

# DECEPTIVE MARKETING PRACTICES FLOURISH IN MEDICARE ADVANTAGE

A Report by the Majority Staff of the U.S. Senate Committee on Finance



The **UNITED STATES SENATE**  
**COMMITTEE** *on* **FINANCE**  
CHAIRMAN RON **WYDEN**, D-OREGON



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## Part I: Executive Summary

The Centers for Medicare and Medicaid Services (CMS) revealed earlier this year that the number of Medicare beneficiary complaints about private sector marketing for Medicare Advantage (MA) plans more than doubled from 2020 to 2021.<sup>1</sup> The Senate Finance Committee Majority Staff (hereinafter “Committee”) launched an inquiry in August 2022, collected information on marketing complaints from 14 states and found evidence that beneficiaries are being inundated with aggressive marketing tactics as well as false and misleading information, such as:

*Seniors shopping at their local grocery store are approached by insurance agents and asked to switch their Medicare coverage or MA plan.*

*Insurance agents selling new MA plans tell seniors that their doctors are covered by the new plans. Seniors who switch plans find out months later that their doctor is actually out-of-network, and they have to pay out-of-pocket to visit their doctor.*

*Seniors receive mailers that look like official business from a Federal agency, yet the mailer is a marketing prompt from an MA plan or its agent or broker.*

*An insurance agent calls seniors 20 times a day, attempting to convince them to switch their Medicare coverage.*

*Widespread television advertisements with celebrities claim that seniors are missing out on benefits, including higher Social Security payments, in order to prompt seniors to call MA plan agent or broker hotlines.*

Each one of these vignettes represents documented instances of aggressive or deceptive MA and Part D marketing practices that this investigation found to be widespread, not isolated events. Other examples submitted by the states are documented in this report.

The Committee received evidence of fraudulent and misleading marketing practices from states and other stakeholders – painting a consistent national picture. These issues were reported more frequently with respect to MA plans compared to stand-alone Part D plans. In addition, nine of the ten states reporting quantitative complaint information found an increase in complaints from 2020 to 2021 that mirrored the trend found by CMS.<sup>2</sup>

Information submitted by states demonstrates that beneficiaries are inundated with fraudulent and misleading communications across all modes of communication (in-person, television,

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<sup>1</sup> Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022). “In 2020, we received a total of 15,497 complaints related to marketing. In 2021, excluding December, the total was 39,617.”

<sup>2</sup> Ibid.

telemarketer, and robo-calls).<sup>3</sup> An egregious example submitted by the states includes marketing materials designed to look like official communications from Federal agencies. A number of states also raised concerns with the use of “Medicare” in the naming and branding of marketing companies to suggest that a marketing company is representing the Medicare program. These practices are intentionally deceptive as they blur the lines between official government communication and private health plan marketing.

The investigation also uncovered a range of predatory actions. Agents were found to sign up beneficiaries for plans under false pretenses, such as telling a beneficiary that coverage networks include preferred providers even when they do not. Of particular concern to the Committee were reports across states of agents changing vulnerable seniors’ and people with disabilities’ health plans without their consent.

The burden of deceptive and predatory marketing practices falls unequally across the already vulnerable Medicare population. The Committee heard that unscrupulous actors are targeting individuals dually eligible for Medicare and Medicaid (so-called “dual eligibles” who are allowed to switch MA plans once every quarter) as well as individuals with cognitive impairments.<sup>4</sup> False and misleading marketing advertisements and fraudulent sales practices undermine access to care and the trust beneficiaries have in the Medicare program.

In the past year, CMS has taken several positive steps to address deceptive marketing in the MA program.<sup>5</sup> But more needs to be done to eliminate these practices. During the Trump Administration, Medicare program oversight deteriorated significantly. Several key protections against misleading and predatory MA marketing practices were undone. Given the prevalence of marketing complaints that the Committee found across a geographically diverse set of states and the severity of the consequences experienced by Medicare beneficiaries, this report makes several recommendations to CMS (outlined in detail in Part VII) to ensure that MA remains a trusted program that delivers value for enrollees.

Specifically, the Committee urges CMS to take the following regulatory action:

1. Reinstate MA plan requirements loosened during the Trump Administration.
2. Monitor MA disenrollment patterns and use enforcement authority to hold bad actors accountable.
3. Require agents and brokers to adhere to best practices.

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<sup>3</sup> Internet advertisements were raised less frequently than mail and television advertisements, but raise significant concerns.

<sup>4</sup> 42 CFR §423.38(c)(4)(i).

<sup>5</sup> Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022); *See also*, Kathryn A. Coleman, Health Plan Management System (HPMS) Memorandum: CMS Monitoring Activities and Best Practices during the Annual Election Period, CMS, (Oct. 19, 2022),

<https://s3.documentcloud.org/documents/23168640/cms-memo-101922-medicare-advantage-marketing.pdf>.

4. Implement robust rules around MA marketing materials and close regulatory loopholes that allow cold-calling.

CMS has broad authority to regulate the marketing and enrollment activities of MA and Part D plans. Congress may need to step in, as it has in the past, but this report identifies a number of commonsense changes that CMS could make to protect beneficiaries today.

## Part II: Background

Following reports from key Medicare stakeholders including state insurance commissioners, State Health Insurance Assistance Programs (SHIPs), and beneficiary advocacy groups, the Committee launched an inquiry into potentially deceptive marketing tactics practiced by MA plans that may take advantage of seniors and those with vulnerable health needs looking for Medicare coverage. This report was prepared by the Majority Staff.

The 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 and Medicare, MA, and the Part D prescription drug program.

This year, nearly 30 million older adults and people living with disabilities receive their Medicare benefits through a private MA plan, and nearly 50 million people have a stand-alone Part D plan or an MA plan with Part D coverage.<sup>6</sup> MA accounts for over half of all Medicare outlays. In 2022, MA is expected to account for \$427 billion of Federal spending.<sup>7</sup> Most MA beneficiaries (69%) are enrolled in a zero-premium plan, meaning there is no additional monthly premium on top of the Medicare Part B premium.<sup>8</sup> For those who do pay a premium for MA coverage, the average monthly premium is \$58.

Congress established MA and Part D plans as important partners in the Medicare program providing Medicare-covered services and extra benefits to seniors and people living with disabilities. However, false and misleading marketing advertisements and fraudulent sales practices undermine access to care and the trust beneficiaries have in the Medicare program. This investigation found seniors and people living with disabilities can experience higher out-of-pocket costs and difficulty accessing their providers after being enrolled in a plan without one’s consent or enrolled in a plan only to find out the agent misrepresented the plan’s benefits. Some people who fall victim to marketing and enrollment scams delay care because of confusion

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<sup>6</sup> Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022).

<sup>7</sup> Baseline Projections - Medicare, Congressional Budget Office (CBO), (May 2022), <https://www.cbo.gov/system/files?file=2022-05/51302-2022-05-medicare.pdf>.

