OPEN EXECUTIVE SESSION TO CONSIDER FAVORABLY REPORTING THE NOMINATION OF MEHMET OZ, TO BE ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

TUESDAY, MARCH 25, 2025

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 9:36 a.m., in Room SD-215, Dirksen Senate Office Building, Hon. Mike Crapo, (chairman of the committee) presiding.

Present: Senators Johnson, Marshall, Wyden, Cantwell, Whitehouse, Hassan, Smith, Luján, Warnock, and Welch.

Also present: Republican staff: Andrew Dell'Orto, Policy Advisor; Kellie McConnell, Health Policy Director; and Gregg Richard, Staff Director. Democratic staff: Daniel Goshorn, Chief Investigative Counsel; Stacy Sanders, Chief Health Policy Advisor; Joshua Sheinkman, Staff Director; Tiffany Smith, Deputy Staff Director and Chief Counsel; and Shade Streeter, Investigative Counsel.

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The committee will come to order. We meet today to consider favorably reporting the nomination of Dr. Mehmet Oz to be Administrator of the Centers for Medicare and Medicaid Services. As we have done with other nominees, this meeting this morning will provide members with the opportunity to make remarks on Dr. Oz's nomination. We will notify members of a time and location later today to conduct a vote.

Dr. Oz has years of experience as an acclaimed physician and public health advocate. His background makes him uniquely qualified to manage the intricacies at CMS. At his hearing, Dr. Oz discussed his vision to ensure CMS provides Americans with access to superb care, especially our most vulnerable patients. I look forward to working with him, if confirmed, to accomplish this goal.

I was also encouraged to hear that he will focus on modernizing federal health care programs, work to fix our broken clinician payment system and will partner with Congress to achieve pharmaceutical benefit manager reform. There is no doubt that Dr. Oz will work tirelessly to deliver much-needed change at CMS.

I will be voting in favor of his nomination, and I encourage my colleagues on both sides of the aisle to do the same.

I now recognize Ranking Member Wyden for his remarks.

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

Senator Wyden. Thank you very much, Mr. Chairman. Later today we are going to vote on the Oz nomination. I am just going to spend a few minutes describing why I cannot support the nomination.

During his confirmation hearing, Dr. Oz was given the chance to assure the American people that he would not be a rubber stamp for Republican plans to gut Medicaid and hike Affordable Care Act premiums. At every turn, he failed the test. When I asked him a yes or no question about whether he would protect Medicaid, he dodged, he weaved, he simply would not answer.

That is a stark contrast to what I heard at town hall meetings open to all in Oregon the past week. In Oregon City, I was joined by Patty and Katina, a mom and a daughter who count on Medicaid to help with Katina's medical expenses. Because of Medicaid, Katina can thrive in the community as an Oregonian who lives with Down's syndrome.

There are countless other families in Oregon and across the country who are terrified of these cuts. Dr. Oz also ducked a number of my other questions. When pressed on whether nurses belong in nursing homes, he

replied that was a complicated question. I just found that a jaw-dropper. It is not complicated for the rest of us, whether nursing homes ought to have adequate staff to take your mom to the bathroom or give your grandpa meals. I told Dr. Oz it was pretty simple.

Not only did the nominee dodge and weave during questioning at his confirmation hearing, he also failed to provide factual responses to our written questions submitted after the hearing. This lack of responsiveness to Congress ought to be unacceptable to every member of our committee.

But the Republican majority once again seems eager to disregard their own Congressional oversight responsibilities when Donald Trump calls the shots. I will once again state that Dr. Oz is the second Trump nominee to come before this committee with a record of dodging Medicare and Social Security taxes. Nurses and firefighters across America pay taxes with every single hard-earned paycheck. But the multimillionaire nominated to run Medicare cannot be bothered to do the same thing.

I am also deeply concerned about Dr. Oz's history marketing Medicare Advantage plans. Mr. Chairman, I would like now to ask for unanimous consent to enter into the record an investigation by my staff on the

Finance Committee into the marketing middlemen that are exploiting Medicare Advantage rules, to aggressively push MA plans on seniors.

The Chairman. Without objection.

[The report appears at the end of the transcript.]

Senator Wyden. Mr. Chairman, this is a continuation of our efforts to spotlight health care middlemen, that in my view are leaching off the health care system at the expense of taxpayers and seniors. Our investigation found that too many for-profit insurance companies are spending billions of taxpayer dollars on marketing middlemen to drown seniors in calls and mailers.

These tactics are designed to pressure them into enrolling in private health plans that might not even cover their preferred doctor or medicines, or that may put up unexpected roadblocks to getting the care they need. Insurance companies and these marketing middlemen have orchestrated a complex and complicated system to line the pockets of shareholders by raising costs for seniors and taxpayers and evading oversight and accountability.

Given Dr. Oz's history of basically acting as a salesman for Medicare Advantage, putting him in charge of regulating these middlemen is almost like letting the

fox guard the proverbial hen house. The bottom line is that American tax dollars are in too many instances being used for profit -- by profit insurance companies for shady marketing practices that take advantage of older people.

For-profit insurance companies spend five times more on marketing and administrative expenses than traditional Medicare, which is of course run by the government. If Elon Musk and his cronies at DOGE actually cared about targeting waste and fraud, they would focused on waste in Medicare Advantage rather than targeting Americans' hard-earned Social Security.

We have successfully fought for more consumer protections against predatory MA marketing, and I asked Dr. Oz to pledge not to roll those protections back. He may be open to our concerns on that, and if he is confirmed I am going to hold him to that and watchdog this issue spotlighting abuses.

But the bottom line, colleagues, is that this is an ability who has shown -- a nominee who has shown no ability to or interest in pushing back on the dangerous Trump health care agenda. I urge my colleagues to vote no.

The Chairman. Thank you, Senator Wyden.

We will now turn to any Senator wanting to make a

statement. I ask each of you who do choose to make a statement to keep your remarks to three minutes or less, so we can keep on time for our Social Security nominee.

Senator Cantwell, you are next.

OPENING STATEMENT OF HON. MARIA CANTWELL, A U.S. SENATOR FROM WASHINGTON

Senator Cantwell. Thank you, Mr. Chairman. I am speaking about this issue today because I want to be clear about the devastating impacts that Medicaid will have on our constituents that is included in the House Republican budget.

While I appreciate Dr. Oz's willingness to consider some interesting and important reforms like PBMs or the basic health plan, he was unwilling to commit to opposing a cut to Medicaid. The math is clear. The proposal from the House budget would require massive cuts to Medicaid.

While I appreciate that my Republican Senate colleagues know this, and which is why it is not in their particular proposal, but now we have to fight the negotiations between the House and the Senate, and hold our colleagues accountable to protect this important program. I know Dr. Oz will not. He would not commit. He would not say no, and certainly not no to President Trump or Elon Musk or to the House of Representatives.

The House committee that oversees Medicaid and Medicare is responsible for funding $880 billion from these cuts. So, you can see from this chart the only

real place to get this is, particularly if Medicare is off the table, is from Medicaid.

Even if the committee completely eliminated every single other program in the E&C account, it still gives them one-sixth of what they need. So, make no mistake. There is no other way to meet this mandate but then to impact Medicaid. My colleagues who are trying to play down this threat or act like there is some other way around it, it is just not so. It is either bad math or bad faith.

Anyone who is telling their constituents otherwise is just not being honest with them. Last week I spoke in my state, in Seattle, Spokane and Tri-Cities about these Medicaid cuts, and was joined by physicians, hospital providers, patients, who do not want to shoulder this burden.

A patient like Gail Halverson from Spokane, who was terrified that the system that provided her and her late partner who just passed with affordable health care, will no longer be there for them. She told me "Who is going to pay for the nursing home? That's Medicare or Medicaid. So, are we just going to be left to die?"

Harborview, a medical center in Seattle with the most advanced trauma care in the region, receives 39

percent of their revenue from Medicaid. The CEO told me that a cut of this magnitude would be existential. So everyone knows that this issue is on the table, and yet we do not have a nominee before us who will say clearly he does not plan to cut Medicaid.

According to the Congressional Budget Office, Medicare-related expenditures account for 93 percent of the non-Medicare spending in the House Energy and Commerce Committee. The lion's share will absolutely have to come from Medicaid.

It is time to now get a nominee who would support that. That is not Dr. Oz. So, with this tsunami of cuts that we are looking at, I cannot support this nomination. I hope my colleagues will turn it down as well, and I hope our colleagues will join us in a fight to say no cuts to Medicaid. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Cantwell, and I appreciate your keeping the three-minute time limit.

Next is Senator Hassan.

OPENING STATEMENT OF HON. MAGGIE HASSAN, A U.S. SENATOR FROM NEW HAMPSHIRE

Senator Hassan. Well, thank you, Mr. Chair and Ranking Member Wyden, for this mark-up and this opportunity to discuss the serious implications of having Dr. Oz oversee health care for more than 160 million Americans.

First of all, Dr. Oz has shown a dangerous willingness to say or do anything that President Trump directs him to do, and during his hearing Dr. Oz refused to commit to following the law in the event that President Trump directs him to do something illegal. That failure to commit is disqualifying.

If confirmed, Dr. Oz would also be tasked with implementing the devastating cuts to Medicaid proposed by Congressional Republicans, which could lead to as many as 30,000 children in my state losing their health insurance. Granite Staters want Congress to increase access to health care, not a budget plan that would take health care away from children, seniors in nursing homes and thousands of people living in rural areas of my state.

Dr. Oz is one of several Trump administration nominees that say that they recognize the real

difference that Medicaid and other health programs make, and yet they are joining an administration and are supported by Congressional Republicans who plan to slash the health coverage and programs that people rely on.

In my state, that includes parents that I just met yesterday of a young man with autism, whose health care is provided by both Medicaid and Medicare and would not be able to obtain private insurance otherwise. It is also my -- my constituent up in the North country over last week expressed her concern that her twins with severe disabilities would also be pushed off of Medicaid, leaving her and her family without access to critical care for them.

Finally, I will note that a number of states, including my state of New Hampshire, has something called a trigger law that applies to its Medicaid expansion program. Should the degree of federal funding for Medicaid expansion, which among other things provides critical mental health care and addiction treatment, should that go below 90 percent, which was the federal commitment for Medicaid expansion, ten states in this country will automatically lose Medicaid expansion.

So, the implications here are real, they are serious, and Dr. Oz's assertion that he cares about

Medicaid, that he understands how important it is is belied by his unwillingness, as Senator Cantwell pointed out, to commit to protecting the Medicaid program, and his willingness to join this administration.

I urge my colleagues to join me in opposing the confirmation of Dr. Oz. Thank you.

The Chairman. Thank you, Senator Hassan. And Senator Smith and Senator Luján have agreed to let Senator Warnock go next.

OPENING STATEMENT OF HON. RAPHAEL G. WARNOCK, A U.S. SENATOR FROM GEORGIA

Senator Warnock. Thank you very much, Mr. Chair, and long before I came to the Senate, I was fighting for my state to expand Medicaid, which would give an estimated 600,000 Georgians access to affordable health care. But here we are 15 years almost to the day of the Affordable Care Act being signed into law, and still Georgia has not expanded Medicaid.

Georgia continues to deny its citizens access to this program that is being supported by the taxpaying Georgians. To make matters worse, now Washington Republicans have proposed to gut almost $900 billion from Medicaid, to give millionaires and billionaires an additional tax cut, potentially kicking millions of Americans off of their health care insurance.

Medicaid covers almost 40 million children across the country, two in five children in Georgia, one in ten veterans, 63 percent of seniors in nursing homes. Medicaid also supports one-fifth of all hospital spending, especially in communities without many hospital options. Washington Republicans and Dr. Oz say they want to make Medicaid more efficient by requiring people who get their health insurance through Medicaid

to fill out government paperwork each month to prove that they are working.

Here are the facts. Here are the facts. Nearly all adults enrolled in Medicaid are either working, in school or are caregivers. By and large, if they can work they do work. I know that may be hard to believe in a country that increasingly maligns poor people for being poor, but by and large these folks are already working or they are caregivers or they are students.

They are construction workers, they are restaurant servers and mechanics. They are doing exactly what Dr. Oz and Washington Republicans want them to do. But here is the deal. Republicans need a whole lot of money to pay for their tax cuts for the wealthiest among us, and they know if you give people enough bureaucratic hoops to jump through, then enough working people will get tripped up by the red tape and lose their health care.

And so that is the plan. Less money spent on a working mom's cancer treatment because she did not fill out the right form every month by the right deadline, so you have more money for billionaire tax cuts. We know this because I live in Georgia. Georgia is the only state with work reporting requirements for its Medicaid program, and all of this program has to show for itself five years later is 6,500 people enrolled.

We have got nearly 600,000 Georgians who are in the Medicaid gap. The governor's program has enrolled a whopping 6,500 people. Mr. Chair, I know I am running out of time. But as I close, and nobody believes a Baptist preacher when he says "as I close," let me be really clear that I am voting against Dr. Oz. I think he is knowledgeable, certainly more knowledgeable than Secretary Kennedy about the program that he is tasked to lead.

But we have to got to take seriously the need of millions of Americans who will lose their health care, and so I am voting no for his nomination and I urge my colleagues to do the same.

The Chairman. Thank you.

Senator Smith?

OPENING STATEMENT OF HON. TINA SMITH, A U.S. SENATOR FROM MINNESOTA

Senator Smith. Thank you, Mr. Chair. Mr. Chair, I am speaking today in opposition to the nomination of Dr. Oz to be the administrator of CMS. I am voting no because of what I see as a concerted effort by the Trump administration and some Congressional Republicans to use Medicaid as an ATM to pay for tax breaks for the biggest, most successful corporations and wealthy individuals.

And at a time when Minnesotans are struggling to afford their lives and President Trump's policies are making it worse, not better, I cannot support the nomination of Dr. Oz, who will be an enthusiastic participant in a plan that will make Medicaid health insurance harder to get and more expensive.

Now in my home state of Minnesota, 1.2 million people get their health insurance through Medicaid. These are seniors in nursing homes, moms and their kids, working families, people with disabilities and patients struggling with mental and behavioral health challenges.

Medicaid is the health insurance that covers more than half of nursing home residents in our state, and it covers one in three Minnesota children. It is the

biggest health insurer for mental and behavioral health care for Minnesotans and Americans. That is 15 million Americans.

And here is the reality. Taking away health insurance coverage from people will not cut sickness. People will still need health care. They just will not be able to get it in the most efficient, cost-effective way. They will get it in emergency rooms, not doctor's offices. Taking away health care insurance will hurt people and that is the most important issue at stake here, but it will also cost more money at the end of the day.

