational and experimental. There are several NLM publications indicating that the Genicular Knee procedure is efficacious and has a high success rate for achieving pain relief. Aetna claims it reviews its policies annually. Nevertheless Aetna developed its own policy statements and cites outdated studies unrelated to Genicular Knee nerve ablation in order to support their denial of coverage. A review of the list of treatments Aetna does not cover in addition to Genicular Knee nerve ablation reveal that Aetna is denying coverage for many procedures that Original Medicare covers. It does not appear that any effort was undertaken by Aetna to research trials published by the National Library of Medicine which is under DHS as is CMS. When speaking to Aetna customer representatives I was told that they are not Medicare and that they offer other benefits when attempting to explain that that they do not have to cover what original Medicare covers. In order to be a conforming Advantage Plan Aetna *must* cover procedures that Original Medicare covers. That requirement is in Federal statutes and the regulations (CFR). CMS has also so advised Medicare eligible individuals that Advantage coverage *must* be the same for part A and Part B in a publication avail-

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[6] *https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.*
[7] *https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.*
[8] *https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html.*
[9] *https://www.medpagetoday.com/special-reports/exclusives/106483.*

able to the public. Advantage plans can offer more not less coverage. Aetna is free to restrict coverage to their private insured under their individual and employer group plans but not in their Advantage plans. Nevertheless it relies on the same company wide global policy statements to routinely deny coverage to their Medicare Advantage insured for treatments that are covered by Original Medicare.

As a retired State of NJ employee I had no choice other than to enroll in a Medicare Advantage plan because the Christie administration discontinued coverage for standard Original Medicare and State secondary coverage where the State is self-insured utilizing a plan administrator. No longer were retiring enrollees able to select Original Medicare and opt to have secondary State Plan coverage that had been offered to retirees throughout the entire course of my employment. The retired coverage offered in the Advantage plan is inferior to the comparable employed coverage I enjoyed due to Aetna's exclusion of what the self-insured plan would have covered. I could have chosen Original Medicare and opted for a private secondary co-insurance plan but the State would no longer subsidize the plan premiums under the terms of my retirement. I would also have to obtain a part D plan because I would no longer be eligible for the state's prescription plan. I and many of my retired coworkers friends never would have chosen an Advantage plan. Many Medicare eligible retirees are at the mercy of their employers who force them into Advantage plans.

In my view, the continued move toward the privatization of Medicare is harmful to patients. Non-conforming Advantage plans such as Aetna's should have their ability to offer the plan to employers or the public revoked. Treatment is delayed for months because Aetna's appeals are multi-level and are routinely denied. To the extent that other services/procedures are covered by some Advantage plans such as vision, dental, prescriptions, prescription review, home health care visits and healthy home visits my plan does not offer vision or dental prescription I am covered by stand alone insurance for vision and dental because the State Advantage plan does not offer vision or dental. If I am not able to have Medicare required treatment covered by Aetna under its Advantage plan there is no added "advantage" to me as an insured because Aetna is not covering what Original Medicare mandates be covered.

I consider the offered prescription reviews and healthy home visits to be an intrusive waste of time. When I attempted to opt out of these reviews I was advised that I would no longer be contacted but I still receive endless calls and numerous mailings. These home services and prescription reviews are all fulfilled by sub-contractors of Aetna. The Advantage Plans are wasting money on their subcontracted "services" rather than covering medically necessary treatment. Although the State offers different Advantage plans (less costly premiums higher co-pays) because I reached 25 years service before a certain date the Advantage plan that I am in is the closest to the employed Blue Cross Blue Shield Direct 15 plan I had when I was employed. Any other retired Advantage plan would require the payment of higher co-pays and co insurance for doctor or hospital visits.

STATEMENT SUBMITTED BY STERLING SHARP

Americas Giant insurance companies which have dominated our Health Care for generations are not about to relinquish their Death Grip on our Health Care.

These Medicare Advantage programs are nothing less than a corrupt scheme to reinstate their Entrenched Private Tax on our entire health care. Despite their claims of efficiency, expertise etc., they are only a blatant and greedy *middleman* which cannot deliver on any of its claims. Adding an unnecessary middleman *cannot* reduce costs; that is a LIE.

Their management for profit at any cost only results in *death panels* and poorer quality of medical care for all Americans. The whole program is only a crutch to support Gigantic, Privileged Corporations with nothing but endless, longstanding greed and corruption as their goal. It is your duty to put an end to the entire program.

A much better course is to modernize and fund Medicare For All so that we Americans can enjoy a modern, effective Health Care System such as Europeans have enjoyed for many years. It is time to root out Corporate Welfare starting with the most Notorious Offender; our bloated Gigantic Insurance Combines.

They cannot and will not be reformed or brought under control.