<sup>8</sup> Freed M. et al, Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings,” Kaiser Family Foundation, (Aug. 25, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>.

over their benefits and coverage instability. Many feel frustrated and embarrassed that they were scammed.

Deceptive advertisements and fraudulent sales practices in the MA program have occurred in prior years. In 2009, the Government Accountability Office (GAO) issued a report on MA marketing finding that “CMS took compliance and enforcement actions for inappropriate marketing against at least 73 organizations that sponsored MA plans from January 2006 through February 2009.”<sup>9</sup> In 2010, the Health and Human Services Office of the Inspector General (HHS OIG) examined the marketing of MA plans from 2008 to 2009. Among other things, HHS OIG found that inappropriate marketing was addressed in part by special election periods (SEP) during which beneficiaries could change their coverage, but that some beneficiaries experienced outcomes that could not be resolved by a SEP, including disruption in care and additional financial costs.<sup>10</sup>

Over a decade later, stakeholders are once again reporting that MA and Part D health plans and their contractors are engaging in manipulative and aggressive sales practices that take advantage of vulnerable older adults and people living with disabilities. In its survey of state insurance commissioners, the National Association of Insurance Commissioners (NAIC) reports there has been an increase in complaints from seniors about false and misleading advertising and marketing of MA plans. Similarly, CMS reported it received more than twice as many complaints in 2021 compared to 2020 (15,497 in 2020 to 39,617 in 2021).<sup>11</sup>

In August 2022, the Committee sent letters to 15 state insurance commissioners and SHIPs requesting data and information on MA marketing complaints.<sup>12</sup> State insurance agencies and SHIPs are uniquely positioned to hear directly from beneficiaries and gather detailed information. The states with the largest MA beneficiary populations were contacted. Additional states were selected to assure regional diversity and that all 10 CMS regions received representation.

The Committee received responses from 14 states (13 state insurance commissioners and 14 SHIPs). Federal law does not require states to collect MA complaints and each state retains complaints data differently. Nevertheless, the Committee was able to review specific examples, examine trends over time, and draw conclusions from the information shared. The investigation also benefited from information provided by stakeholders including independent agents, health plans, and consumer groups. This report summarizes findings from those responses and provides relevant background on the issue.

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<sup>9</sup> CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue, GAO (Dec. 2009), <https://www.gao.gov/assets/gao-10-36.pdf>.

<sup>10</sup> Beneficiaries Remain Vulnerable to Sales Agent’s Marketing of Medicare Advantage Plans, HHS OIG (Mar. 2010), <https://oig.hhs.gov/oei/reports/oei-05-09-00070.pdf>.

<sup>11</sup> Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022).

<sup>12</sup> Letters were sent to Arizona, California, Colorado, Florida, Georgia, Illinois, Massachusetts, Michigan, Missouri, New York, North Carolina, Ohio, Oregon, Pennsylvania, and Texas.

## Part III: Discussion of Findings

### A. Key Findings

Based on the materials submitted by the 14 responsive states and other stakeholders interviewed during the investigation, the Committee found the following:

- Nine of the ten states that tracked complaint data reported an increase in complaints to the insurance commissioners and/or SHIPs from 2020 to 2021.
- States reported mail advertisements, television advertisements, telemarketers, and robo-calls as the primary sources of complaints.
- States reported instances of deceptive marketing material, such as mailers that appeared to be official government documents or advertisements that use “Medicare” in the company’s name or branding.
- States reported a variety of other issues, including marketing of plans to beneficiaries with dementia, beneficiaries being enrolled in a new plan without their consent, and examples of beneficiaries being switched to plans that did not cover their providers.
- Some plans experienced substantial disenrollment from their plans due to misleading and aggressive marketing practices by other plans (or their agents and brokers).

### B. Summary of Findings

**Complaints Received.** Between 2020 to 2021, CMS received more than twice the number of beneficiary complaints related to the marketing of MA plans.<sup>13</sup> Similarly, when asked specifically about MA and/or Part D complaints received, nine out of the ten states that provided quantitative data saw an increase in complaints reported to their insurance commissioners and/or SHIPs from 2020 to 2021. Most notably, two states saw increases of over 500%, with Massachusetts seeing a 700% increase and Arizona seeing a 614% increase. Only one state, Colorado, reported a decrease in complaints. The remaining four states do not track such complaint data.

**Complaint Themes.** The Committee identified several sources of beneficiary complaints. Ten states reported that mail advertisements were a source for complaints, nine states reported that robo-calls and telemarketers were a source for complaints, and eight states reported that television advertisements were a source for complaints. These findings are consistent with CMS’s recent report that it has “seen an increase in third-party print and television ads, which appears to be corroborated by State partners.”<sup>14</sup>

In addition to establishing these communication trends, the Committee found that advertisements promising an increase in a beneficiary’s Social Security checks were a frequent source of complaints. MA plans may buy down Medicare Part B premiums for their enrollees, which

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<sup>13</sup> Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022). “In 2020, we received a total of 15,497 complaints related to marketing. In 2021, excluding December, the total was 39,617.”

<sup>14</sup> Ibid.

would result in a higher Social Security payment for the beneficiaries who choose the plans. For many low-income seniors and people living with disabilities, these savings are meaningful. However, brokers and agents appear to use the promise of this additional benefit as a “bait and switch” tactic to lure beneficiaries into plans, even when lower Part B premiums are not offered by plans in the geographic area or the plan does not cover beneficiaries’ needed services and providers. Ultimately, this marketing strategy harms beneficiaries more than it helps them.

In their response to the inquiry, six states noted misleading claims about Social Security benefits as a concern. For example, in Oregon a dual-eligible Medicare beneficiary and SSI recipient was enrolled into a plan after seeing a television advertisement, calling the number and learning that he could gain an extra \$135 in his monthly Social Security check, to which he said, “he wasn’t sure what that meant but it sounded good.”<sup>15</sup> However, the plan he was ultimately enrolled into did not cover his medications, which he only realized when he went to the pharmacy to fill his prescriptions. The complaint continued, “The key issue is that he was not told by the MA-only plan phone agent that the plan does not cover Rx and does not include Part D. He would never have agreed to this.... He was astonished and very stressed out when he went to the pharmacy on [Date of Service] and was told he did not have Rx coverage. It sounds as if the agent was not forthcoming with the fact that this plan does not include drug coverage. He says he was never told that and would never have enrolled in a plan that would not provide Rx coverage.”<sup>16</sup>

**Deceptive Advertisements.** The Committee also received concrete examples of false or misleading marketing materials from the states (Appendix A). States shared examples of deceptive marketing materials, such as mailers that appeared to be official government documents or documents that used the word “Medicare” in the company’s name or branding.