Mr. Chair, I was home this past weekend, this past week and I have heard so many stories about Medicaid and how it saves lives. I want to share one story with the committee. Last week I met a remarkable young woman. Appropriately her name is Hope. As a teenager and young adult, Hope suffered from debilitating and life-threatening psychosis.

If it were not for Medicaid, says Hope, "I would not be alive today." In Minnesota, Medicaid covers inpatient mental health care. Hope was committed and she was treated in inpatient care, and she got intensive treatment for her psychosis, covered by Medicaid. A diagnosis of psychosis can feel so hopeless.

But Hope was able to get intensive care. She needed to learn how to understand and control her illness, and today she is able to live independently and is able to manage her mental health. Today, she gets her health insurance through her employer.

So, colleagues, I am voting no on Dr. Oz because I do not trust him or this administration to follow the law and to protect our health care. I cannot trust him or this administration to run CMS, to protect access to health care for Hope or the 1.2 million Minnesotans who get their insurance through Medicaid. Thank you, Mr. Chair.

The Chairman. Thank you, Senator Smith.

Senator Luján?

OPENING STATEMENT OF HON. BEN RAY LUJÁN, A U.S. SENATOR FROM NEW MEXICO

Senator Luján. Thank you, Mr. Chairman. Mr. Chairman, recently a mom from New Mexico shared the story of her son, who was diagnosed with hemophilia at the age of six. Six year-olds should be entering the first grade, outside playing with neighbors, watching superhero movies, arguing with their siblings about whose turn it is to do the dishes.

Six-year-olds should not have to worry about whether or not they get to see a doctor or whether they will get the medicine they need to feel better, so they could do all the things a six year-old should be doing. That mom from New Mexico told me she is scared, scared that if her son's Medicaid is ripped away, she will lose her son.

Now I know that each of us is hearing similar stories from our constituents, and based on news accounts, there are lots of town halls and gathering across America this last week, some where members of the House participated, some where there was just an empty chair.

From the meetings I had with this nominee and from what I have seen so far from this administration, it is

clear to me that they plan to gut the Medicaid program that serves 784,000 New Mexicans. That is 784,000 lives that depend on this coverage to survive, get the help they need and the medical support that is crucial to living happy and productive lives.

I will not stand by and watch as families are left behind by this administration. There are better ways to improve our health system. But slashing essential programs like Medicaid that pay for a Trump tax cut is not one of them. I cannot support a nominee who will tear apart a health care system to justify giving millionaires and billionaires more money.

You know, folks making two million bucks a year, congratulations. I wish them well. I hope they make more. To the folks across the country making the median income and less, should they not be getting the brunt of this tax cut? That is where this should be going. This is not about wealthy people or not. This is about who deserves help, support across the country. That is what we are talking about here.

So, I urge my colleagues to think about the millions of Americans, their constituents, my constituents who depend on the programs that this nominee will have control over, and I urge them to vote no. I yield back.

The Chairman. Thank you.

Senator Whitehouse?

OPENING STATEMENT OF HON. SHELDON WHITEHOUSE, A U.S. SENATOR FROM RHODE ISLAND

Senator Whitehouse. Thanks very much, Mr. Chairman. First of all, let me express my appreciation to Senator Cantwell for her remarks, which I thought pretty well summarized where we are with respect to the looming attack on Medicaid. I just want to point out that in Rhode Island, 60 percent of our nursing home folks are funded by Medicaid, and nursing homes are not in great shape to begin with.

This could be a case not only of people's aunts and grandmothers losing the funding that keeps them in the nursing home, but the nursing home not being able to survive financially. 45 percent of births in Rhode Island at Women and Infants Hospital, which is a legendarily expert OB/GYN hospital, are funded by Medicaid.

But for a variety of reasons, women and infants cannot afford to have Medicaid stripped away, and it would put that hospital in financial peril to lose Medicaid. And then many of us lived through the opioid epidemic. Senator Hassan up in New Hampshire experienced the same sort of thing that we did in Rhode Island, and many of the people in Rhode Island and

around the country who are in that brave and noble path to addiction recovery are supported by Medicaid. To undercut them would be cruel as well as stupid.

I have three topics that I have raised with Dr. Oz that I would like to get some progress on. It looks like when CMS, in a massive abundance of stupidity, turned on one of its best-performing national ACOs and tried to strip it because of a brief and disputed departure below the 5,000-patient minimum, that got thrown out by a court.

It shows how weak the CMS case was, and I hope that CMS does not go back for revenge and leaves things as they are and lets one of the nation's highest-performing ACOs continue to be a high-performing ACO.

Rhode Island suffers from a 20-plus percent differential in payments. Backus Hospital is probably 25 minutes from our border in Connecticut. St. Anne's is probably five minutes from our border in Massachusetts. Neither of those hospitals provide the high level services that Rhode Island Hospital and Women and Infants Hospital and Hasbro Children's Hospital, all on the same campus, provide, and yet they are paid more.

And CMS sits on its hands and could not care less about doing anything about that differential, even as it

erodes the financial security of Rhode Island's health care base.

And last of all, I have been working since CMS since the first Trump administration, and it has been Ground Hog damn day with people changing and having to get back to square one, on trying to let Rhode Island be a model for a better way to treat families and patients where the individuals are nearing the end of their life. We do really stupid things to people because of Medicare rules that do not make any sense in that circumstance, and make even less sense when there is a value-based care model that is in place.

So I hope we can make some real progress on those three things, and we have to defend Medicaid. It is just wrong to go after it. Thank you, Mr. Chairman.

The Chairman. Thank you.

Senator Welch, did you wish to make a statement at this point? All right.

I think, Senator Marshall, you are the wrap-up.

OPENING STATEMENT OF HON. ROGER MARSHALL, A U.S. SENATOR FROM KANSAS

Senator Marshall. Okay, Mr. Chairman. Thank you so much, and this is such a very important topic. I just want to emphasize that as I talk to President Trump and the administration and my fellow Republicans, we are here to save Medicaid. We are here to save it, that we want to strengthen Medicaid for the most vulnerable.

And then that is our goal, and I look forward to working with my colleagues across the aisle on figuring out how to save it. But I think you would also agree with me that what we are spending on Medicaid now looks like a rocket ship, that we have increased spending on Medicaid by 50 percent over the last five years. We will spend a trillion dollars this year on Medicaid.

We want to make sure that Medicaid dollars are spent on the most vulnerable of people, the ones that really, really need it as well. That should be the focus, is on how we save Medicaid. I think there is opportunities. When you are spending a trillion years [sic] on Medicaid, when it has gone up 50 percent in five years, I think there are opportunities to address the fraud and the waste, eligibility issues.

You know, I wake up every morning hoping to do

what is fair, to do justice, and what is being done in one state with Medicaid is simply unfair to what is being done in Kansas, that some states are manipulating the system. They are gaming the system. If we do not get our arms around it, there will be no Medicaid left for those who are the most vulnerable.

So that would be our goal. I think we -- if we can at least agree on the goal that we want to save Medicaid and want to use it for the most vulnerable, that is a great starting point.

And I will just close with a little thought on Medicare Advantage. Like Dr. Oz, I thought Medicare Advantage was a good thing when it came out. But unfortunately it has been manipulated. They found loopholes to manipulate and now we are spending probably $83 billion more a year on Medicare Advantage patients as opposed to if they had been on traditional Medicare, and I think similar situations are happening with Medicaid managed care systems as well.

So, I look forward to working with my colleagues across the aisle, and I hope that there is an amendment or there is an opportunity to fix that very broken system that my friends across the aisle who speak so boldly about changing Medicare Advantage, that they will vote for reforming it as well, whenever we have that

opportunity.

So again, just emphasize that Republicans are here to save Medicaid, that we want to make sure that we strengthen Medicaid for the most vulnerable of our society who needs it. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Marshall.

Now procedurally, so everyone understands what will happen with regard to this nomination, the committee will recess at this point briefly before we then move to our Social Security hearing, and we will reconvene to vote on the nomination of Dr. Oz off the Senate floor at a time to be announced today when we know when the votes are happening.

Members will be notified at the time that we get that confirmed. The committee will be recessed briefly until we begin the next hearing.

[Whereupon, at 10:03 a.m., the meeting was recessed.]

The open executive session was reconvened, pursuant to notice, on Tuesday, March 25, 2025, at 2:15 p.m., in Room S-216, The President's Room, U.S. Capitol, Hon. Mike Crapo (chairman of the committee) presiding.

The Chairman. The committee will come to order.

We now have a quorum. I move that we favorably report the nomination of Mehmet Oz.

Senator Grassley. Seconded.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Grassley?

Senator Grassley. Aye.

The Clerk. Mr. Cornyn?

Senator Cornyn. Aye.

The Clerk. Mr. Thune?

Senator Thune. Aye.

The Clerk. Mr. Scott?

Senator Scott. Aye.

The Clerk. Mr. Cassidy?

Senator Cassidy. Aye.

The Clerk. Mr. Lankford?

Senator Lankford. Aye.

The Clerk. Mr. Daines?

Senator Daines. Aye.

The Clerk. Mr. Young?

Senator Young. Aye.

The Clerk. Mr. Barrasso?
Senator Barrasso. Aye.
The Clerk. Mr. Johnson?
Senator Johnson. Aye.
The Clerk. Mr. Tillis?
Senator Tillis. Aye.
The Clerk. Mrs. Blackburn?
Senator Blackburn. Aye.
The Clerk. Mr. Marshall?
Senator Marshall. Aye.
The Clerk. Mr. Wyden?
Senator Wyden. Nay.
The Clerk. Ms. Cantwell?
Senator Cantwell. Nay.
The Clerk. Mr. Bennet?
Senator Bennet. Nay.
The Clerk. Mr. Warner?
Senator Warner. Nay.
The Clerk. Mr. Whitehouse?
Senator Whitehouse. Nay.
The Clerk. Ms. Hassan?
Senator Hassan. Nay.
The Clerk. Ms. Cortez Masto?
Senator Cortez Masto. Nay.
The Clerk. Ms. Warren?

Senator Wyden. Nay by proxy.

The Clerk. Mr. Sanders?

Senator Sanders. Nay.

The Clerk. Ms. Smith?

Senator Smith. Nay.

The Clerk. Mr. Luján?

Senator Luján. Nay.

The Clerk. Mr. Warnock?

Senator Warnock. Nay.

The Clerk. Mr. Welch?

Senator Wyden. Nay by proxy.

The Clerk. Mr. Chairman?

The Chairman. Aye.

The clerk will announce the vote.

The Clerk. Mr. Chairman, the final tally is 14 ayes and 13 nays.

The Chairman. The “ayes” have it.

I thank my colleagues for their attendance. The committee stands adjourned.

[Whereupon, at 2:42 p.m., the meeting was adjourned.]

SUBMITTED BY SENATOR WYDEN

I. Executive Summary

In 2024, 68 million seniors and people with disabilities were enrolled in the Medicare program.[1] It is estimated that 11,000 people are turning 65 each day as the "baby boom" generation continues to age into Medicare.[2] More than half of all Medicare enrollees receive their Medicare covered benefits through a Medicare Advantage (MA) plan.[3] MA plans are the most profitable business for many insurance companies with gross profits nearly twice the individual marketplace and more than twice the group market or Medicaid managed care.[4] In order to expand their MA memberships some insurers are funding, with taxpayer dollars, a secretive network of companies who profit off lead generation, and contact potential enrollees, in some cases relentlessly, with targeted advertising, phone calls, and mailers.

Prior work by the Senate Committee on Finance Democratic Staff ("the Committee") examined how MA marketing activities have harmed seniors and left them confused and in doubt about Medicare's guarantee of high-quality health care. The Committee's November 2022 report documented examples where marketing led seniors to enroll in MA plans that did not meet their needs, such as not including prescription drug coverage or their preferred providers.[5] The staff report also documented numerous cases where individuals were called multiple times by marketers in clear examples of harassment. Mismatch between what a senior needs and what a for-profit insurance company is selling has led to delayed access to care, higher out-of-pocket costs, as well as stress and anxiety.

In this report, the Committee documents that insurers' engagement of middlemen to market their MA plans is expensive, a cost that is passed along to Medicare enrollees and taxpayers. While the Centers for Medicare & Medicaid Services (CMS) has capped reimbursements for broker enrollment services, marketing and administrative services are not capped. This investigation finds that payments for marketing and administrative services have outpaced MA enrollment growth, and that payments for certain types of enrollees (such as those enrolled in Dual-Eligible Special Needs Plans, or D-SNPs) can be 5-10 times greater than general enrollments. On top of these costs, insurers have found loopholes to pay brokers and

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[1] Centers for Medicare & Medicaid Services, Medicare Monthly Enrollment, June 2023. Retrieved from: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/

[2] Anne Marie Lee, America is hitting "peak 65" in 2024 as record number of boomers reach retirement age. Here's what to know, CBS News, Jan. 29, 2024, https://www.cbsnews.com/news/retirement-medicare-401k-what-to-know-peak-65/.

[3] 2024 Medicare Trustees Report.

[4] Ortaliza J et al, Health Insurer Financial Performance in 2023. KF, July 2, 2024. Available at: https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/

[5] Senate Finance Committee minority staff, *Deceptive Marketing Practices Flourish in Medicare Advantage*, Nov. 2022, https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.

their back-end administrative support companies more through questionable assessments and other post-enrollment services. Where Traditional Medicare spends less than 2% percent of its budget per year on administrative costs, MA plans spend an average of 10% of their budgets per year on administrative costs.[6] Although CMS attempted to curb the administrative spending through rulemaking, those efforts stalled following an injunction in the Fifth Circuit.[7]

More than 35 million people are projected to be enrolled in MA plans in 2025. Because of insufficient protections against aggressive marketing practices, these beneficiaries are increasingly being steered toward plans that don't meet their needs as companies spend more to incentivise marketing and lead generation, increasing program costs.

A. Key Findings

1. Medicare Advantage plans are engaged in costly marketing practices.

Medicare Advantage Plans (MA plans) are engaging in marketing practices that increasingly rely on third party marketing organizations (TPMOs) and lead generators, inflating costs for enrollees and taxpayers. These practices result in a complex ecosystem of middlemen that evade oversight and regulation. Seniors and people with disabilities may be misled by aggressive marketing practices and steered by third parties into MA plans that do not meet their needs.