LETTER SUBMITTED BY PAUL W. SUTTON

October 18, 2023

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Committee Members,

Advantage Plans do not advise or disclose to participants that Advantage plans may refuse to cover certain Part A or Part B procedures where CMS has not issued a coverage policy for the particular procedure. Where CMS has not issued a written policy treatment for a given procedure code that procedure is covered under Original Medicare. Advantage plans, however, are allowed to develop their own polices and deny treatment when CMS is silent as to coverage under Original Medicare. Advantage plans advertise that they cover everything that Original Medicare covers but fail to disclose that they are permitted to deny coverage where CMS is silent as to its policy for coverage. This results in Medicare Advantage participants being denied coverage for many procedures that are covered under Original Medicare. No one reads the plan book or website when signing up for a plan. The ability to deny coverage should be prominently disclosed up front. It is not in the best interests of a plan enrollee to forgo covered part A or B coverage in exchange for healthy home visits or prescription review that have been contracted out to third parties only to learn that a treatment that is covered by Original Medicare may be denied by an Advantage plan because it can set its own policies where CMS has been silent. It should be noted that some Advantage enrollees had no choice other than to accept the offered Advantage plan because their employer discontinued coverage under traditional Medicare that in the past covered co-insurance.

The best solution would be for CMS to require coverage by Advantage plans for all procedures where CMS is silent as to policy. Both federal statutes and regulations require that Advantage Plans cover everything that Original Medicare covers. Because this requirement is mandated by governing law, it seems that it is beyond CMS' scope of authority to grant what is essentially the ability for a private plan to cut costs and essentially create a system that permits different treatment of enrollees based upon whether they have enrolled in a private plan or the original government plan. Allowing private insurers to deny coverage results in cost saving to the detriment of the enrollee.

VOICES FOR HEALTH AND HEALING
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(360) 683–0735

Thank you, Senators, for this hearing on Medicare, a program second only to Social Security in providing urgently needed benefits for 60 million senior citizens, in this case health care.

My organization, Voices for Health and Healing, is a local, grassroots organization in Clallam County, Washington, that works to promote health care as a basic human right. We are deeply concerned that through aggressive marketing and deceptive practices, Medicare Advantage providers have succeeded in luring more than half of Medicare-eligible seniors into so-called "Medicare Advantage" plans.

They are not Medicare and are not advantageous. They are private insurance plans, the corporate provider paid a "capitation fee" from the Medicare Trust Fund for every person enrolled. In recent months, *The New York Times* and other media have exposed Medicare Advantage providers like Aetna, United Healthcare, Humana, and Kaiser Permanente filing tens of billions of dollars in false claims, draining the Medicare Trust Fund. These are tax revenues that all of us paid from every paycheck we earned to keep Medicare solvent. They are stealing our money. It is the sworn duty of every elected Federal official to protect Medicare and Social Security.

We refer you to the October 8, 2022 *New York Times,* an article headlined: "'The Cash Monster Was Insatiable,' How Insurers Exploited Medicare for Billions." This article is only the tip of the iceberg. Medicare Advantage is a racket that has fattened the profits of private insurance companies while denying care to millions of patients and pushing the Medicare Trust Fund toward insolvency. Estimates of the total cost of this corporate theft now total $140 billion.

We believe that health care is a human right. The cure and healing of the sick and wounded should never be a source of corporate profits. The insurance corporations use deceptive tricks like "upcoding" to a patient's diagnosis to add additional charges to the bill submitted to the Center for Medicare Services for conditions that have nothing to do with the patient's health care needs. They refuse or deny coverage for conditions even when medical doctors have certified the procedure or treatment is needed. Sometimes it leads to the death or severe, permanent, injury of the patient.

Documentation for these charges can be found in the records of the Inspector General of the Center for Medicare and Medicaid Services and other Federal oversight investigators. Organizations like Puget Sound Advocates for Retirement Action (PSARA), Physicians for a National Health Plan, and Social Security Works, have joined in defense of traditional Medicare, to protect it from runaway corporate profit greed. Lawmakers like our own Representative Pramila Jayapal and Representative Adam Smith, both Washington State Democrats, have spoken out against the drive to privatize Medicare, a program that we all paid for and should serve our entire population.

We are convinced that the only way to prevent the full corporate takeover of Medicare is to level the playing field so that the costs and benefits of traditional Medicare are equal to those of Medicare Advantage. It means reducing or terminating the monthly charge that traditional Medicare recipients must pay for Medigap policies. It means Medicare offering dental, vision, and hearing benefits. If the Federal government truly "cracks down" on the private insurance profiteering, it will bring in tens of billions of dollars that can be used to pay for these benefits and also insure the continued solvency of the Medicare Trust Fund.

We welcome this hearing. We urge you to continue this airing of views on how to improve Medicare and sustain it, how to protect it from the deceptive practices of Medicare Advantage providers. We urge you to invite grassroots organizations that are working to strengthen, improve and expand traditional Medicare.

Tim Wheeler
Acting Chair