Six states reported concerns about false or misleading marketing materials. For example, in response to the Committee’s inquiry, Director Michael Wisheart from the Arizona Department of Economic Security (DES) wrote that, “The onslaught of mail appearing to be official correspondence from Medicare or Centers for Medicare and Medicaid Services, was noted as misleading and prevalent. This type of correspondence can divert the beneficiary’s attention and cause confusion about plan providers.”<sup>17</sup> One example provided by the Georgia Department of Human Services shows an insurance agent that uses “MedicareAdvantage.com” as its website.<sup>18</sup> Another example provided by the Ohio Department of Insurance (ODI) shows a company that used a bus with Medicare in its name and website.<sup>19</sup> When a beneficiary visits the advertised “MedicareBus.com,” they are automatically redirected to another website for an independent insurance agency.

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<sup>15</sup> OHDS-SHIBA MA Marketing Response, pg 14. (document on file with Committee).

<sup>16</sup> Ibid.

<sup>17</sup> Arizona SHIP Medicare Fraud Response Letter, pg 2 (document on file with Committee).

<sup>18</sup> MedicareBus.com Image, (see Appendix A: Selected Supporting Materials Received by the Committee Document IVG).

<sup>19</sup> MA Improper Marketing Response ODI, pg 3, (document on file with Committee).





The form below, also submitted by ODI, exemplifies another deceptive marketing tactic. The enrollment mailer is designed to look like an official government tax document.<sup>20</sup>

<b>T-2</b>	<b>MEDICARE SAVINGS PROGRAM</b>	<b>2022</b>										
<p><b>Do you qualify</b> to have your Medicare Part B premium paid for by the state?? <b>If you do qualify, you will receive your \$170.10 back into your Social Security check.</b> Do you qualify for the Extra Help Program with your prescription drugs from SS? Do you qualify for Medicaid or have you been receiving all the extra benefits such as Dental, Vision, Hearing, Transportation and FREE over the counter Health Products? <b>Return this inquiry card today. This is a FREE service to you, PLEASE READ.</b></p> <p style="text-align: center;"><input type="checkbox"/> <b>YES, I would like to find out if I qualify for any or all of the benefits listed above.</b></p>												
<p>Please Respond By [REDACTED] 2022</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>		<p style="text-align: center; font-size: small;">Complete and return the information below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; font-size: x-small;">NAME</td> <td style="width: 30%; font-size: x-small;">AGE</td> </tr> <tr> <td style="font-size: x-small;">SPOUSE'S NAME</td> <td style="font-size: x-small;">AGE</td> </tr> <tr> <td colspan="2" style="font-size: x-small;">STREET ADDRESS (No PO boxes)</td> </tr> <tr> <td colspan="2" style="font-size: x-small;">PHONE (With Area Code) (    )    -      </td> </tr> <tr> <td colspan="2" style="font-size: x-small;">Not affiliated with or endorsed by any government agency.</td> </tr> </table> <p>[REDACTED]</p>	NAME	AGE	SPOUSE'S NAME	AGE	STREET ADDRESS (No PO boxes)		PHONE (With Area Code) (    )    -		Not affiliated with or endorsed by any government agency.	
NAME	AGE											
SPOUSE'S NAME	AGE											
STREET ADDRESS (No PO boxes)												
PHONE (With Area Code) (    )    -												
Not affiliated with or endorsed by any government agency.												
<p>To opt out of future mailings please [REDACTED] and enter this 9 digit code [REDACTED]</p>												

<sup>20</sup> MA Improper Marketing Response ODI, pg 4, (document on file with the Committee).

**Additional MA Marketing Concerns.** States reported a variety of other issues around MA plan marketing, including marketing to beneficiaries with cognitive impairments. For instance, five states shared examples where brokers targeted beneficiaries with a cognitive impairment. Of particular concern to the Committee, six states included examples where beneficiaries were not even aware that they had been signed up for an MA plan.

The North Carolina Department of Insurance shared that its Seniors' Health Insurance Information Program (SHIIP) had received a number of complaints involving dually eligible beneficiaries who had their enrollment changed to a different MA plan even though neither the beneficiary, family member, or power of attorney had been engaged in an enrollment discussion with the plan or an agent. Two states reported instances where individuals were approached by plan marketers in public areas such as grocery stores and outside of health centers.

Furthermore, ten states reported instances of provider network confusion, where the beneficiary was switched into a new plan and was unaware that their current doctors were not covered under their new plan's network until they began to use the new plan. For example, in Oregon, a Medicare beneficiary's current Medicare Supplement policy was replaced with a MA plan with Part D prescription drug coverage (MAPD) by an agent who came to her house. The complaint follows that, "her mental health provider submitted claims to her new MAPD plan which were denied as out of network. Original Medicare Part B had been paying 80% for the mental health provider visits and the Medicare Supplement was paying 20%. The agent admitted to the unsuitable enrollment mistake."<sup>21</sup>

Out-of-network issues were raised in accessing medical and dental health plan benefits. States also reported that because there is a limited time period during which an individual may disenroll from a plan, beneficiaries end up staying with a plan even if it means paying for out-of-network services. It is unclear from our interviews and document review whether plans willfully market plans with poor network coverage or if systemic issues such as "ghost networks" are part of the problem. Ghost networks have been defined by the Government Accountability Office as "providers who are listed in a particular provider directory as an in-network provider but are either not taking new patients or are not in a patient's network."<sup>22</sup> However, beneficiaries only have a limited window to disenroll from a new plan and might not realize network problems until it is too late. These disruptions in care, whether from uncovered providers, medications, or services, can cause delay in needed care and be detrimental to a beneficiary's health.

When asked if third-party marketing organizations (TPMOs) were a source of complaints, three states reported that this was a problem. TPMOs are "organizations and individuals, including agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment."<sup>23</sup> In their response, Arizona DES stated that, "[t]he most frequently-mentioned marketing material is the appearance of TPMO ads on TV featuring celebrities as trusted sources of information."<sup>24</sup> However, many

<sup>21</sup> OHDS-SHIBA MA Marketing Response, pg 14 (document on file with Committee).

<sup>22</sup> Access challenges for Covered Consumers and Relevant Federal Efforts, Government Accountability Office, (Mar. 2022), <https://www.gao.gov/assets/gao-22-104597.pdf>.

<sup>23</sup> 42 CFR §422.2260 "Third party marketing organization (TPMO)."

<sup>24</sup> Arizona SHIP Medicare Fraud Response Letter, pg 2 (document on file with Committee).

states reported they do not segment complaints in this way and were therefore unable to respond to the Committee’s request. In addition to the states, CMS also noted that TPMOs were a large source of complaints, stating, “We are unable to say that every one of the complaints is a result of TPMO marketing activities, but based on a targeted search, we do know that many are related to TPMO marketing.”<sup>25</sup>

During the investigation the Committee also heard from Medicare beneficiaries who received a confusing communication from an integrated medical group informing certain patients that their doctor would no longer accept their coverage because it is out-of-network, and encouraged impacted patients to contact the medical group’s insurance specialist team for “how to update/switch coverage.”<sup>26</sup> This example raises questions around the relationships between health care providers, health plans, and insurance agents, and the gray line between referring patients for advice and steering patients away from or to certain health plans.