This system significantly increases costs. MA Plans at issue in this investigation paid a significant amount of money on broker fees and commissions, showing a drastic increase in recent years. Based on insurer reported information, spending on "agents and brokers fees and commissions" increased $2.4 billion to $6.9 billion from 2018 to 2023 – a 19% compound average growth rate (CAGR). By comparison, over the same time period spending on "direct sales salaries and benefits" increased from $1.5 billion to $2.2 billion, a 7% CAGR.[8]

2. State and Federal regulators have limited oversight of marketing practices.

Because of the way insurers are able to contract for marketing activities, state and federal governments have limited oversight and regulatory access. TPMOs nominally oversee their

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[6] Dalit Baranoff, PhD, Etti G. Baranoff, PhD, Thomas W. Sager, PhD, Bo Shi, PhD, *Comparing Apples With Oranges: Administrative Expenses and Finances in Medicare Systems*, 27 American Journal of Managed Care 4, Apr. 1, 2021, https://www.ajmc.com/view/comparing-apples-with-oranges-administrative-expenses-and-finances-in-medicare-systems.

[7] *See Americans for Beneficiary Choice v. HHS*, No. 4:24-cv-00439 (N.D. Tex.), *Council for Medicare Choice v. HHS*, No. 4:24-cv-00446 (N.D. Tex.).

[8] Medicare Trustees Report, Table V.B3.—Medicare Enrollment, 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2024. Available at: https://www.cms.gov/oact/tr/2024.

contracted lead generators and downstream contractors through contract terms that require compliance with regulation and consumer protections, but which do not always require TPMOs to proactively audit or otherwise ensure middlemen are in compliance with the law.

3. **Marketing practices incentivize placing seniors in MA plans that do not necessarily meet their health needs.**

The MA marketing boom creates financial and other incentives for companies to limit which MA plans a broker presents to a client. This may result in brokers offering enrollees MA plans that do not meet their health needs in order to access commissions or administrative payments. As lead generation proliferates the MA marketing space, lead generators and brokers regularly use aggressive or misleading tactics, likewise steering enrollment. Uncapped spending drives aggressive lead generation tactics, including persistent calling and advertisements that create a sense of urgency.

II. BACKGROUND

A. Jurisdictional Statement

The Senate Committee on Finance has jurisdiction over matters related to "health programs under the Social Security Act and health programs financed by a specific tax or trust fund," as provided by Rule XXV of the Standing Rules of the Senate, including CMS, which administers Medicaid, CHIP, Medicare, Medicare Advantage (MA), and the Part D prescription drug program.

B. Legislative History

Medicare Advantage plans provide Medicare coverage to 35 million seniors and people with disabilities through private insurance plans. Medicare Advantage provides enrollees with coverage exceeding that offered under Traditional Medicare coverage. In theory, these MA plans are meant to increase enrollee choice and access to necessary health services and to reduce costs for the government. However, in recent years, MA plans have been accused of deceptive marketing tactics and structuring financial incentives that run counter to an enrollee's best interests. By engaging an ever-increasing number of middlemen to acquire leads and place marketing materials, concern has arisen that Medicare Advantage Plans are using an increasingly complex stream of marketing middlemen to deceptively market their products, contact beneficiaries overmuch, and steer beneficiaries toward plans with upstream incentives.

Medicare Part C, or Medicare Advantage, was created in 1997 through the passage of The Balanced Budget Act (BBA), in an attempt to mitigate concerns over program solvency.[9]

[9] Medicare Rights Center, *Medicare Advantage History: Legislative Milestones*, 2023, https://www.medicarerights.org/pdf/medicare-advantage-101-legislative-milestones.pdf; P.L. 105-33.

Following this intervention, enrollment in Medicare fell, leading Congress to pass the Medicare Modernization Act of 2003 (MMA) which expanded private plan options and created Medicare Part D (prescription drug coverage).[10] Since 2007, MA enrollment has grown from 19% of the program to 54% in 2024.[11] It is estimated that 35.7 million people will enroll in an MA plan in 2025.[12]

The presence of private insurance plans in the Medicare market offers seniors and people with disabilities options to obtain additional coverage of services and benefits not typically covered by Medicare, such as vision, hearing, dental care, and an out-of-pocket maximum on cost sharing. There are tradeoffs: enrollees are also faced with a difficult and limited disenrollment process, access to limited provider networks, and coverage restrictions through prior authorization and referral requirements on medical and supplemental benefits not limited in Traditional Medicare.

In 2008, the Senate Special Committee on Aging and the Senate Finance Committee documented blatantly deceptive MA Plan marketing tactics such as brokers going door to door in white lab coats, misleading consumers into believing that they were medical professionals.[13] Subsequently, in 2009, the Medicare Improvements for Patients and Providers Act (MIPAA) amended the Medicare statute to provide that brokers' advice to a potential Medicare Advantage enrollee should be free of influence from financial incentives.[14] This law was intended to address a rapid rise in aggressive and misleading practices by agents and brokers in the market.

As the baby boom generation began reaching Medicare eligibility in 2011, the program saw an increase in enrollments, expected to continue into 2030.[15] Enrollees began to trend younger and with longer life expectancies.[16] This trend tracked the rapid increase of Medicare Advantage enrollments, which increased from 14 percent to 28 percent between 2005 and 2013.[17] Because of this growing Medicare-eligible population, projected to live longer and with more well-managed chronic health conditions, Medicare Advantage plans have been an increasingly profitable endeavor for private insurers. Around the expansion of this market to include more plans and more enrollees, marketing for Medicare Advantage plans likewise

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[10] Medicare Rights Center, *Medicare Advantage History: Legislative Milestones*, 2023, https://www.medicarerights.org/pdf/medicare-advantage-101-legislative-milestones.pdf.
[11] Kaiser Family Foundation, *Medicare Advantage in 2024: Enrollment Update and Key Trends*, Aug. 8, 2024, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/.
[12] 2024 Medicare Trustees Report.
[13] Senate Finance Committee minority staff, *Deceptive Marketing Practices Flourish in Medicare Advantage*, Nov. 3, 2022, chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.
[14] P.L. 110-275.
[15] Report to the Congress: Medicare and the Health Care Delivery System, Chapter 2: The Next Generation of Medicare Beneficiaries at p 35, 37, MedPac, Jun. 2015, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-.pdf.
[16] *Id.*
[17] *Id.* at 45.

expanded. Marketing efforts were initially handled by smaller, independent brokerages and agents. While some brokers still operate independently or in small brokerages, marketing activities have coalesced into TPMOs or field marketing organizations that provide back-end administrative support for agents and brokers and serve as the primary contact for insurers. TPMOs are regulated by CMS insofar as they provide MA and Part D services to enrolled individuals.

In 2021-22, CMS reported an alarming uptick in consumer complaints related to marketing of MA Plans – up to 41,000.[18] The surge in complaints lent support to consumer advocate concerns that increasingly confusing and deceptive advertising tactics were being deployed to enroll beneficiaries in MA Plans. From spring 2022 through fall of 2024, Democratic staff investigated these complaints. Democratic staff conducted interviews with numerous industry experts, state regulators, former government regulators, and individuals currently employed within the industry. In November 2022, Democratic staff released a report documenting a rise in complaints across multiple states and clear examples of deceptive advertising featuring celebrities, high-pressure tactics, and marketing materials designed to appear like official government notices.[19] During the course of this work, experts pointed to questionable lead generation techniques, the role of on-shore and off-shore call centers, and a marketing and administrative payments arms race.

In October 2023, the Committee held a hearing on enrollment experiences into MA plans. At that hearing, Krista Hougland, chief executive officer of Security Health Plan from Marshfield Wisconsin, testified that:

> 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.[20]

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[18] Commonwealth Fund, *The Role of Marketing in Medicare Beneficiaries' Coverage Choices*, Jan 5, 2023, https://www.commonwealthfund.org/publications/explainer/2023/jan/role-marketing-medicare-beneficiaries-coverage-choices.

[19] Senate Finance Committee, Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences, Oct. 18, 2023, https://www.finance.senate.gov/hearings/medicare-advantage-annual-enrollment-cracking-down-on-deceptive-practices-and-improving-senior-experiences.

[20] Prepared testimony of Krista Hoglund, "Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences", U.S. Senate Finance Committee, October 18, 2023.

The Association for Community Health Plans was the first to publicly point out that marketing and administrative spending in addition to regulated commissions for agents and brokers could exceed $1,000 per new enrollee.[21]

Following the hearing, Committee Democratic staff requested information from selected large MA insurers on the nature of their practices and relationships with TPMOs, requested information on marketing and commission spending from the National Association of Insurance Commissioners, interviewed brokers and other industry experts, and publicly requested information from five large TPMOs.[22] This report summarizes the quantitative data and the interviews, hearings, contracts, and other information collected. Together this evidence indicates that MA Plans are investing substantial taxpayer dollars in marketing practices. The resulting third-party marketing ecosystem is opaque, complex, and costly, and is inadequately overseen by CMS. CMS needs additional statutory authority and direction to appropriately regulate this industry that is fueled with taxpayer dollars to ensure people with Medicare are educated on their coverage options with an unbiased advisor who puts that individual's best interest first.

C. Regulatory Landscape

This section describes the federal agencies and recent rulemaking impacting MA plan marketing. In addition to federal agencies, courts play a role in interpreting federal regulation in line with statutory language. States have limited authority in regulating MA plan marketing.

Federal Communications Commission The FCC is responsible for regulating communication by radio, television, wire, satellite and cable. In 2023, the FCC finalized a rule to limit unwanted contact by lead generators across all industries.[23] In relevant part, this rule requires that lead generators contacting consumers by text or call must acquire the consumer's prior express written consent before that contact is made. Further, this consent must also be "one-to-one," or granted by a consumer with conspicuous and clear disclosure of what communications they are signing up for and in regards to a specific product. In order for this consent to be valid, a consumer may only be giving consent to be contacted to one seller at a time– that is, consent may not be obtained by a lead generator in one consumer interaction for multiple different buyers to contact the consumer. This rule further dictates that communications by lead generators following this consent must be "logically and topically associated" with the platform through which the consumer gave consent.

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[21] Connolly C and Bagel M, MA for Tomorrow: Moving Beyond the Status Quo to Advance Concrete Policy Changes for the Future of Medicare Advantage, The Health Care Blog, Jun. 12, 2023, https://thehealthcareblog.com/blog/2023/06/12/ma-for-tomorrow-moving-beyond-the-status-quo-to-advance-concrete-policy-changes-for-the-future-of-medicare-advantage/.

[22] Letter from Chairman Wyden to TPMOs, Jan. 11, 2024, *see, e.g.* https://www.finance.senate.gov/imo/media/doc/wyden_letter_on_questioning_medicare_marketers_business_tactics_12324.pdf.

[23] 89 FR 5177.

Centers for Medicare & Medicaid Services Since 2003, MA plan marketing activities have generally fallen into the jurisdiction of the Centers for Medicare & Medicaid Services (CMS). The Medicare Modernization Act (MMA) of 2003, limited state regulatory authority to plan solvency and licensing.[24] In addition to these areas, states retain oversight authority over insurance agents and brokers. CMS oversees the administration of MA plans, which allows the agency to regulate the practices of the MA Plans by terms of yearly contracts. Generally, CMS annually promulgates a Final Rule that describes adjustments to its administration of the Part C (Medicare Advantage) program.This rule is typically proposed in November or December and finalized in April of the next calendar year.

CMS addressed marketing abuses in the 2024 Final rule and 2025 Final Rule.[25] The 2024 Final Rule focuses on deceptive marketing practices and prohibits MA plans from placing ads that do not mention a specific plan name and from using words or pictures, as well as plan logos, in ways that may be confusing or misleading.[26] The 2025 Final Rule focuses on consumer privacy and the contractual relationships between MA Plans, TPMOs, and lead generators, identifying incentives and loopholes that allow for impermissible marketing tactics.

In July 2024, this new rule was enjoined, in part, by a U.S. District Court in Texas, halting the enforcement of its provisions that would constrain workarounds to its broker compensation cap and contractual or financial incentives for brokers to steer enrollees toward a certain Medicare Advantage Plan.[27]

In the remaining provisions of the rule, CMS adopted a consent structure similar to the FCC 2025 final rule. The rule clarified that TPMOs contracting with CMS-regulated MA Plans are subject to FCC regulation governing lead generators. Further, CMS's rule clarifies that the FCC applies its Telemarketing Sales Rule and Section 5 of the FTC Act to the activities of TPMOs, prohibiting abusive marketing tactics and making unlawful deceptive marketing.

This rule further applies the FCC's standard of prior express written consent, one-to-one between consumer and seller, through clear and conspicuous disclosure to communication of beneficiary information between TPMOs, rather than prohibiting this information exchange outright. In these instances, a TPMO must obtain written consent either through a website interface or through an email or text message to a consumer expressing their consent to have their information shared. The purpose of this provision is to limit the number of TPMOs with authority to contact a single consumer. Likewise, robo texts and robocalls to consumers in

[24] Letter from NAIC to Senator Schumer and Senator McConnell, May 5, 2022, https://content.naic.org/sites/default/files/State%20MA%20Marketing%20Authority%20Senate%20Letter%20.pdf.
[25] 89 FR 30448.
[26] CMS, 2024 Medicare Advantage and Part D Final Rule Fact Sheet, Apr. 5, 2023, https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.
[27] *See Americans for Beneficiary Choice v. HHS*, No. 4:24-cv-00439 (N.D. Tex.), *Council for Medicare Choice v. HHS*, No. 4:24-cv-00446 (N.D. Tex.).

relation to MA Plans are prohibited unless a consumer has offered their prior express written consent. These rules apply to every "TPMO that is involved in the marketing or enrollment chain" where a consumer's information is collected with the intention of eventually marketing a Medicare Advantage Plan.