In an Oregon case, a dual eligible beneficiary had their MA plan enrollment changed without his consent to a plan that did not include his primary care provider. According to the case report the beneficiary reported, “[h]e was intending to look over the plan benefits before enrolling but then received confirmation of enrollment.”<sup>27</sup> Although Medicaid provides cost-sharing protections, the beneficiary became “uncomfortable and nervous” and did not want to move forward with medical tests recommended by the doctor. On top of delaying needed care, the beneficiary felt like the plan change was their fault, “He regrets making the change. He thought he was still thinking about it and by the time he got [the] paperwork it was too late. . . . He had been trying to call the agent who enrolled him, but he said her phone voicemail is always full. Unfortunately, he never tried to call the main MAPD phone number.”<sup>28</sup>

**Other MA Marketing Reports.** In the course of the inquiry, the Committee spoke with members of the Alliance of Community Health Plans (ACHP) to share member companies’ experiences with misleading and aggressive MA marketing. ACHP represents 23 community-based health plan member companies across 36 states and the District of Columbia.<sup>29</sup>

ACHP members explained how, “Medicare consumers have become an easy target for these high-pressure sales tactics whether it be a lonely widow who is excited by the prospect of someone to talk to or an aging senior who suffers from dementia.” Adding to that concern, ACHP believes that these tactics affect many more consumers than identified because beneficiaries may be embarrassed to report marketing abuses.

Community health plans reported experiencing substantial disenrollment of members because of marketing abuses. For example, Independent Health Plan in Buffalo, New York, could attribute 22% in 2021 and 35% in 2022 of their members who disenrolled to one national competitor as

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<sup>25</sup> Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022). “In 2020, we received a total of 15,497 complaints related to marketing. In 2021, excluding December, the total was 39,617.”

<sup>26</sup> Letter to a Patient (see Appendix A: Selected Supporting Materials Received by the Committee, XA).

<sup>27</sup> OHDS-SHIBA MA Marketing Response, pg 21 (document on file with Committee).

<sup>28</sup> Ibid.

<sup>29</sup> Alliance of Community Health Plans, Members, (last visited Oct. 28, 2022), <https://achp.org/members/>.

due to misleading marketing tactics.<sup>30</sup> Similarly, beginning in 2020, Security Health Plan in Marshfield, Wisconsin, saw its decade long retention rate of 90% drop and, “[d]ue to marketing tactics, including aggressive, unsolicited calls, Security experienced a disenrollment rate of about 27 percent above [its] historical average during the last annual enrollment period.”<sup>31</sup>

ACHP attributed some of these aggressive marketing practices to TPMOs using the Community Health Automated Medicaid Processing System (CHAMPS) and the Medicare Advantage Prescription Drug (MARx) systems to access Medicare beneficiary personal information for marketing purposes. These databases contain personal details about beneficiaries including name, place of residence, and health care utilization history.<sup>32</sup>

### C. Case Study: “IRS Mailers”, “Official Mailers”, and the Lead Generation Game

The Committee received multiple examples of mailers made to look like official notices coming from the Internal Revenue Service (IRS) or the Medicare Program (see exhibits IID and IIIB). These mailers are both misleading and serve an important role in lead generation that allow TPMOs to get around many of the marketing prohibitions currently in law, per Section 103 of the Medicare Improvement for Patient and Providers Act (MIPPA) of 2008 that prohibits MA and Part D plans from conducting certain marketing activities, including cold calling.<sup>33</sup> These mailers allow TPMOs to skirt the rules because after the beneficiary initiates contact in response to an advertisement these prohibitions are no longer in place per CMS rules. Mailers framed as urgent that look like official notices from the IRS or other government entities serve the explicitly misleading purpose of prompting beneficiaries to “initiate contact,” so that MA marketing prohibitions can be circumvented. This loophole allows bad actors to inundate older Americans with unsolicited calls and other aggressive marketing.

TPMOs may also be using other ambiguities in regulation to bypass requirements intended for MA plans. In response to the Committee inquiry, the Ohio Department of Insurance reported, “As insurance companies and agents are bound by state insurance laws (as well as the Medicare Marketing Guidelines), it appears they may be using TPMOs to do what they cannot. A majority of TPMOs do not hold insurance licenses due to the fact that lead generation falls outside the definition of solicitation under the National Association of Insurance Commissioners (NAIC) Producer Licensing Model Act.”<sup>34</sup>

### D. Case Study: Misleading Information about Provider Networks

False or misleading claims around in-network and out-of-network providers were reported and are of high concern because they have serious impacts on beneficiary health. In response to the March 2022 Advance Notice released by CMS, the National Organization for Rheumatology Management (NORM) submitted a letter describing the provision of incorrect information about MA plan provider networks. In its letter to CMS, NORM reported that “When researching MA plan options, beneficiaries are often told by MA plan enrollment representatives that there will

<sup>30</sup> ACHP Comments on MA Marketing Letter, pg. 2 (see Appendix A: Selected Supporting Materials Received by the Committee Document VIIA).

<sup>31</sup> Ibid, pg. 1.

<sup>32</sup> Ibid, pg. 2.

<sup>33</sup> Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275 §103).

<sup>34</sup> MA Improper Marketing Response ODI, pg 8, (document on file with the Committee).

be no disruption in their treatment, and they can continue seeing their current care providers. Some beneficiaries will contact their rheumatology practice for confirmation. The practice administrator can share whether the treating rheumatologist is “in-network,” whether the prescribed medications are on the plan’s formulary and/or subject to prior authorization or step therapy, or whether the patient would need to be “switched” to another option, as well as what their expected out-of-pocket costs would be, if they proceed with MA plan enrollment. Far too often, beneficiaries learn the information shared by the MA plan representative was incorrect.”<sup>35</sup> The letter goes on to say, “practice administrators learn of a patient’s change in coverage at the time the patient requests an appointment (and the practice does not participate in the plan) or visits the pharmacy to request a refill (and learns they either need prior authorization or the medication is now cost-prohibitive). At that time, the damage has been done, as the patient is “stuck” with the new MA plan until the next open enrollment period.... In these situations, the patient’s care is severely disrupted solely as a result of misleading marketing tactics used by the plan to increase enrollment.”

The Missouri Department of Insurance detailed similar beneficiary stories in a letter responding to the Committee’s inquiry. The letter states: “A 94-year-old woman with dementia was sold a MA plan. The consumer lives in a rural area, and the hospital and providers she utilizes are not in-network with the plan chosen for her by the insurance salesperson. The plan did not allow for continuity of care for the consumer and forced her to obtain care (with the help of staff) miles away from her residence.”<sup>36</sup>

### E. Case Study: Aggressive Lead Generation

Another example of misleading marketing reported by states is the Medicare Coverage Helpline television advertisement campaign, which first aired in 2018 and features former football star Joe Namath. In the ad, Mr. Namath says, “get what you deserve,” and “the benefit that adds money back to your Social Security check.” After numerous lawsuits, the ad was recently updated to comply with current CMS regulations. However, it still fails to mention basic information about the MA program, including that not all providers are in-network and was only recently updated to mention that benefits vary by zip code. Through this inquiry, the Committee received five letters from states specifically calling out the Medicare Coverage Helpline commercial campaign.

The Joe Namath ad is sponsored by TogetherHealth, a subsidiary of Benefytt Technologies, formerly known as Health Insurance Innovations (HII).<sup>37</sup> According to a 2020 investigation by the House Committee on Energy and Commerce, 14,000 third-party agents and brokers across 40 states were tied to the company.<sup>38</sup> The Committee found “HII’s operation and business structure

<sup>35</sup> NORM Letter to CMS (see Appendix A: Selected Supporting Materials Received by the Committee, Document IXA).

<sup>36</sup> Missouri Department of Commerce And Insurance Letter (document on file with the Committee).

<sup>37</sup> Complaint for Permanent Injunction Monetary Relief and Other Relief, Federal Trade Commission v. Benefytt Technologies, (M.D.F.L. 2022) (No. 22-cv-1794), [https://www.ftc.gov/system/files/ftc\\_gov/pdf/1923141%20Benefytt%20-%20Complaint%20-%20MD%20Fla.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/1923141%20Benefytt%20-%20Complaint%20-%20MD%20Fla.pdf).

<sup>38</sup> Shortchanged: How the Trump Administration’s Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk, US House of Representatives Committee on Energy and Commerce (Jun. 2020) [https://drive.google.com/file/d/1uiL3Bi9XV0mYnxpyaIMeg\\_Q-BJaURXX3/view](https://drive.google.com/file/d/1uiL3Bi9XV0mYnxpyaIMeg_Q-BJaURXX3/view).

incentivizes third-party agents and brokers to actively target vulnerable consumers seeking comprehensive health coverage.” The company went on to face penalties for its misleading marketing tactics, entering into a multistate regulatory settlement agreement... to pay \$3.4 million” in 2018. As part of its settlement, the company was required to more closely monitor its sales and marketing practices, and to more clearly advise consumers of restrictions on pre-existing conditions and coverage limitations of insurance products. The company was also required to improve monitoring of agent sales calls, and to closely monitor external sales practice of external third-party agents.”<sup>39</sup>

While TogetherHealth does not exclusively focus on MA plans, the company utilizes television advertisements, websites such as healthinsurance.com, a 1-800 number, and online plan finder tools to generate “leads” for thousands of agents and brokers. Leads are individual contacts determined to be prospective MA beneficiaries.<sup>40</sup> TogetherHealth, with its subsidiary structure, lead generation functions across multiple products (including MA), and third-party relationships with agents, brokers, and carriers represents the tangled web of actors that regulators must unravel to monitor and regulate MA plan marketing.

These types of television advertisements can be particularly effective at targeting Medicare beneficiaries. For example, the Missouri Department of Commerce and Insurance reported instances of consumers “reaching out to insurance agencies after seeing a television advertisement. For example, an elderly consumer in a long-term care facility and without the capacity to make her own decisions, called the number advertised on television. During the call she was switched from one plan to another.”<sup>41</sup>

Oregon reported a similar case where a dual eligible Medicare beneficiary and Social Security Income recipient was enrolled in a plan without prescription drug coverage. The beneficiary reported that they “did not remember making any changes to his coverage; however, remembered seeing a TV advertisement and called about it. He said the plan representative mentioned getting \$135 more in his Social Security check ([the beneficiary] wasn’t sure what that meant but it sounded good). [The beneficiary] already had the State of Oregon paying his Part B premium. [The beneficiary] was told he would have a gym membership and dental coverage (which he already has dental through his Medicaid benefit). The key issue is that he was not told by the MA-only plan phone agent that the plan does not cover Rx and does not include Part D.”<sup>42</sup>

## Part IV: Warnings for Consumers

The Committee’s investigation uncovered a concerning pattern of false or misleading advertisements and fraudulent sales practices that go beyond isolated incidents. Reports from state insurance departments and SHIPs confirm that vulnerable seniors are being targeted for enrollment into MA plans, independent of what is best for the beneficiary and by deceptive means. Enrollment growth by MA plans has been substantial year over year, yet some of this

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<sup>39</sup> Ibid.

<sup>40</sup> See Appendix B.

<sup>41</sup> Missouri Department of Commerce and Insurance Letter (document on file with the Committee).

<sup>42</sup> OHDS-SHIBA MA Marketing Response, pg. 14 (document on file with the Committee).

growth has arisen from plans utilizing subsidiaries, third-party organizations, and “bait-and-switch” tactics that evade existing Medicare rules on plan marketing and communications to beneficiaries. Furthermore, unscrupulous actors appear to be taking advantage of the loosening of marketing regulations, which has ratcheted up confusion and pressure on beneficiaries as well as enrollment into different plans without their consent.

During this Annual Enrollment Period (October 15 to December 7), the Committee urges CMS to issue the following warnings for seniors and people living with disabilities.

**Warning 1: USE CAUTION IF CALLING A TV HELPLINE .** The Federal Medicare program does not advertise MA plans or benefits on television. These so-called helplines will connect you with an agent or broker. That agent or broker does not have to tell you about all of your options in the Medicare program, and does not have to ensure that your plan will meet your needs.

**Warning 2: IF YOU THINK YOU HAVE BEEN ENROLLED IN A NEW PLAN THAT DOESN’T WORK FOR YOU, CALL 1-800-MEDICARE FOR HELP.** Seniors and people living with disabilities can also get no-cost counseling from the local State Health Insurance Assistance Program (SHIP) or Senior Medicare Patrol (SMP) office. In some situations, you may be eligible for a special enrollment period to switch back into your original plan. During the first three months of the year, you can also change your enrollment.

**Warning 3: BE CAREFUL WHAT YOU CLICK.** Third-Party Marketing Organizations are using sneaky tactics to get your information and then sell your information to agents or brokers who can call you. When in doubt, don’t provide your information on unfamiliar websites or unfamiliar people. The Medicare Call Center (1-800-MEDICARE) and your local State Health Insurance Assistance Program (SHIP) office can help you understand your Medicare choices and enroll in a plan that will meet your needs.

## Part V: Legislative and Regulatory Context

### A. Background Legislative and Regulatory History of Marketing

The original authorizing statute creating Medicare private plans (then called Medicare+Choice) in the Balanced Budget Act of 1997 required CMS to review and approve marketing literature to prevent misleading or deceptive practices.<sup>43</sup> Congress required plans to submit material for Secretarial approval, prohibited cash or other monetary inducements, and allowed for the prohibition of a plan or agent of the plan from completing enrollment paperwork. If a plan or agent of the plan materially misrepresented plan provisions when marketing, then the beneficiary was eligible for a special election period to change plans.