Federal Courts Two provisions of the 2025 Final Rule are currently enjoined by the Fifth Circuit. The first is CMS's attempt to proscribe administrative payments by MA Plans to TPMOs. In response to concerns that MA Plans were circumventing the compensation cap on payments to brokers and agents by classifying payments as "administrative fees," this new CMS rule would have directed that all payments to agents and brokers having to do with initial enrollment, renewal, or services related to a plan are considered compensation. As justification for this change, CMS stated:

> For instance, we stated in the November 2023 proposed rule that we understand that many plans are paying agents and brokers for conducting health risk assessments (HRAs) and categorize these HRAs as an "administrative service." We understand the fair market value of these services, when provided by non-medical staff, to be approximately $12.50 per hour and the time required to complete an HRA is intended to be no more than twenty minutes.[156] However, we explained that we have been made aware of instances of an agent or broker enrolling a beneficiary into a plan, asking the enrollee to complete one of these short assessments, and then being compensated at rates of up to $125 per HRA. Compensation at these levels is not consistent with market value and CMS believes that compensation at these levels far exceeds the fair market value of the actual service being performed and therefore should not be categorized as an "administrative service."[28]

This attempted change seeks to ensure that brokers do not have incentives to enroll consumers in MA plans that do not best meet their coverage needs. CMS notes that, by circumventing compensation caps to brokers and agents, as well as to Field Marketing Organizations (FMOs) and TPMOs, MA Plans may be incentivising actors in their chain of enrollment to steer beneficiaries toward particular products when those beneficiaries would be better served by a different plan. Administrative payments to TPMOs have been increasing, seemingly in order to increase compensation without conflicting with prior CMS rules involving broker compensation caps. The Fifth Circuit found that this change was arbitrary and capricious where it set a compensation cap at $100 without sufficient justification for that specific threshold.[29]

The second enjoined provision attempts to restrict terms in contracts between MA plans and their intermediaries. The rule states that MA plans may not contract with TPMOs or other

[28] 88 FR 78476.
[29] *See Americans for Beneficiary Choice v. HHS*, No. 4:24-cv-00439 (N.D. Tex.), *Council for Medicare Choice v. HHS*, No. 4:24-cv-00446 (N.D. Tex.).

intermediaries on terms that have a "direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary."[30] The Fifth Circuit found that this provision was over-broad and underdeveloped in the Rule, failing to provide notice of prohibited conduct.[31]

States. State Departments of Insurance oversee insurance broker and agent licensure. These state agencies are responsible for enforcing state rules. The National Association of Insurance Commissioners recently developed a model law for states to regulate lead generation activities, which are largely regulated under state law. Under this model law, states could adopt a uniform definition of "lead generator" and restrict fraudulent and deceptive lead generation activities.

States regulate supplemental Medicare coverage offered by private plans, commonly referred to as Medigap coverage. The marketing rules governing Medigap plans can differ from MA, including allowing door-to-door sales and cold calls.

D. Data Collected

In an aim to understand the relationships between health plans, third party marketers, and lead generators, the Committee collected information from insurers, TPMOs, and other experts in addition to conducting research of publicly available websites related to marketing and enrollment. Then-Chairman Wyden requested information from five MA health plans in a non-public letter. Based on the information submitted, Chairman Wyden requested information from the five largest TPMOs used by the initial pool of insurers for each year between 2018 and 2022.[32] Staff analyzed contracts between four of the TPMOs investigated and their lead generators or other TPMOs for the procurement of valid leads. The Committee also requested insertion orders and secondary documents to the contracts where internally referenced, but only received these documents in the case of one TPMO.

In addition to these documents, the Democratic staff was contacted by a range of individuals who work in MA marketing, including call center workers, insurance agents and brokers, field marketing organization leaders, and consumers. These conversations informed our work by providing context to observed trends in the contracts and quantitative data as well as offering opportunities to understand practices not described in the requested information. Democratic staff also collected medical loss ratio information reported to the National

[30] 89 FR 30448, https://www.federalregister.gov/d/2024-07105/p-4754.
[31] *See Americans for Beneficiary Choice v. HHS*, No. 4:24-cv-00439 (N.D. Tex.), *Council for Medicare Choice v. HHS*, No. 4:24-cv-00446 (N.D. Tex.).
[32] Senate Finance Committee, Wyden Questions Medicare Marketers' Business Tactics, Jan. 23, 2024, https://www.finance.senate.gov/chairmans-news/wyden-questions-medicare-marketers-business-tactics

Association of Insurance Commissioners and examined publicly available insurer, marketer, and broker websites and CMS issued regulations and subregulatory guidance.

III. CONSUMER JOURNEY

The Senate Finance Committee Democratic staff's 2023 report documented that consumers who are targeted by lead generators can get 20 or more calls a day.[33] Lead generation activities account for much of the barrage of calls received by people nearing eligibility throughout the rest of their lives, an experience that ranges from annoying to concretely harmful. Reporting has detailed the experience of people living with dementia who have unenrolled and re-enrolled in MA plans rapidly after receiving repeated marketing calls.[34]

The "typical" experience of a consumer targeted for Medicare marketing was outlined in a TPMO B corporate presentation, differentiating its consumer experience from others in the industry, that staff obtained during its investigation.[35] This presentation was meant to demonstrate harmful marketing practices experienced by consumers, and was compiled by the TPMO using secret shopping.

The presentation explains that once a consumer's contact information is obtained by a TPMO (through online lead forms, mail, or purchased data), that data can then be sold to other TPMOs. Specifically, TPMO B notes that this could include offshore TPMOs which could sell beneficiary's data "dozens of times." The beneficiary's data is then used to contact them by someone who is "probably offshore," likely without a consumer's consent. Once that caller connects with the consumer, the consumer would then be transferred to a U.S.-based agent who "gets paid a commission if he/she enrolls [the] beneficiary in a new plan."

In a scenario like the one laid out by the presentation, the beneficiary is ultimately at risk for being sold a plan that is not the best plan for them, but instead fits the agent's sales goals or which is one of only a few MA plans the agent is appointed to sell. Furthermore, the use of offshore TPMOs limits the effectiveness of oversight by U.S. regulators.

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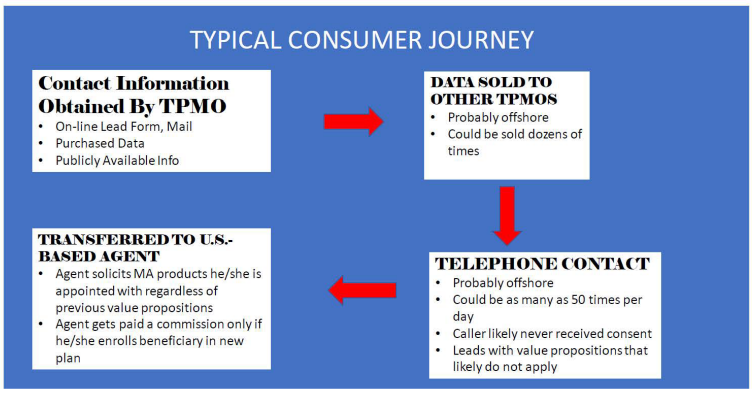
[33] U.S. Senate Finance Committee, Democratic Staff, *Deceptive MarketingPractices Flourish in Medicare Advantage*, Nov. 3, 2022, https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf

[34] David Lazarus, *A telemarketer. An Alzheimer's patient. A health insurance nightmare*, LA Times, May 4, 2021, https://www.latimes.com/business/story/2021-05-04/column-alzheimers-health-insurance.

[35] Exhibit 13 - AAAB Presentation, on file with the Committee.



The presentation later described an example of an actual consumer journey where a beneficiary who, after filling out an online lead form, was transferred between three individuals. Two of these individuals worked offshore, and both requested the same information from the beneficiary. Only the agent, the last person the beneficiary was transferred to, was in the U.S. Ultimately the licensed agent the beneficiary was connected with advised the person to change out of the plan the beneficiary was enrolled in.

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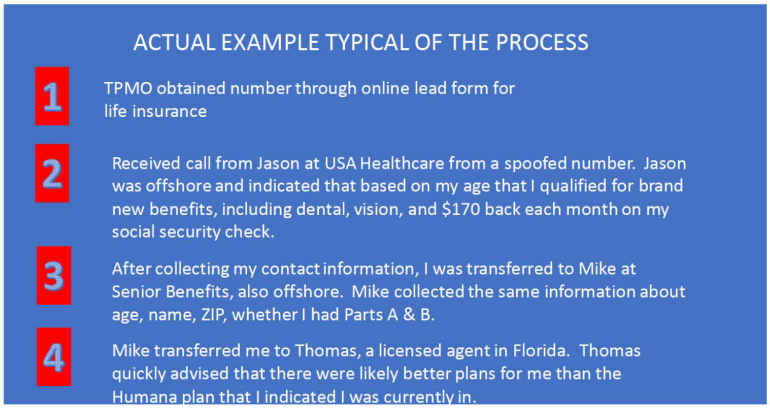

The Democratic staff received multiple additional examples from licensed agents and other experts corroborating the above consumer journey. For example, one insurance broker provided a recording of a series of marketing calls, beginning with receipt of an unsolicited call

from someone with a robotic voice asking about Medicare eligibility that then transferred her call to a person based in Houston, Texas who then transferred her to a licensed insurance agent who could sell Medicare Advantage products in the recipient's geographical area.[36]

IV. Investigative Findings

The Committee's study of third-parties in the MA marketing system found that insurers' drive to enroll more and more beneficiaries is resulting in a complicated and costly stream of enrollment. Insurers surveyed in this investigation enroll the majority of MA beneficiaries in the country. Each insurer marketed its services by contracting with TPMOs who place advertisements and engage beneficiaries on behalf of MA plans. In order for those TPMOs to reach beneficiaries, each collects consumer information from lead generators or other TPMOs, or collects consumer information through their own placed advertisements. Lead generation often relies on dubious marketing practices, most notably repeated unsolicited calls and advertisements that create a sense of urgency. As insurers spend more on third-party marketing services, the TPMOs they engage are spending increasingly more on consumer leads, resulting in increased marketing costs borne by taxpayers; confusing, unwanted contact with consumers; and an opaque stream of enrollment that is difficult for regulators to conduct oversight of and ensure is operating in the best interests of consumers.

A. MA Marketing Ecosystem is Multi-Layered, Opaque and Driven by Multiple Funding Streams

A review of the MA marketing ecosystem, as well as of contracts between insurers and TPMOs provided to the Committee, illustrate the funding streams available to third-parties in the Medicare Advantage marketing system.

a. Commission Payments

Insurance brokers and agents can receive commissions from MA, stand-alone prescription drug plans (PDP), and Medigap plans for submitting enrollment applications for eligible Medicare beneficiaries. MA and PDP commission caps are determined by CMS through an annual notice. Federal regulation stipulates that these payments must be at or below fair market value (FMV); renewal commissions are capped at 50% of the FMV; and payments are limited for referrals. Commissions are also higher in certain geographies, such as New York and California and lower in others (Puerto Rico and the U.S. Virgin Islands). In contrast, Medigap commissions are regulated by states and are typically a percent of the plan premium (e.g., 15% of plan premium).

[36] Committee conversation with broker, Call recordings on-file with the Committee.

Agents and brokers who are appointed with an MA plan can receive a higher commission for new enrollees (those newly eligible for Medicare and those who are switching from an "unlike plan type") and typically half that amount, a "renewal commission," in future years if the individual stays enrolled in that plan.[37]

If an enrollee is switching between similar types of MA plans, agents and brokers are eligible for the renewal commission in the first year of a plan policy. Renewal commissions often continue for the life of a policy so long as the agent remains licensed, but can be limited to a specific number of years. The table below presents the MA and PDP commission caps as finalized by CMS following the District Court stay of the 2025 final rule.

Table 1. CY 2025 FMV updated amounts (previously published in June 28, 2024)[38]

Compensation Type	National	Connecticut, Pennsylvania, District of Columbia	California New Jersey	Puerto Rico, U.S. Virgin Islands
Initial Year	$626	$705	$780	$428
Renewal Year	$313	$353	$390	$214

MA insurers responsive to this investigation reported paying commissions for completed enrollments directly to agents or brokers or to the TPMO representing the agent or broker. These commission rates were often the FMV established by CMS. Some insurers (Insurer E, Insurer A, Insurer D) did pay less for some plans reflecting company policy and geography. Some insurers (Insurer E, Insurer A) also paid less for plans depending on whether the enrollment application was submitted on paper or electronically and the writing agent's position in the TPMO hierarchy. Dependent on plan contracts, some MA plans were commissionable in some states, but not others. Below is an example of a fee schedule for one insurer for plan year 2023:

[37] CMS, Agent Broker Compensation, https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/medicare-marketing-guidelines/agent-broker-compensation.
[38] CMS, Memo: UPDATED: Contract Year 2025 Agent and Broker Compensation Rates, Submissions, and Training and Testing Requirements, July 18, 2024.

Table 2. Commission and Administrative Fees for Selected States and Plan by TPMO Upline, 2023[39]

			PMO	NMO	RMO	MMO	GMO	LMO	Agent 4	Agent 3	Agent 2	Agent 1	LOA 7	LOA 6	LOA 5	LOA 4	LOA 3	LOA 2	LOA 1
California, New Jersey	Lump sum	CMS New Electronic	$1,037	$1,012	$957	$937	$897	$847	$762	$694	$624	$567	$762	$694	$624	$567	$369	$296	$211
		CMS New Paper	$1,012	$987	$937	$912	$887	$847	$762	$694	$624	$567	$762	$694	$624	$567	$369	$296	$211
		Base Rate Electronic	$656	$631	$576	$556	$516	$466	$381	$338	$302	$272	$381	$338	$302	$272	$175	$138	$96
		Base Rate Paper	$631	$606	$556	$531	$506	$466	$381	$338	$302	$272	$381	$338	$302	$272	$175	$138	$96
	PMPM	Renewal	$493	$481	$456	$446	$431	$411	$381	$338	$302	$272	$381	$338	$302	$272	$175	$138	$96
Florida SNP	Lump Sum	CMS New	$976	$951	$901	$876	$851	$811	$611	$568	$509	$450	$611	$568	$509	$450	$273	$200	$127
		Base Rate	$671	$646	$596	$571	$546	$506	$306	$277	$247	$218	$306	$277	$247	$218	$134	$97	$60
	PMPM	Renewal	$671	$646	$596	$571	$546	$506	$306	$277	$247	$218	$306	$277	$247	$218	$134	$97	$60
Florida HMO	Lump Sum	CMS New	$976	$951	$901	$876	$851	$811	$611	$568	$509	$450	$611	$568	$509	$450	$273	$200	$127
		Base Rate	$671	$646	$596	$571	$546	$506	$306	$277	$247	$218	$306	$277	$247	$218	$134	$97	$60
	PMPM	Renewal	$406	$391	$371	$361	$351	$336	$306	$277	$247	$218	$306	$277	$247	$218	$134	$97	$60

[39] Page 221 of Senior Market Sales Upline Agreement, Insurer A Production, on file with the Committee (abstracted).

Below is a second example of a different insurer's commission table showing variation geography for plan year 2023:

Table 3. "Initial Year" Commissions, New Enrollments for CMS Plan Year 2022 [40]

	Agent		GA		MGA		FMO		[Redacted]	
	Min. Amount Payable to Level	Max. Amount Payable Based on Roll-up from Non-existent Lower Levels	Min. Amount Payable to Level	Max. Amount Payable Based on Roll-up from Non-existent Lower Levels	Min. Amount Payable to Level	Max. Amount Payable Based on Roll-up from Non-existent Lower Levels	Min. Amount Payable to Level	Max. Amount Payable Based on Roll-up from Non-existent Lower Levels	Min. Amount Payable to Level	Max. Amount Payable Based on Roll-up from Non-existent Lower Levels
California	$715	$715	$60	$775	$85	$860	$30	$890	$50	$940
New Jersey	$715	$715	$50	$765	$75	$840	$25	$865	$75	$940
Connecticut, Pennsylvania & District of Columbia	$646	$646	$50	$696	$75	$771	$25	$796	$75	$871
All Other States	$573	$573	$50	$623	$75	$698	$25	$723	$75	$798

b. Referral Payments

In addition to commissions, CMS also regulates bonuses, gifts, prizes, awards and finder's or referral fees related to the sale or renewal of a Medicare Advantage plan.[41]

Previously CMS has noted in memoranda to MA plans that referral fees have been one way that MA plans have circumvented compensation caps. In 2009, CMS published a memo noting that "we are finding that these fees exceed the total compensation that could be paid to the writing agent…Organizations must cease this practice immediately as it is not compliant with our regulation and guidance."[42] CMS issued a similar warning in 2011, "CMS has recently become aware that some Medicare Advantage Organizations (MAOs) are offering excessive fees to agents for referrals in the south Florida market that in some cases are as high as the cap on total compensation in that area (the national fair market value amount in Miami-Dade and Broward counties is $402). MAOs appear to be soliciting such referrals on behalf of their employed or captive agents, who then complete the enrollment."[43]

[40] Insurer E-SFC-00000715, page vi, on file with the Committee (abstracted).
[41] Medicare Drug and Health Plan Contract Administration Group, CMS, Memo on Payment of Referral Fees, February 24, 2009, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/payment%20of%20referral%20fees.pdf.
[42] Medicare Drug and Health Plan Contract Administration Group, CMS, Memo on Payment of Referral Fees, February 24, 2009, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/payment%20of%20referral%20fees.pdf.
[43] Medicare Drug and Health Plan Contract Administration Group, CMS, Memo on Excessive Referral Fees for Enrollments, October 19, 2011,

Based on contracts obtained during this investigation, staff found some examples where referral fees were separately itemized as a payable service. Sometimes these fees were a flat dollar amount per sale. Other insurers varied these fees by the TPMO hierarchy. For example, one insurer (Insurer A), which has since ceased paying referral fees, paid referral fees in 2015 based on the TPMO hierarchy as follows[44]:

> If a Compensable Referral for a Medicare Advantage Plan is made by an Agent who has been assigned a hierarchy level of agent level 4, and the hierarchy above such Agent is composed of an LMO and an NMO, the Referral fee payable for such Compensable Referral would be as follows:
>
> - The Agent would receive a Referral fee equal to the "Referral Fee for Medicare Advantage" for Agent 4 ($10);
> - The LMO would receive a Referral fee (i.e., override) equal to the "Referral Fee for Medicare Advantage" for LMO less the "Referral Fee for Medicare Advantage" for Agent 4 ($15 - $10 = $5 (total amount payable to LMO)); and
> - The NMO would receive a Referral fee (i.e., override) equal to the "Referral Fee for Medicare Advantage" for NMO less the "Referral Fee for Medicare Advantage" for LMO ($30 - $15 = $15 (total amount payable to NMO)).

Among contracts where the referral fee was a flat dollar amount, that amount was typically the maximum amount of $100 contemplated under enjoined CMS guidance.[45] Based on contracts provided by one insurer (Insurer A) where referral fees varied by TPMO hierarchy, the total referral fee paid exceeded $100.[46]

Level	Referral Fee for Medicare Advantage Plans
NMO	$200
RMO	$175
GMO	$150
LMO	$125
Agent 4	$100
Agent 3	$80
Agent 2	$70
Agent 1	$60

https://www.cms.gov/medicare/health-plans/healthplansgeninfo/downloads/excessive-referral-fees-for-enrollment-.pdf.

[44] The Insurer stipulates that this example blends administrative and referral fees, which it would consider separate within such a hierarchy.

[45] 42 CFR 422.2274.

[46] Insurer A, Upline agreement, page 35 of 157, on file with the Committee (abstracted).

LOA7	$100
LOA6	$80
LOA5	$70
LOA4	$60
LOA3	$50
LOA2	$40
LOA1	$30

c. Administrative and Post-Enrollment Services

The Committee's review found that insurers pay agents, brokers, and TPMOs for a wide range of activities both pre-enrollment and post-enrollment. Payments were often calculated on a per enrollment basis and could vary by service, bundle of services, or by the type of enrollment. Generally, payments for administrative services included recruiting independent agents, operational overhead (such as access to sales technology platforms to compare MA plans and enroll individuals), helping agents navigate training and certification requirements, providing agents with ongoing marketing and sales support, and providing post-enrollment member service.

Some insurers bundled administrative services together while others provided separate payments for certain services, specifically marketing expenses and completion of a health risk assessment. Based on interviews, the staff understands that some insurers also separately pay for completion of an enrollee portal sign up, enrollee email address, and arranging an appointment with a primary care provider.

Health Risk Assessments. Broker-led health risk assessments, or HRAs, can be used to collect risk adjustment eligible diagnoses to inform payments to MA plans. They are similar, but not the same as, in-home health risk assessments that are conducted by a clinician. While not all insurers surveyed reported collecting broker led HRAs, insurers that did collect them reported using this information to inform other care management activities. For example, one insurer described the utility of HRAs in this way: "HRA data is used to identify and refer members to [COMPANY] programs (including case management), and to help generate a preliminary plan of care, which is made available in the [COMPANY] provider portal for assigned Primary Care Providers to access and review. HRA data is also used to close gaps in care (including social determinants of health) when [COMPANY] staff is engaging with members."[47] Two insurers reviewed during this investigation (Insurer C and Insurer A) spent in the aggregate more than $35 million on broker-led HRAs for plan year 2022.

Insurers provided a range of HRA-specific payment rates to the Committee. For an individual enrolling in a Dual Eligible Special Needs Plan (D-SNP), observed fees ranged from

[47] Insurer E Second response to SFC, page 12, on file with the Committee.

$50 for a completed HRA to $110 for a completed HRA.[48] The Committee also reviewed publicly available information containing information on payments for HRAs. For example, one website advertised that in 2025 Alignment Health Plan would pay "$50 or more for every HRA" while brokers could earn "$150 per completed HRA for D-SNPs in Nevada and Texas.[49] Another plan offered brokers $50 for help completing an HRA in 2025 and noted "It takes less than 10 minutes to complete."[50]

In interviews with Committee staff, agents and brokers noted that these HRAs could be performed by someone other than the selling agent or broker to maximize the selling agent's time during the Annual Enrollment Period. For example, one FMO executive noted to Committee staff that their company maintained a separate team to conduct HRAs following an enrollment.

Other Post-Enrollment Services. TPMOs are paid to perform a wide range of post-enrollment services including arranging physician visits, connecting to third-parties to collect demographic and health information, helping individuals enroll on plan portals, and facilitating in-home health risk assessments. Service fees for these activities were not consistently provided.

One TPMO executive similarly informed Committee staff that some TPMOs contract with certain value-based practices to direct new MA enrollees for an appointment. One physician group complained about this practice noting that it resulted in discontinuities of care as a patient's assigned primary care physician for purposes of value-based payments would change if a physician appointment was scheduled with a different practice. The importance of physician assignment creates pressure on competing value-based care practices to also contract with TPMOs for these services.

In December 2024, the HHS Office of Inspector General issued a Special Fraud Alert raising awareness around two practices that could result in unfair competition and improper steering of Medicare enrollees to a particular MA plan: payments from MA plans to health care providers for marketing their plan; and, payments from health care providers to brokers for referring Medicare enrollees to a particular health provider for a visit.[51]

Administrative Services. Insurers pay TPMOs to provide a range of administrative services. Contracts provided to the Committee reflected "administrative" payments made to

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[48] Insurer A, TPMO A Master Services Agreement. Page 23 of 43. Insurer A, Marketing Services Agreement, page 22 of 22, on file with the Committee.
[49] Alignment Health marketing material, https://saversmarketing.com/wp-content/uploads/2024/10/Alignment-Health_HRA-Incentives-Update-2025.pdf.
[50] Devoted Health Plans marketing material, https://saversmarketing.com/wp-content/uploads/2024/09/2025-Devoted-HRA-FAQ.pdf.
[51] HHS OIG, Special Fraud Alert: Suspect Payments in Marketing Arrangements Related to Medicare Advantage and Providers, Dec. 12, 2024, https://oig.hhs.gov/documents/special-fraud-alerts/10092/Special%20Fraud%20Alert:%20Suspect%20Payments%20in%20Marketing%20Arrangements%20Related%20to%20Medicare%20Advantage%20and%20P.pdf.

TPMOs since at least 2010.[52] Based upon the data provided, insurers paid between $120 to $200 per enrollment for new MA and MAPD enrollments in 2012. Since then fees have largely remained consistent ranging from $100 to $200 in 2022 depending on the range of services provided and type of enrollment. On a per-enrollment basis, one insurer (Insurer D) paid $250 for administrative services in the initial year and $200 per enrollment for renewal years two through eight, but only paid $0-$200 for the initial year only for enrollments that were within Company plan changes.[53] Some insurers paid administrative service fees as a flat fee while others paid fees based upon the upline hierarchy.

Some insurers (Insurer C, Insurer E) also offered additional administrative payments based upon TPMO performance, including for oversight and compliance work. For example, Insurer E offers additional payments ranging from $35-$75 per eligible member or enrollment based on performance along metrics related to complaints, rapid disenrollments, and member engagement.[54] In 2020, Insurer C offered a limited-time enhanced administrative fee program for TPMOs that met a specific volume threshold (500 active members) or met specific sales thresholds (10% growth in MA or MAPD membership).[55] In 2021, Insurer C's enhanced program was replaced with a Complaint Tracking Module (CTM) Administrative Fee program. The revised administrative payments program compensated TPMOs which had at least 500 active MA and MAPD enrollees with a $12.50 CTM administrative fee per sale if the TPMO's book of business CTM rate was below 2.0 per thousand. The program compensated TPMOs with a $25 fee per sale if the CTM rate was below 1.5 per thousand.[56] This CTM Administrative Fee program did not include a sales growth goal. Two insurers (Insurer E, Insurer A) offered their highest administrative payments for services targeting D-SNPs enrollments.[57] One insurer attributed these higher payments to verification of a beneficiary's dual-eligible status in Medicare and Medicaid and the increased complexity of these beneficiaries' health needs.

d. Additional Marketing Spending

While marketing is often defined as an administrative expense, insurer contracts also provided for stand-alone marketing fees. TPMOs were paid for social media advertisements, web-based ads, print advertising, television campaigns, and lead purchasing. Some contracts included specific quantitative targets for lead purchases (e.g., "The campaign shall include the purchase and use of 232,800 leads."[58]). Insurers reported paying FMOs and TPMOs for marketing expenses using a variety of payment models including co-op marketing fees, per campaign, or on a per qualified lead basis.[59]

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[52] Insurer C, TPMO A Insurance original MDA from 2010, on file with the Committee.
[53] See Appendix B.
[54] Second Response to the Committee, Oct. 31, 2023, on file with the Committee.
[55] Insurer C MDA Amendment 61 (10-1-20), on file with the Committee.
[56] Insurer C MDA Amendment 65 (10-1-21), on file with the Committee.
[57] Insurer E-SFC-00000538 and 539, on file with the Committee; Insurer A marketing service agreement with TPMO A, Exhibit A-3, page 14 of 43, TPMO A-DSNP Purchase Model Full File at 3, on file with the Committee.
[58] Insurer C, TPMO C MDA Amend 26 (8-15-18), on file with the Committee.
[59] Insurer C letter to the Chairman, October 6, 2023. Insurer C, Oct 6 letter: These payments are either made in a lump-sum for a particular campaign or on a per enrollment basis that is at or below FMV. "To support this multi-carrier marketing, MarketPoint pays external FMOs and e-brokers administrative payments for their

Consistent with growing pressure to generate new enrollments, insurers created new ways to pay TPMOs for marketing. One insurer (Insurer C) created a mechanism to provide hundreds of dollars in additional payments per sale through a "supplemental marketing expenses administrative fee program."[60] According to the program, "[TPMO] shall use its compliant Medicare Advantage marketing process to drive prospects into its choice platform (i.e., creative, testing, consumer eligibility screening, marketing placement reviews, brand use, HPMS filing, marketing analytics, lead acquisition expertise, and robust marketing QA and marketing compliance reviews). The marketing activities may include television, online, offline, digital, and/or print marketing."[61]

e. <u>Other Factors Influencing Agents and Brokers</u>

Industry executives reported observing that insurers can threaten TPMOs to terminate contracts below particular enrollment thresholds or sell certain MA plans. The executives noted that these threats can influence what plans an agent or broker presents to a consumer.

This investigation also uncovered that some insurers included explicit production requirements in their contracts, summarized in the following examples:

Example 1:
Production Requirement. Parties mutually agree to implement production requirements under this Agreement and Field Marketing Organization will be required to submit a minimum of 1000 qualifying [Insurer B] Medicare Advantage, Medicare Part D or Medicare Advantage Part D plans that are approved, accepted, and remain in fore [sic] for a minimum of ninety (90) days, per contract year, and every contract year thereafter.[62]

Example 2.
In addition to performance requirements which the Company may establish from time to time under Section 2.2[n], [Party] shall meet any and all standards related to and established from time to time by the Company for [Party] which may include but are not limited to (i) production and (ii) the number of Agents working under [Party] who are appointed and actively producing sales for Company's Products (hereinafter, "Active Agents").[63]

Example 3.
"During any twelve (12) month period of time, [TPMO] Agents appointed by Insurer C shall maintain compliance with at least one of the objectives below as either a writing agent or Agent

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operational overhead and administrative costs (as contemplated in 42 CFR 422.2247(e)) associated with marketing campaigns and services that drive awareness of MA benefits across multiple MAOs' plan offerings. These payments are either made in a lump-sum for a particular campaign or on a per enrollment basis that is at or below FMV." (page 4), on file with the Committee.
[60] Insurer C, TPMO C MDA Amendment 58 1-1-2023, on file with the Committee.
[61] Insurer C, TPMO C MDA Amendment 58 1-1-2023, on file with the Committee.
[62] Insurer B Production. Contract with TPMO Page 25 of 73, on file with the Committee.
[63] Insurer E-SFC-00000625 p. 5, on file with the Committee.

of Record (as identified on the applicable application for coverage or enrollment form): Sell three (3) or more Medicare plans from any of the following: Medicare Advantage, Medicare Advantage with Prescription Drug, Prescription Drug, or Insurer C Medicare Supplement Plans in total in any combination; or" "Sell two (2) or more new Group plans" or "Sell one (1) or more new Individual plans" or meet similar sales goals for in force or individual major medical policies referral program.[64]

Regarding these contractual requirements in example two, the insurer noted in a letter to the then-Committee Chairman: "While some contracts from 2018 and 2019 contained language setting forth such benchmarks (typically calling for enrollment of at least 1,500 new members each calendar year), administration of those requirements was at the Company's discretion and was not enforced. [Company] eliminated this language from all contracts in 2020."[65]

In addition to explicit production requirements, a TPMO's place in an upline hierarchy can be determined by the number of writing agents or production targets. As discussed above, administrative commissions can be higher for TPMOs higher up in the hierarchy. One insurer reported that their lowest benchmark to an FMO started at 250 enrollments and the highest was greater than 20,000.[66]

f. Other Non-Contract Mechanisms

Enrollment Software. TPMOs often offer contracted agents software to search plan options and enroll clients into MA plans. These services are explicitly included in contracts defining the suite of administrative services TPMOs are expected to offer.