Congress has made a number of changes to alternatively loosen and tighten requirements related to private plan marketing. In the Consolidated Appropriations Act, 2001, Congress reduced the number of days that private plans (then called Medicare+Choice) that replicate model marketing

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<sup>43</sup> Balanced Budget Act of 1997 (P.L. 105-33).

language without modification were permitted to distribute the material from 45 days after submission to 10 days.<sup>44</sup> The Medicare Prescription Drug and Modernization Act (MMA) of 2003 expanded Medicare to cover outpatient prescription drugs and renamed Medicare+Choice the MA program. The MMA also preempted State laws and regulations related to MA, and maintained States' authority to regulate agents, brokers and health plan licensing and solvency laws.

Following the implementation of the MMA and Medicare prescription drug plans, reports of aggressive marketing practices by overzealous agents and plans skyrocketed. Senator Wyden, along with Senate Special Committee on Aging Chair Herb Kohl and Senator Byron Dorgan, introduced the Accountability and Transparency in Medicare Marketing Act of 2007 to address these practices. The Kohl-Wyden-Dorgan Bill served as the basis for the marketing provisions included in MIPPA which prohibited direct and unsolicited cold calls to potential enrollees; required annual agent and broker training and testing, and required MA organizations to only use agents and brokers licensed under state law to sell MA and Part D plans.<sup>45</sup>

MIPPA also required MA plans to disclose the plan type in the plan name and required plans to report agent and broker terminations to the State. In 2011, CMS required MA plans to require non-English language translations of MA and Part D marketing material into languages spoken by more than 5% of people in the plan service area.<sup>46</sup> During this time, CMS also conducted and published market surveillance and audits including secret shopper studies and made these reports publicly available in 2009-2011.<sup>47</sup>

In the 2015 Final Rule, CMS removed the language requiring agent/broker training and testing being CMS-endorsed or approved, though CMS indicated it would continue to provide guidance on annual training and testing requirements.<sup>48</sup> In 2016, the 21st Century Cures Act created a continuous open enrollment and disenrollment period – the first three months of the year (or the first three months of enrollment for a person newly eligible for Medicare). As part of the open enrollment period, the Cures Act prohibited unsolicited marketing and mailing marketing materials to individuals who are eligible for the new open enrollment period.<sup>49</sup>

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<sup>44</sup> Consolidated Appropriations Act for 2001 (P.L. 106-554).

<sup>45</sup> Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275).

<sup>46</sup> CMS Manual System, Pub. 100-16 Medicare Managed Care (Aug. 7, 2009), <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/downloads/r91mcm.pdf>.

<sup>47</sup> Centers for Medicare & Medicaid Services, Contract Year 2009 Marketing Surveillance Summary Report, (ND.), [https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/downloads/surveillance\\_report\\_092309.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/downloads/surveillance_report_092309.pdf); Centers for Medicare & Medicaid Services, Marketing Surveillance Industry Summary Report Contract Year 2010, (Aug. 10, 2010),

<https://www.cms.gov/medicare/health-plans/managedcaremarketing/downloads/surveillancereport081010.pdf>; Centers for Medicare & Medicaid Services, Contract Year 2011 Annual Election Period (AEP), (Sept. 13, 2011), [https://www.cms.gov/medicare/health-plans/managedcaremarketing/downloads/2011\\_aepreport091311.pdf](https://www.cms.gov/medicare/health-plans/managedcaremarketing/downloads/2011_aepreport091311.pdf).

<sup>48</sup> Medicare Program; Contract Year 2016 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 80 Fed. Reg. 7911, 7912 (Feb. 12, 2015), <https://www.federalregister.gov/documents/2015/02/12/2015-02671/medicare-program-contract-year-2016-policy-and-technical-changes-to-the-medicare-advantage-and-the>.

<sup>49</sup> 21st Century Cures Act of 2016 (PL 114-255 § 17005 “Preservation of Medicare Beneficiary Choice Under Medicare Advantage), <https://www.govinfo.gov/content/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf>; See also, Social Security Act §1851(e)(2)(G)(iv).



In 2018, the Trump Administration rolled back commonsense marketing regulations.<sup>50</sup> The 2018 Final Rule significantly redefined marketing in regulations to be a subset of communication materials, and narrowed the definition to focus on materials “intended to draw a beneficiary’s attention to the plan or plans and influence a beneficiary’s decision-making process when making a plan selection.”<sup>51</sup> The rule also removed the requirement that marketing materials include a description of grievance and appeals processes and removed the requirement that plans terminate unlicensed agents and brokers and notify the enrollee.<sup>52</sup> This impedes regulators from identifying bad actors and holding them accountable and fails to inform beneficiaries that they may have received misinformation and could be eligible for a SEP. In 2020, the Trump Administration allowed health plans and their agents to hold educational and marketing events on the same day.<sup>53</sup> On January 19, 2021, CMS issued the 2022 MA and Part D Final Rule that expanded allowable marketing activity in health care settings including in waiting rooms and common entryways.<sup>54</sup>

Under the Biden-Harris Administration, CMS has taken action to address the increase in marketing complaints. In the 2022 Final Rule,<sup>55</sup> CMS required MA plans to increase their oversight over TPMOs and other downstream entities and required TMPOs to add a new disclaimer reporting that they do not offer every plan in a beneficiary’s area.<sup>56</sup> In October 2022, CMS also released sub-regulatory guidance notifying plans that CMS will be conducting more oversight of marketing materials and conducting secret shopper studies during the 2023 Annual Enrollment Period. Starting in 2023, CMS will prospectively review television advertisements to ensure they meet CMS requirements.<sup>57</sup>

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<sup>50</sup> Medicare and Medicaid Programs: Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, etc., Rules and Regulations, 84 Fed. Reg. 6822, 15680 (Apr. 16, 2019), <https://www.regulations.gov/document/CMS-2018-0133-0192>.

<sup>51</sup> Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program, Rules and Regulations, 83 Fed. Reg. 7197, (Apr. 16, 2018), <https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf>.

<sup>52</sup> Ibid.

<sup>53</sup> Medicare Communications and Marketing Guidelines, Centers for Medicare & Medicaid Services, (Aug. 6, 2019), [https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare\\_Communications\\_and\\_Marketing\\_Guidelines\\_Update\\_Memo\\_-\\_8-6-19.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare_Communications_and_Marketing_Guidelines_Update_Memo_-_8-6-19.pdf).

<sup>54</sup> Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, Rules and Regulations, 86 Fed. Reg. 5864, 6108 (Jan. 19, 2021), <https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-00538.pdf>.

<sup>55</sup> Medicare Program: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefits Programs; etc, Rules and Regulations, 87 Fed. Reg. 9375, 27704 (May 9, 2023), <https://www.regulations.gov/document/CMS-2022-0012-4335>.

<sup>56</sup> Ibid at 27822, “Standard Disclaimer --- ‘We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-Medicare to get information on all of your options,’” <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>.

<sup>57</sup> Kathryn A. Coleman, Health Plan Management System (HPMS) Memorandum: CMS Monitoring Activities and Best Practices during the Annual Election Period, CMS, (Oct. 19, 2022), <https://s3.documentcloud.org/documents/23168640/cms-memo-101922-medicare-advantage-marketing.pdf>.

## B. Summary of Medicare Advantage and Part D Marketing Oversight and Enforcement Actions

CMS is responsible for establishing MA and Part D plan marketing requirements, monitoring, and enforcement. CMS Medicare Part C and Part D enforcement actions fall into the following categories: (i) noncompliance with the Medical Loss Ratio requirement for three consecutive years, (ii) engagement in cost-sharing or coinsurance practices that are statutorily prohibited, (iii) failure to provide medically necessary items and services covered by PACE, (iv) administrative issues relating to timeliness, coverage determinations, and appeals, and (v) enrollment issues. The table below summarizes the information posted on the CMS website related to its Part C and Part D Enforcement Actions.<sup>58</sup> The earliest listed action occurred on September 26, 2017, and the most recent action occurred on March 22, 2022.

**CMS Actions by Type Since September 2017**

<b>Action</b>	<b>Number of Medicare Plans</b>
<i>Release</i>	14
<i>Civil Monetary Penalties</i>	41
<i>Suspension of Enrollment</i>	15
<i>Immediate Suspension of Enrollment</i>	3
<i>Immediate Suspension of Enrollment &amp; Marketing</i>	2
<i>Termination</i>	1
<b>Total Actions</b>	<b>76</b>
<b>Total Enforcement Actions</b>	<b>62</b>

Since September 2017, CMS has initiated 76 enforcement actions related to Medicare Part C & Part D Plans. Of the total, 62 were enforcement actions, including civil monetary penalties, suspensions, and terminations. Of these actions, only one enforcement decision was related to deceptive marketing practices.

According to the CMS Notice, a contracted provider clinic for Solis Health Plans, Inc. would market to potential patients with “the promise of transportation, snacks, a clinic tour, and activities.” Interested patients were then “transported to the clinic where Solis agents would conduct a marketing presentation in a secluded area and enroll patients.” Solis enrolled 196

<sup>58</sup> Part C and Part D Enforcement Actions, CMS, (last updated Apr. 11, 2022), <https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartD-EnforcementActions->.

members through this scheme, over 84% (164 beneficiaries) of whom later requested enrollment cancellation or disenrollment.<sup>59</sup>

In addition to marketing audits and enforcement actions, CMS tracks marketing complaints as part of the Complaint Tracking Module (CTM), a centralized database of complaints (and resolutions). Complaints are submitted through Medicare's beneficiary call center (1-800-MEDICARE), State Health Information Assistance Programs, SMP, agents/brokers, and MA and Part D plans. CTM data has been publicly reported as part of the Part D plan Star Rating since 2006, and reported as part of the Part C Star Rating since 2010. While CMS has made changes to the time frame used for this measure over time, the measure has generally incorporated CTM records that include enrollment/disenrollment issues, marketing, benefits, access, quality of care, premium and costs, legal and administrative issues, and provider-specific complaints.<sup>60</sup> CMS standardizes complaints across MA contracts to allow for comparisons across plans of different sizes; complaint rates are standardized as per 1,000 enrollees on a 30-day basis. CMS has increased the weight (or impact) of the complaint measure over time. The complaint measure had a weight of 1.5 prior to 2021; a weight of 2 in 2021 and 2022; and starting in 2023, a weight of 4.<sup>61</sup>

Committee examined complaints for both Part C and Part D measures to assess trends over time and between MA and Part D plans. Using the publicly reported MA and Part D performance measure data reported for plan years 2012 through 2023, we found that complaints among MA and Part D only plans were comparable in 2011 (0.45 in MA to 0.34 among PDPs) and generally decreased through 2018. However, since 2019, complaints among MA plans have increased faster than stand-alone Part D plans.

The Part C and Part D complaint measure is scored as 1 through 5 stars based on the distribution of complaints in that year and a clustering methodology. This means that each year, the threshold to be a high performing contract (5 stars) or a low performing contract (1 star) changes. For example, in 2018 a 5-star MA contract had between 0 and 0.06 complaints per 1,000 enrollees per 30 days, while for 2022, a 5-star plan had between 0 and 0.19 complaints per 1,000 enrollees per 30 days. This means that 5-star plans could have more complaints per enrollee in 2022 than in 2018, reflecting a higher rate of complaints overall. Similarly, plans incurring 0.88 complaints or more in 2018 were designated 1-star plans, while in 2022 plans incurring 1.59 complaints or more were assigned 1-star. By using a relative distribution each year, CMS is grading marketing

<sup>59</sup> John A. Scott, Acting Director, Medicare Parts C and D Oversight and Enforcement Group, "Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug Contract Number: H0982" letter to Daniel Hernandez, Chief Executive Officer, Solis Health Plan, December 4, 2019.

<https://www.cms.gov/medicarecompliance-and-auditspart-c-and-part-d-compliance-and-auditspartcandpartdenforcementactions/solishealthplancomp1242019>

<sup>60</sup> Complaints Tracking Module (CTM) Plan Standard Operational Procedures (SOP), CMS, (May 20, 2019), [https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ctm%20plan%20sop%20eff053019\\_72.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ctm%20plan%20sop%20eff053019_72.pdf).

<sup>61</sup> Star Ratings Technical Notes, CMS, (2019, 2021-2023), <https://www.cms.gov/files/document/2023-star-ratings-technical-notes.pdf-0>, <https://www.cms.gov/files/document/2022-star-ratings-technical-notes-oct-4-2022.pdf>, <https://www.cms.gov/files/document/2021technotes20201001.pdf-0>, <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf>.

complaints on a curve instead of setting clear standards as to what is an acceptable level of complaints.

## Part VII: Policy Recommendations

The pattern of problematic and deceptive marketing activity by private plans identified by this investigation threatens consumer protections under Medicare and suggests a number of commonsense regulatory changes to put the needs of the beneficiary first. This year, CMS has taken some positive steps to address concerning trends, including requiring TPMOs to provide the disclaimer that they do not represent all plans and subregulatory guidance released in October announcing that CMS would resume the conduct of secret shopper studies during the 2023 open enrollment period and start proactively reviewing television advertisements.<sup>62</sup>

However, much more should be done to make sure seniors and people living with disabilities are not subject to harassment, fraudsters, and misleading communications by any plans offering Medicare benefits or their subcontractors. This investigation found evidence that some TPMOs, brokers, and agents are cold calling seniors, enrolling seniors and people living with disabilities in plans without their consent, and enrolling seniors in plans that don't meet their needs. Most troubling, it appears that vulnerable individuals with cognitive impairments and dual eligibility are being targeted. At the same time, since September 2017, CMS has only taken one enforcement action against an MA plan for marketing abuse. Building on these steps, the report makes the following recommendations to CMS and Congress:

**1. Reinstate requirements loosened during the Trump Administration.** Based on the findings of this report, we strongly urge CMS to take decisive action to ensure that the MA program is delivering value for beneficiaries starting with the marketing and enrollment activities conducted by plans and its contracted agents. CMS should reinstate consumer protections in place prior to the Trump Administration, such as:

- Conduct regular proactive oversight over a broad range of marketing materials to ensure that MA plans and their subcontractors are not purposefully misleading beneficiaries.
- Prohibit educational events and marketing events from happening on the same day at the same place.
- Require marketing materials to describe the grievance and appeals process.
- Require plans to report unlicensed agents to the State and notify beneficiaries who were enrolled in a plan by an unlicensed agent.