These provisions give TPMOs the opportunity to control which plans were selected by their agents. Industry experts informed Committee staff that insurers sought to reduce enrollment in some MA plans by forcing technology platforms to "suppress" MA plans on their enrollment platforms, effectively discouraging enrollment.[67] Industry experts also reported that not all TPMOs limit plan searches to those that pay commissions; however, for those MA plans that do not pay commission, the broker may have to support paper enrollment, a hurdle that can limit enrollment.

Registering with Multiple Insurance Carriers is Time Consuming. In written responses to the Committee, TPMOs noted that they were contracted with dozens of insurance carriers. But their contracted or employed brokers typically represented a subset of those contracts. One former TPMO executive noted that registering with multiple carriers was a time intensive process. For example, in addition to CMS regulatory requirements that agents and brokers undergo annual training provided by the Association for Health Insurance Plans and pass CMS testing, each carrier also maintains its own annual web-based training that can last several hours and include registration fees. As a result, many brokers reported gravitating to national

[64] Insurer C, MDA Amend 12 (5-1-15), on file with the Committee.
[65] Insurer E Oct 31, 2023 letter to Ranking Member Wyden, page 4, on file with the Committee.
[66] Oct 6, Letter from Insurer B to the Committee, page 5, on file with the Committee.
[67] Conversation with Chapter; https://youtube.com/watch?v=fFGMpGKKQ3A at 35:00.

carriers that are likely present in multiple counties. In discussions with Committee staff, the former TPMO executive recommended the creation of a universal registration process to enable brokers to represent a broader set of MA plans.

Offshore Call Centers. Several industry experts reported to Committee staff that offshore call centers were bad actors employing prohibited tactics including cold calling and deceptive marketing. Insurer contracts with TPMOs did not regularly address offshore call centers. Some contracts required TPMOs that used offshore call centers to notify the insurer.

B. MA Plans increasingly rely on middlemen for marketing.

MA plans regularly contract with TPMOs to enroll Medicare enrollees into MA plans. In 2019, four of the five MA plans surveyed by the Committee reported paying TPMO agent/broker commissions for enrollments. In 2022, all five large MA plans surveyed used TPMO agents and brokers. These contracted TPMOs rely on a ballooning sector of lead generators to source insurance leads, which TPMOs may further refine and sell themselves.

Lead generation, a term meant to encompass a wide range of activities employed by downstream entities to access and aggregate consumer data for the purposes of marketing, is increasingly relied upon by marketing entities to target their efforts and contact consumers directly. For this reason, the volume of leads purchased from lead generators, lead aggregators, and data brokers is increasing. TPMOs are spending more on leads than they were previously, increasing the cost of their marketing services for MA plans.

a. MA Plans are contracting with TPMOs to market their product.

As discussed above, health plans and brokers are increasingly marketing MA plans to beneficiaries through TPMOs.[68] In general, the overall U.S. marketing industry has reached record-breaking revenues in recent years, reaching a record-high of $225 billion in 2023, a 7.5% year-over-year increase from the prior year. [69]

The Medicare marketing space is a particularly profitable and growing field. For example, in their 2021 10-K filing, a large TPMO projected that the "current commissionable market" for the Medicare space to be $30 billion, noting the "nearly 11,000 Americans turning 65 years old every day."[70] This trend is expected to continue into 2030, with the number of MA beneficiaries exceeding 80 million.[71]

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[68] Jeannie Fuglesten Biniek, Alex Cottrill, Nolan Sroczynski, Meredith Freed, Tricia Neuman, Breeze Floyd, Laura Baum, and Erika Franklin Fowler, *How Health Insurers and Brokers Are Marketing Medicare*, Sep. 20, 2023, https://www.kff.org/medicare/report/how-health-insurers-and-brokers-are-marketing-medicare/.

[69] Interactive Advertizing Bureau, *2023 U.S. Digital Advertising Industry Hits New Record, According to IAB's Annual Internet Advertising Revenue Report*, Apr. 16, 2024, https://www.iab.com/news/2023-u-s-digital-advertising-industry-hits-new-record-according-to-iabs-annual-internet-advertising-revenue-report/

[70] GoHealth 2021 10-K.

[71] Report to the Congress: Medicare and the Health Care Delivery System, Chapter 2: The Next Generation of Medicare Beneficiaries at 35, MedPac, Jun. 2015,

Because Medicare enrollment presents complicated options for consumers, marketing intervention greatly affects a consumer's choice of health plan. A survey of Medicare beneficiaries conducted by the Kaiser Family Foundation (KFF) showed that many Medicare beneficiaries felt that the landscape of choosing a Medicare plan is so complex and confusing that they relied on a broker to steer them toward the best plan to fit their needs.[72]

While MA plans engage marketing organizations, Traditional Medicare is not meaningfully marketed.[73] MA Plans studied in this investigation paid a significant amount of money on broker fees and commissions, showing a drastic increase in recent years. Across MA Plans, spending on agent and broker fees and commissions reached $3.114 million in 2022, a nearly 25% increase since 2018.[74]

b. <u>TPMOs invested more in leads between 2018 and 2022.</u>

As TPMOs become increasingly integral to the marketing of Medicare plans, they are increasingly relying on the use of lead generation to support enrollment in MA plans. The FTC has explained in educational materials that *lead generation* is, "marketing activity that generates consumer interest in a company's product or service." The FTC further defines a lead "as a person that has expressed interest in a company's product or service [such as] Data form submission, Call [and] Click-to-call."[75] At this time, neither CMS, the FTC, nor any other government agency defines "lead generation" or "lead" in regulation.[76]

<u>i. Expenditures on leads are increasing.</u>

Lead purchasing is an integral part of TPMO operations, and TPMOs expect that it takes 8 unique qualified leads to result in an MA plan enrollment.[77] As part of the Committee's investigation, TPMOs were asked how many individual leads they purchased from another TPMO or lead generator in 2018 and 2022. As discussed above, each TPMO varied in how they defined what constituted a "lead." Overall, the Committee found that each company had increased the total volume of leads purchased between 2018 and 2022. However, the degree to which each company increased their volume of purchased leads varied drastically. For example, TPMO D increased its lead volume from 2018 to 2022 by 706%. Although less drastic of a

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https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-.pdf.

[72] KFF, *What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?*, Sep. 30, 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/.

[73] The Commonwealth Fund, *The Role of Marketing in Medicare Beneficiaries' Coverage Choices*, Jan. 5, 2023, https://www.commonwealthfund.org/publications/explainer/2023/jan/role-marketing-medicare-beneficiaries-coverage-choices.

[74] Email from NAIC to Senate Finance Committee, Oct. 12, 2023, on file with the Committee.

[75] FTC, Follow the Lead: An FTC Workshop on Lead Generation at 4, https://www.ftc.gov/system/files/documents/public_events/684511/leadgeneration-presentationslides_0.pdf.

[76] No definitions found in the eCFR.

[77] See Insurer A TPMO A Marketing Services Agreement, page 11 and 19 of 43, on file with the Committee.

percentage increase, TPMO C reported the highest volume of purchased leads in 2022, with an increase from 2018 to 2022 of 269%.

Table 4. TPMO company number of leads purchased, 2018 and 2022.

TPMO	TPMO C[78]	TPMO B[79]	TPMO D[80]	TPMO A[81]
Years Purchased	**2018-2022**	**2020-2022[82]**	**2018-2022**	**2018-2022**
Percent Increase	**269%**	**51%**	**706%**	**N/a**

C. <u>Insurers' increasing use of middlemen to market their MA plans is costing taxpayers.</u>

The National Association of Insurance Commissioners (NAIC) annually collects carrier MLR data from carriers in the MA and other markets to facilitate the public report required under 45 CFR §158.403.[83] These reports include data from all MA plans required to fill out an annual financial report with the NAIC.[84] Based on insurer reported information, spending on "agents and brokers fees and commissions" increased $2.4 billion to $6.9 billion from 2018 to 2023 – a 19% compound average growth rate (CAGR). Over the same time period spending on "direct sales salaries and benefits" increased from $1.5 billion to $2.2 billion, a 7% CAGR. Meanwhile, enrollment in MA increased by 10.8 million individuals from 21.3 million to 32.2 million, a 7% average annual increase.[85]

Committee staff note several limitations with the NAIC data. Not all MA plans report to NAIC, data from California is limited, and those MA plans that do report may not include spending on marketing and administrative costs under "agent and broker fees and commissions," causing the data to potentially underestimate the total market spending.

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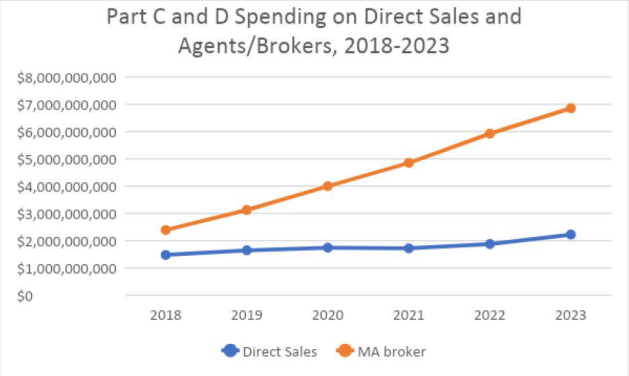
[78] RE SFC follow-up TPMO C (lead prices), on file with the Committee.
[79] Ex. 23 - TPMO Cost Breakout by Period, on file with the Committee.
[80] 1.31.2024 TPMO D response to Chairman Wyden (pg. 9), on file with the Committee.
[81] Letter_to_The_Honorable_Ron_Wyden_-_October_3_2024, "TPMO A is not able to retrieve such data for time periods before 2021 because TPMO A switched systems for managing such calls during 2021, and the staff who set up and maintained the previous system no longer work at TPMO A." (pg.2), on file with the Committee.
[82] TPMO reported data from 2020-2022.
[83] MLR Examination Reporting Instructions, Mar. 2016, https://content.naic.org/sites/default/files/inline-files/committees_e_examover_related_mlr_procedures_temp.pdf.
[84] The NAIC notes these data only include insurers that are required to file to the NAIC. These data are not supplemented with health premium information from health insurers that are exempt from filing to the NAIC. Some insurers regulated by the California Department of Managed Health Care do not also report to NAIC.The accuracy of the reports included in this publication depends on the accuracy of the information contained in the Supplemental Health Care Exhibits filed by insurers. Even though the data elements used to prepare the reports are extracted from exhibits filed with the NAIC, the NAIC cannot verify or guarantee the accuracy of every data element. (Abstracted from September 5, 2023 email between NAIC and staff).
[85] Medicare Trustees Report, Table V.B3.—Medicare Enrollment, 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2024. Available at: https://www.cms.gov/oact/tr/2024.

Increased spending by MA plans increases costs to taxpayers, including through higher Medicare Part B premiums. The government must cover increased program costs through an increased premium, which is paid by Traditional Medicare and MA enrollees alike. Overall, the cost of Medicare Advantage continues to increase relative to the cost of Traditional Medicare.[86] This report demonstrates how marketing costs in MA are increasing in particular.



D. <u>Oversight and regulation are more difficult to enforce as middlemen proliferate.</u>

Oversight of MA marketing practices is essential to maintaining consumer privacy and wellbeing. As vulnerable populations, such as older adults and people with disabilities, become the target of an enrollment competition among MA plans, they may receive repeated and confusing calls and may be encouraged to enroll in MA plans that do not meet their needs. Though CMS and other federal agencies issue regulation to curb deceptive Medicare Advantage marketing practices, their enforcement authority often does not extend to third parties, leaving MA plans and third-party contractors largely responsible for consumer protection oversight.

a. <u>By contract, insurers and TPMOs often do not assume any affirmative obligation to audit for compliance.</u>

MA Plans often outsource consumer protection oversight obligations to TPMOs, who in turn outsource oversight to the lead generators from whom they source consumer information. At each tier of the process, entities require that their contractors maintain proof of valid consumer

[86] Jeannie Fuglesten Biniek, Juliette Cubanski, and Tricia Neuman, *Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges*, KFF, Aug. 17, 2021, https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/.

interaction and authorize contracting parties to audit, but do not always by contract assume a clear obligation to audit such information without a triggering incident or to conduct routine oversight.

Consumer enrollment decisions are directly affected by interaction with third-parties. Oversight of the marketing tactics used to encourage enrollment in a particular plan are defined by contracts between insurers and TPMOs, and between TPMOs and their marketing affiliates. These contracts allow for interactions at each stage of the stream of enrollment before consumers are passed along to the next entity, eventually reaching a licensed insurance agent who will attempt to enroll them in a plan. The requisite call-time under these contracts at each stage of lead-generation and procurement varies.[87]

Contracted TPMOs engage in marketing activities to drive engagement with contracted MA plans and to speak with consumers about health plan options. TPMOs contract with insurers to place advertisements for health plans and to interact with consumers in enrollment activities in conformity with the plan's specifications. Based on contracts reviewed by the Committee, some MA Plans also assign oversight of TPMO activities to the TPMO itself, reserving the right, but bearing no clear obligation, to audit the TPMO's activities regularly.

For example, by the terms of Insurer E's 2023 contracts with TPMO B and TPMO A, TPMOs are required to comply with consumer protection law and regulation, including state and federal marketing guidelines. TPMOs are required by the contract to maintain "records and accounts" of consumer transactions governed by the contract and to allow Insurer E, within business hours and with seven days notice, to inspect such records. Insurer E also retains the right by terms of this contract to audit TPMOs in the event of a consumer complaint or legal infraction, which TPMOs are required to report to the insurer. However, these contracts do not lay out terms under which Insurer E shall proactively audit a TPMO or its partners. Under the terms of the contract, TPMOs themselves are required to ensure that entities with which they contract "strictly comply with the Company's policies and procedure and all applicable federal and state laws, rules and regulations…relating to promoting the Products to Members."[88] The insurer asserts that these company policies require additional oversight of their contracted TPMOs, including some proactive audits beyond the scope of contract terms.

Downstream of the plan, these TPMOs engage in oversight of their own contracted lead generators under divergent terms. In a contract with one of its lead generators, TPMO B requires its contractors to comply with relevant law and to ensure that its practices and the leads it supplies are in conformity with legal and regulatory requirements.[89] TPMO B requires new partners to participate in a "discovery call" to understand the partner's marketing practices. The company will then initiate the "intake process," which includes disclosure of partner business information, disclosure of partner's third-party relationships, and disclosure of marketing

[87] TPMO A and TPMO B require 90 seconds of "talk time" for a call transfer to be a valid lead, TPMO C includes a talk time requirement but the specifics are included in IOs that were not produced. For TPMO A: SFC-00000045; for TPMO B: SFC_0089, on file with the Committee.
[88] Insurer E-SFC-00000186, on file with the Committee.
[89] Ex. 01 - 2019.02.26 - Agreement, on file with the Committee.

materials used by the partner.[90] After intake, TPMO B attests that it engages in continued monitoring of its marketing affiliates' activities, including by a quality assurance team that conducts "an initial small sample audit followed by the execution of the formal audit process."[91]

Furthermore, according to the contract, the marketing affiliate is further required to report to TPMO B, on a monthly basis, whether the marketing affiliate "was alerted to any compliance issues in the generation of Leads, including but not limited to, any staff or vendor compliance issues, any violations or suspected violations of Medicare laws/rules and/or violations or suspected violations of telemarketing laws[.]"[92]

The Committee asked TPMO B for the dates of all audits conducted by the company of its lead generators in calendar year 2024. TPMO B reported "continuously" auditing its lead generators. It cited its "onboarding" process, during which time a lead generator must "complete an onboarding form" describing its lead generation process. TPMO B further attested that it "conducts secret shopping" of partners' activity, engages third-parties to monitor whether partners' websites are consistent with their representations during the onboarding process, "uses data" to monitor compliance, and conducts audits when a complaint is filed by a consumer or carrier.[93] TPMO B attests that it "continuously" audits lead generators, but did not identify the dates on which it conducted this activity during calendar year 2024.

TPMO A, on the other hand, requires by contract that its partners comply with state and federal law and regulation regulating Medicare marketing activities. However, this contract does not require TPMO A to proactively audit for compliance or ensure that its partners are complying with the law. Instead, TPMO A requires by contract that its lead generators comply with regulation when transferring calls to the TPMO, asserting that any call transferred without required consent is "not authorized."[94] Lead generators are required to keep "accurate books and records" of their fees to TPMO A, which by this contract, TPMO A reserves the right to audit "from time to time (*but no more than once in any twelve (12) month period)*." (emphasis added)[95] The Committee requested information regarding the regularity of TPMO A's audits of partners for compliance and the dates of such audits for calendar year 2024. TPMO A shared that it last conducted an annual audit on "a set of existing referral partners" in July of 2024 and investigates partner compliance when an issue arises.[96]

The divergent practices of two TPMOs who contract with the same plan illustrate the broad spectrum of consumer protection practices in the space as well as challenges to regulators in curbing harmful marketing practices. Though some TPMOs assume an affirmative obligation to handle consumer information carefully and to ensure entities downstream from them are in compliance, others do not. Because of the complexity of lead generation downstream of the TPMO, merely contracting for legal and regulatory compliance without routine oversight leaves

[90] Ex. 17 - SFC Partner Compliance Procedures, on file with the Committee.
[91] Ex. 18 - Practices Relating to Lead Development and Purchasing, on file with the Committee.
[92] Ex. 22 - Marketing Affiliate Agreement, on file with the Committee.
[93] Email from TPMO B to the Committee, Dec. 23, 2024, on file with the Committee.
[94] Letter from TPMO A to the Committee, Apr. 25, 2024, on file with the Committee.
[95] TPMO A, SFC-00000027 at 31, on file with the Committee.
[96] Letter from TPMO A to the Committee, Dec. 20, 2024, on file with the Committee.

TPMOs and MA Plans open to partnerships driven by harmful lead generation tactics. Most insurers and TPMOs by contract reserve the right to terminate relationships that are in breach of contract and in violation of law and regulation, and a number of carriers did report terminating relationships with TPMOs who were found in violation.

b. <u>Lead generators supplying TPMOs with consumer information are often buying leads from other lead generators and data aggregators, further complicating oversight.</u>

Although TPMOs impose contractual requirements on lead generators and marketing affiliates with whom they have entered into direct contractual agreements, these contracts often have difficulty touching parties from whom the lead generator is sourcing consumer data.

The complexity of the lead generation ecosystem feeding into TPMOs and their directly-contracted lead generators potentially allows for bad actors to flourish without effective oversight. This is in part because consumer data may be obtained and synthesized by entities multiple steps downstream from the lead generator with whom a TPMO contracts. As described in prior sections, the consumer may pass through multiple lead generators before reaching the TPMO, sometimes beginning with an offshore lead generator or data aggregator.

To that end, the Committee asked TPMOs whether they engage lead generators who source data from offshore call centers and, if not, how they screen for offshore involvement. Their answers revealed the weaknesses of TPMO oversight in this space, often citing retroactive consequences for offshore sourcing instead of proactive screening. In the case that TPMOs explicitly prohibited their lead generators from sourcing from third-parties, their responses were silent as to how this prohibition is actually monitored and enforced.

TPMO B responded that it "does not permit the use of offshore marketing." TPMO B explained that it will hold partners in breach of contract if it discovers they have sourced from offshore entities and will add such entities to its "do not use list." TPMO B described that it monitors lead generators in response to complaints and "continuously monitors" partners' activities using "secret shopping" and third-parties who look at partners' websites to check for conformity with contract specifications. Additionally, the company lays out compliance requirements in contract with lead generators and through onboarding.[97]

TPMO D defines a "lead" as an inbound call made in response to approved advertisements placed by lead generation partners.[98] These advertising materials are reviewed periodically for compliance with TPMO D and CMS requirements.[99]As part of its initial response to the Committee, the company explained that "[a]ny party that generates inbound calls that may be routed to TPMO D must agree to TPMO D's compliance requirements and, as part of TPMO D's third-party management policy, must be assessed to confirm its ability to perform the services in compliance with all applicable requirements. They remain subject to ongoing oversight by TPMO D, including periodic audits." Under the terms of its lead generation

[97] Letter from TPMO B to the Committee, Feb. 13, 2024.
[98] 1.31.2024 TPMO D response to Chairman Wyden, on file with the Committee.
[99] 1.31.2024 TPMO D response to Chairman Wyden, on file with the Committee.

contracts, TPMO D enters into agreements with "lead vendor[s]" who it compensates on the basis of "cost per valid lead."[100] These contracted vendors are prohibited from transferring calls from a third party, unless TPMO D consents to the sale.[101] TPMO D responded that it screens for offshore involvement during audit periods by requiring third-party contractors to identify each advertisement used to source a percentage of inbound calls, which it reviews to confirm were approved advertisements.[102] TPMO D also responded that it checks for offshore involvement by screening the caller IDs of inbound calls.[103]

TPMO C responded that its onboarding process "require[s] lead generators to be located in the United States." It further stipulated that its partners who "augment their staff through offshore call centers to conduct outreach on U.S. sourced leads must disclose the relationship, meet all U.S. disclosure and oversight requirements, and are included in…reporting to carriers."[104] However, this response did not address the Committee's questions as to how TPMO C screens its contracted lead generators for use of offshore call centers to source lead information, rather than partners' use of offshore call centers to "augment their staff." Further, it is unclear if the company's requirement that its lead generators be located in the U.S. would extend to the lead generators and data aggregators supplying its lead generators.

TPMO A responded that it "does not source call transfers generated by offshore call centers." It further attested that "this issue is one of the first questions that we ask potential partners; and if they do not give a clear answer that they will not send us calls from offshore call centers, then we do not proceed with further discussions with them." TPMO A stipulated that part of its partner onboarding process involves reviewing a sample of calls from the partner for compliance with this and other terms.[105] However, it is unclear how the company consistently confirms the attestations of its partners on an ongoing basis or how it ensures that calls from offshore call centers are not transferred to its agents.

c. <u>A wide variation in industry standards and definitions frustrates effective oversight.</u>

The FTC has noted that the, "Lack of transparency in the lead generation ecosystem and an active regulatory environment make marketing compliance complicated, labor intensive and expensive."[106] In contracts produced by TPMOs during this investigation, insurers sought to define and regulate the use of lead generation by lead generators with whom they contracted for marketing services. Each TPMO surveyed in this investigation defines "lead" slightly differently, establishing different requirements under contract with lead generators for a lead to be considered "valid" and thus purchasable. The validity of a lead generally was defined by its completeness and the attested affirmative consent of the consumer to collection of their data.

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[100] *See, e.g.*, 1.1 Advertising and Lead Generation Agreement, on file with the Committee.
[101] *Id.* at 4.
[102] TPMO D email to the Committee, Mar. 24, 2025, on file with the Committee.
[103] TPMO D email to the Committee, Mar. 24, 2025, on file with the Committee.
[104] Email from TPMO C to the Committee, Jan.10, 2025, on file with the Committee.
[105] *Id.*
[106] FTC, Follow the Lead: An FTC Workshop on Lead Generation at 22, https://www.ftc.gov/system/files/documents/public_events/684511/leadgeneration-presentationslides_0.pdf.

To better understand industry practices, the Committee analyzed contracts between the 4 largest (as measured by dollar value per year) TPMOs and lead generators or other TPMOs for each year between 2018 and 2022 for the procurement of valid leads. The Committee also requested insertion orders and secondary documents to the contracts where internally referenced, but only received these documents in the case of one TPMO. Overall, the Committee found that TPMOs defined valid leads in a variety of ways, potentially presenting a difficult landscape for lawmakers to regulate uniformly.

All contracts had provisions regarding TPMOs' definitions of valid, and therefore purchasable, leads and marketing practices allowed by the TPMO. All four TPMOs and their lead generators agree that a lead is a prospective customer who has expressed interest in a healthcare plan or product.[107] "Interest" is not defined in contract and it is unclear how it is gauged prior to call transfer.

All four TPMOs accept referrals, "leads," by phone.[108] TPMOs have established a set number of seconds that a lead must spend on the phone with the lead generator point-of-contact in order to qualify as a valid lead.[109] Three of the four TPMOs utilize online advertising services run by the lead generators which in turn sell "click" leads back to the TPMO.[110]

TPMOs also differ in their demographic parameters for valid leads. For example, two of the TPMOs examined define a lead as a customer who is 64 ½ or older, while TPMO B stipulates only that leads must be over 19.[111]

Among the TPMOs analyzed, all have terms that reject what they call "duplicate" leads, meaning the lead generator sending the TPMO the same lead they had already referred to them. However, three of the TPMOs accept duplicates after either 30 or 90 days.[112]

V. Conclusion

Medicare beneficiaries earned their benefits by paying into the program out of every paycheck. They rightly expect a guarantee of affordable, quality health care. Congress expanded the Medicare program to include private insurance companies that can contract with CMS to offer equivalent and additional coverage to beneficiaries. Currently more than half of all

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[107] TPMO A_Partner Referral Agreement_(...)SFC-00000027-52 (at 28) [hereinafter TPMO A Lead Contract]; TPMO B_Affiliate Marketing Agreement_(...)-SFC-0087-98 (at 87-88) [hereinafter TPMO B Lead Contract]; TPMO C_1BSOW_at 6 (internal pagination) [hereinafter TPMO C Statement of Work]; TPMO D_001 Insertion Order_1 [hereinafter TPMO D Insertion Order], on file with the Committee.

[108] TPMO A Lead Contract at 00000029; TPMO B Lead Contract at 0088; TPMO C Statement of Work at 6; TPMO D_Advertising and Lead Generation Agreeement_1 (internal pagination) [hereinafter TPMO D Lead Contract]; *see also* TPMO D Insertion Order, on file with the Committee.

[109] TPMO A Lead Contract at 00000045 (90 seconds); TPMO B Lead Contract at 0089 (90 seconds); TPMO C Statement of Work at 6 (time specified in IO, did not receive IO), on file with the Committee.

[110] TPMO A Lead Contract at 00000029; TPMO B Lead Contract at 0088; TPMO C Statement of Work at 6, on file with the Committee.

[111] TPMO A Lead Contract at 00000071; TPMO D Insertion Order; TPMO B Lead Contract at 0088, on file with the Committee.

[112] TPMO A Lead Contract at 00000045 (indefinitely); TPMO B Lead Contract at 0088 (30 days); TPMO C Statement of Work at 1 (90 days); TPMO D Insertion Order (30 days), on file with the Committee.

Medicare beneficiaries are enrolled in a MA plan. Unlike Traditional Medicare, Medicare Advantage plans rely on complex marketing activities to drive enrollment and profits, with questionable benefits for seniors and people with disabilities. Consumers are vulnerable to marketing tactics by a ballooning stream of third-party marketing organizations, lead generators, and data brokers fueled by federal tax dollars that fund MA plans. While insurers are engaging more middlemen, including marketers and lead generators, and paying increasingly more for marketing activities, this complex web becomes harder to untangle for lawmakers, watchdogs and regulators. Meanwhile, costs to seniors and taxpayers increase.

Medicare enrollees face a confusing and overly complex landscape of health plan options. While Traditional Medicare does not meaningfully market its services, MA plans flood the zone with mailers, online advertisements, and phone calls. These marketing services are conducted by a vast array of plan marketing affiliates, all for the purpose of directing eligible beneficiaries toward a private plan. They are sometimes deceptive and sometimes unclear. By the time a beneficiary speaks with an insurance agent, they may have been steered on the basis of minimal information about their health needs and are dramatically more likely to make an enrollment decision on the basis of their conversation with a broker. A resulting plan enrollment may not meet their health needs, may constrain choice of health care provider, and might impose the added burden of prior authorization and referral requirements.

VI. Recommendations

The findings of this investigation suggest that insurer spending on and engagement of marketing affiliates– TPMOs and lead generators– harms consumers in three distinct ways. First, harm to consumers arises out of a secretive maze of marketing and enrollment incentives that subject seniors to persistent phone calls and other interactions that leave them confused. This maze is increasingly difficult for CMS to oversee and regulate through contracts with MA Plans. Second, consumers and taxpayers are harmed by MA Plans' exorbitant spending on marketing, which contributes to increased Medicare spending overall and higher Medicare Part B premiums. . Last, consumers are harmed by marketing affiliates who are incentivized to steer consumers toward certain insurers through agreements with those insurers, which may result in a senior enrolling in a plan that doesn't work well for them.

These findings point to a need for commonsense legislative and regulatory changes to protect consumers and taxpayers. The Centers for Medicare & Medicaid Services' (CMS') 2025 Medicare Advantage Final Rule sought to address this problem. However, this rule did not fully address the range of issues identified by this report and several provisions were enjoined following a suit in the 5th Circuit, maintaining a largely deregulated, complex, and confusing enrollment maze for consumers to navigate.

To address this gap, the report makes the following recommendations:

1. Ban out-of-whack marketing and other service fees that influence agents and brokers to recommend certain MA plans and drive up taxpayer costs. Congress

should instruct CMS to ban MA plans from paying more to TPMOs or other related entities for any enrollment-related administrative or service for dually eligible beneficiaries or other enrollees. This investigation found substantial disparities in administrative service fees from $0 to over $1,000. These administrative service fees may influence what insurer a TPMO contracts with as well as what MA plans are presented to customers. Customers deserve a level playing field and payments from MA plans should align with that goal.

2. Prohibit MA plan payments for any technology that limits or hides what MA plans an agent or broker sees when supporting an enrollee. Current technology solutions paid for by MA plans for agents and brokers can be manipulated by the technology platforms to suppress some MA plans – essentially to discourage agents and brokers from presenting these MA plans. CMS should prohibit MA plans from including suppression lists in their contracts with technology platforms and prohibit MA plans from supporting TPMO administrative services that limit what MA plans a broker may see.

3. Regulate marketing organizations and lead generators. The complex, opaque web of TPMO enrollment and marketing has created opportunities for some bad actors to take advantage of vulnerable seniors. Congress must give CMS the authority to directly regulate marketing organizations and lead generators, and the full amount that is expended on marketing across entities, to ensure that these companies are not using deceptive or high-pressure sales tactics, and MA plans should only be allowed to contract with marketing and lead generation companies approved by CMS. CMS should consider banning offshore call centers because of the potential for abuse. CMS should partner closely with the states around enrollment-based activities for which agents and brokers are licensed.

4. CMS should implement and enforce policies designed to hold brokers, lead generators, and markets, and insurers accountable. Any individual or company involved in the chain of enrollment who systematically violates or ignores CMS requirements should face appropriate penalties including meaningful financial penalties, loss of renewal commissions, loss of licensure, and jail time if appropriate. Congress should update the penalties under 1857(g) to increase the penalties to be commensurate with appropriate levels.

5. A fixed fee should be established for all MA plan enrollments. This fee should be indexed to inflation, not Medicare program enrollment growth and determined through a CMS-led study to examine the fair market value for MA plan commissions and related administration and service fees. This fee should be provided for all MA plans enrollments to compensate agents and brokers *for their time.* Administrative fees should similarly be determined by CMS to ensure that agents, brokers, and the administrative apparatus that supports them is free from financial influence when presenting plan options to consumers. Based upon the Committee's report, administrative fees are generally

between $150-$200, but could be less if required to be paid for all available MA plans. MA plans should be prohibited from providing or creating additional service fees to TPMOs or other marketing firms to end-run around the fixed fee requirements..

6. Agents and brokers should be required to act as a fiduciary for MA enrollees. Agents and brokers can serve as trusted advisors to millions of Medicare beneficiaries helping guide seniors and people with disabilities to compare types of Medicare coverage, including Traditional Medicare and available MA plans. Requiring agents and brokers to have a fiduciary responsibility means that they have to put the consumer's needs first even though the agent and broker is paid a commission by the insurer. In supporting Medicare enrollees in choosing their coverage, agents and brokers help consumers weigh costs for premiums relative to plan network size; coverage restrictions, like prior authorization and other limits; deductibles, cost-sharing, and maximum out of pocket thresholds. These decisions can have substantial financial implications and influence which providers a person sees. Given these considerations, there should be no question that an agent or broker is acting in the consumer's best interest, not an insurance company.

7. CMS should standardize the language and definitions used to describe the chain of enrollment. There are currently no uniform definitions of key parties and stages in the stream of enrollment offered by CMS. Most notably, CMS does not define "TPMO" or "lead generator." This allows certain parties to operate in a regulatory grey zone, complicating and undermining oversight efforts. In order to better regulate the activities of MA Plans, FMOs and TPMOs, and lead generators, CMS should adopt uniform definitions of these terms in regulation.

8. Support unbiased sources of information for beneficiaries, including State Health Insurance Assistance Programs (SHIPs)s, Senior Medicare Patrol (SMP), 1-800-MEDICARE and ombudsman programs. Departments of Insurance, SHIPs, the SMP, 1-800-MEDICARE, and other CMS communications and ombudsman programs are trusted sources of information for many seniors, people with disabilities, and family caregivers. Congress should provide sufficient, sustained resources to meet the needs of the nearly 60 million seniors and people living with disabilities who could benefit from access to these unbiased sources. SHIPs and SMP programs, in particular, are valuable partners in assisting consumers and identifying local and national actors who are misleading or deceiving beneficiaries.

Appendix A–Definitions

This section defines the technical terms used in this report and the relationship of these organizations to MA plans and CMS.

Agent or Broker

Definition. Agents and brokers are licensed by states to sell health insurance products. Agents and brokers may be a contractor or employee of a field marketing organization (FMO). Agents and brokers may also be contracted to, or employed directly by, an insurance carrier. Additionally, some agents and brokers operate independently. Other terms that can be used for brokers include producer, solicitor agent, field sales representatives, telesales representatives, licensed only agents (LOA), or street agent.

Relationship to MA Plans. Brokers are appointed to sell certain Medicare Advantage plans, which means that the broker has completed training required both by the plan and CMS, and has a contract to sell its products within a specific market.

Relationship to Regulators. Agents and brokers are directly regulated by states through licensure. Agents and brokers are also indirectly regulated by CMS through their contracts with MA plans.

Broker Commissions

Definition. Brokers are agents appointed to sell certain MA plans and are typically contracted to or employed by third party marketing organizations. A MA plan may pay an appointed broker a commission for enrolling an individual into a product. Brokers may receive a commission in an enrollee's first plan year as well as subsequent years if the enrollee remains in the plan and the broker remains appointed with the insurer.

Relationship to MA Plans. Commissions are paid by insurers either directly to the broker or to the FMO. MA Plans have various tools for assessing consumer satisfaction, and TPMOs may mediate how its agents are able to receive commissions.

Relationship to Regulators. Broker commissions are regulated by CMS and capped at a set amount based on the cap in each state.

Administrative Fees

Definition. Administrative fees are fees paid by a plan to enrolling agents. Unlike broker commissions, administrative fees are not capped by regulation. This has allowed MA plans to cover expenses such as travel cost, training cost, and office support costs through administrative payments resulting in an increase in the use of these unregulated payments to supplant regulated broker commissions. Sometimes these fees will cover other costs like technology and compliance and oversight costs.

Relationship to MA Plans. MA plans have historically been able to use administrative fee payments to compensate brokers for enrollments. The effect of these administrative payments has been that FMOs and TPMOs are able to exceed the commissions cap.

Relationship to Regulators. The 2025 proposed rule sought to remove the administrative fees loophole. Beginning in Contract Year 2025, this would have meant that administrative fees and commissions alike will be defined as "compensation" and capped. However, this provision has been enjoined pending litigation and is not in effect.

Field Marketing Organization

Definition. Field Marketing Organization or "FMO" is an umbrella term meant to encompass entities at the "top of hierarchy," including third party marketing organizations. FMOs serve as an intermediary between the brokers and agents they employ and MA plans, and provide administrative support to brokers and agents.

Relationship to MA Plans. FMOs contract directly with insurers to perform marketing functions for their MA plans

Relationship to Regulators. CMS is able to regulate FMOs through its regulation of MA plan contract terms. In many instances, Federal Communications Commission (FCC) regulations that apply to telephonic and internet marketing entities apply either directly through FCC regulation, or have been imported into recent CMS regulation of MA Plans and their FMOs.

Third Party Marketing Organization

Definition. The term Third Party Marketing Organization or "TPMO" is a broad term that refers to a type of FMO, as well as agents, brokers, and organizations performing marketing functions for MA Plans. Within the field, the nomenclature to describe field marketing organizations vary between firms. TPMOs typically contract with one or multiple MA Plans to place lead-generation materials, purchase leads from lead generators, and refine and direct leads to health plans to which their agents are appointed for enrollment. This can create a myriad of contractual relationships. This report uses the term "TPMO" to describe entities at-issue because the term is more specific than the more broadly-encompassing "FMO."

Relationship to MA Plans. As the primary entity downstream of the MA Plan, TPMOs contract with MA Plans to provide marketing services. CMS defines TPMOs as "organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under § 422.2, but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR."[113] TPMOs will typically be in contact with consumers who voluntarily reach out to them after seeing an advertisement, after obtaining consumer contact information and express written consent obtained through advertisement, or with consumers whose contact information they have received from lead generators who have obtained a consumer's express

[113] 42 CFR 422.2260.

written consent to marketing by the Plan's TPMO. As described below, recent rulemaking by CMS adopted stronger rules around obtaining and sharing consumer information.

Relationship to Regulators. TPMOs are a private alternative to the public Medicare.gov website where consumers can compare and enroll in MA Plans through the Medicare Plan Finder. The Medicare Plan Finder does not allow individuals to enroll in a Medigap plan. CMS is able to regulate TPMOs through its regulation of Plan contract terms. In many instances, Federal Communications Commission (FCC) regulations that apply to telephonic and internet marketing entities apply either directly through FCC regulation, or have been imported into recent CMS regulation of MA Plans and their TPMOs.

First-Tier Downstream Entity

Definition. At times, TPMOs may function as a first tier, downstream or related entity (FDRs), as defined under 42 CFR § 422.2, but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR."[114] A FDR is an entity indirectly regulated by CMS that delivers administrative services to Medicare beneficiaries.

Relationship to MA Plans. Entities operating downstream of MA Plans, such as TPMOs and other administrative third-parties, may be FDRs and thus indirectly regulable by CMS.

Relationship to Regulators. FDRs are not regulated directly by CMS, but through MA plan contracts with CMS which stipulate how and with whom MA Plans may contract.

Lead Generator

Definition. "Lead generation" is not defined in CMS or FCC regulation, but is distinguished from the activities of a TPMO. In general, a lead generator is an entity that is collecting consumer information for the purpose of selling it to a TPMO or other advertising entity.

Relationship to MA Plans. As subcontractors to TPMOs, lead generators operate to obtain consumer data and consumer consent to marketing activities. By terms of contract, MA Plans attempt to regulate the types of leads a TPMO may obtain from a lead generator and the validity of a lead which the Plan pays for. Lead generators may source their leads from other lead generators, who may in turn have sourced that data from another lead generation entity.

Relationship to Regulators. The terms of this collection are, as discussed above, regulated by the FCC and must offer a consumer clear and conspicuous notice of what marketing activities they are submitting their information for and require that a lead generator sell information obtained in that interaction to only one entity at a time.

[114] 42 CFR 422.2260 "Third-party marketing organization (TPMO)."

Data Aggregator

Definition. A data aggregator is an entity that serves to collect data used by TPMOs and MA Plans to contact consumers. In general, lead aggregators and data brokers may also supply consumer information, though these categories are likewise ill-defined and overlapping. Data aggregators typically operate downstream of lead generators, and may be hosted in offshore call centers. Their activities serve to compile lists of leads, piecing consumer contact information together so that lead generators may engage with listed consumers to generate interest in a service or product. While data brokers typically offer pieces of consumer information, lead generators work to gather further information on each lead so that the eventual buyer is able to target consumers most likely to engage with their product.

Relationship to MA Plans.
Data aggregators may be indirectly related to MA plans where their activities are used to generate leads that lead generators procure, refine, and sell to TPMOs, who in turn use such data to enroll consumers in MA plans.

Relationship to Regulators. Data aggregators, much like lead generators, are ill-defined entities in regulation. They may be regulable by FCC action where they contact consumers by telephone or through the internet. Otherwise, MA Plans may attempt to prohibit the use of data aggregators by terms of their contracts with TPMOs.

Appendix B–Administrative Service Fee Example[115]

Administrative Services Tier	Level 1	Level 2	Level 3	Level 4
First Year MA/MAPD Administrative Fee	$ [Redacted]	$ [Redacted]	$ [Redacted]	$ [Redacted]
Identify and recruit all qualified agents	x	x	x	x
Ensure all agents are properly licensed, contracted, and certified to sell Medicare Products throughout the year	x	x	x	x
Provide ongoing training around the proper selling and servicing of Medicare Products to agents. Including: SCOPE retention, sales presentations, and client follow-up	x	x	x	x
Reinforce [Redacted] policy updates, compliance alerts, and other communications with agents	x	x	x	x
Aid in the collection of agent responses when necessary	x	x	x	x
Review and enforce actionable information provided by [Redacted], monitor compliance statistics, identify negative trends, and take action proactively	x	x	x	x
Participate in [Redacted] initiated audits and provide assurances of remediation of deficiencies	x	x	x	x

[115] Insurer C MDA Amend 73 10-1-22. (abstracted).

Assist in the maintenance of accurate agent phone and address and other contact information to ensure accuracy for important outreach communications		x	x	x
Ensure compliance with CMS and [Redacted] requirements for any 3rd party sites used to generate leads	x	x	x	x
Ensure compliance with CMS and [Redacted] requirements for printed material, digital material, direct mail, and all in-field marketing activity	x	x	x	x
Develop and maintain Policy and Procedures documentation to reinforce and monitor compliant sales practices	x	x	x	x
Commission support, audits, research, and issue resolution for agents			x	x
Dedicated compliance officer or team to provide oversight and monitoring of sales processes including tracking and reporting				x
Dedicated business enhancement team to implement new initiatives to address any emergent issues and provide opportunities that focus on member engagement activities.				