**2. Monitor disenrollment patterns and use CMS's enforcement authority to hold bad actors accountable.** MA plans have become increasingly complex, creating opportunities for deception and confusion. CMS should track rapid disenrollments and those receiving a Special Enrollment Periods (SEPs) for marketing issues by MA plans as well as by brokers and agents. CMS should

<sup>62</sup> Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022); Kathryn A. Coleman, Health Plan Management System (HPMS) Memorandum: CMS Monitoring Activities and Best Practices during the Annual Election Period, CMS, (Oct. 19, 2022), <https://s3.documentcloud.org/documents/23168640/cms-memo-101922-medicare-advantage-marketing.pdf>.

target low performing contracts for audits to ensure compliance with marketing regulations, and problematic agents and brokers should be reported to the State.

**3. Require agents and brokers to adhere to best practices.** CMS should hold agents and brokers accountable for their actions through their regulations of MA plans such as requiring agents and brokers to review a beneficiary's prescription drugs and regularly visited health care providers to ensure that a new or renewing plan meets a beneficiary's health care needs. Agents and brokers should be held accountable to these best practices by attesting that they have discussed what providers, facilities and prescription drugs may be out-of-network.

**4. Implement robust rules around MA marketing materials and close regulatory loopholes that allow cold-calling.**

- Prohibit MA plans from contracting with TMPOs, agents and brokers that design materials that suggest that they are from the Medicare program or another federal agency. This should include the use of "Medicare" in a business name or the use of the Medicare logo in their marketing materials.
- Prohibit MA plans from contracting with agents and brokers that purchase lists of leads. The generation of leads from online "bait and switch" advertisements as well as more conventional mail marketing and other means to identify seniors who want "more information about their Medicare" is overwhelming seniors with large amounts of confusing mail and aggressive telemarketing.
- Prohibit MA plans from contracting with agents and brokers that call beneficiaries multiple times a day for multiple days in a row.
- Prohibit MA plans and their contracted agents from marketing benefits that are not available in a beneficiary's geography.
- In its Star Rating, MA plans should be accountable for the complaints resolved by CMS as well as those they resolve through the MA Star Rating system. CMS should also set absolute thresholds for each Star ranking to set a clear benchmark that 5-star plans must be the best even if the rate of complaints increases among other plans over time.
- CMS should simplify the process for comparing plans off-line and online. The Medicare Plan Finder should include a way to search and compare MA plan provider networks.
- Review the agent/broker compensation model to ensure that agent/broker incentives align with a beneficiary's interest and do not distort the incentives for choosing in an MA, standard alone Part D, or Medigap plan.
- Require plans to clearly explain the extra benefits including benefits for the chronically ill. CMS should provide model language for MA plan marketing to clearly explain the out-of-pocket costs and network limitations for extra benefits such as dental, vision and hearing as well as the eligibility criteria for Special Supplemental Benefits for the Chronically Ill.

**5. Support unbiased sources of information for beneficiaries, including SHIPs and SMP.**

Departments of Insurance, SHIPs, and the SMP are trusted sources of information for many seniors and people living with disabilities. This report recommends Congress provide sufficient resources to meet the needs of the nearly 60 million seniors and people living with disabilities who could benefit from access to these unbiased counselors. They are valuable partners in

assisting consumers and identifying local and national actors who are misleading or deceiving beneficiaries.

### **Part VIII: Conclusion**

Many MA and Part D plans deliver valued benefits and trusted coverage for millions of Medicare beneficiaries. Once again, however, we are seeing that marketing practices by private plans (or their agents and brokers) need to be reined in: bad actors are trying to cash in by taking advantage of loopholes and loosened rules around marketing and enrollment to beneficiaries – badgering seniors on the phone, confusing them on television, and inundating them with mountains of mail. An increasing number of marketing materials are fraudulent or deceptive, undermining beneficiary access to care and trust in the Medicare program. Of particular concern to the Committee were reports of vulnerable seniors’ and people with disabilities’ health plans without their consent. CMS has broad authority to regulate the marketing and enrollment activities of MA and Part D plans. Congress may need to step in, as it has in the past, but this report identifies a number of commonsense changes CMS could make to protect beneficiaries today.

## Appendices

### Appendix A. Selected Supporting Materials Received by the Committee

- I. **Documents Submitted by Arizona**
  - A. 2020 Medicare Open Enrollment Flyer
  - B. Medicare Eligibility Review Letter
- II. **Documents Submitted by Georgia**
  - A. 2022 Cigna Medicare Advantage Mailer
  - B. Clover Health LiveHealthy PPO Mailer.
  - C. MedicareAdvantage.com About Us Webpage
  - D. North American Senior Benefits Mailer
  - E. WellCare Important Medicare Information Mailer
- III. **Documents Submitted by Missouri**
  - A. 2020 Medicare Has Changed Mailer
  - B. 2020 Medicare Health Plans Evaluation Center for Americans Turning Age 65 Mailer
- IV. **Documents Submitted by Ohio**
  - A. 2022 Benefit Information for Ohio Citizens Only Mailer
  - B. Medicare Card Lookalike
  - C. Medicare Coverage Helpline Mailer
  - D. Medicare Eligibility Notice
  - E. Medicare Resource Center Webpage
  - F. Medicare Savings Program Mailer
  - G. MedicareBus.com Image
- V. **Documents Submitted by Oregon**
  - A. Aetna Medicare Advantage Benefits Table
  - B. Cigna Medicare Supplement Insurance Policy Image
  - C. Medicare at a Glance Flier
  - D. Medicare Benefit Update Mailer
  - E. Original Medicare OR Medicare Advantage Plan Image
  - F. United Healthcare Medicare Advantage Webpage
- VI. **Documents Submitted by Pennsylvania**
  - A. 2022 Commercial with JJ Walker Image
  - B. Medicare Supplement Insurance Advertisement
  - C. Medicare Coverage Helpline Commercial with Joe Namath Image
  - D. Medicare Information – Final Attempt Document
  - E. Medicare Savings Program Postcard
  - F. Unemployment Benefits Guide Urgent Medicare Notice Mailer
  - G. Update for Residents – 2022 Medicare Savings Program Mailer
  - H. [Redacted] Commercial Image

- I. Visa Flex Card Advertisement
  
- VII. **Documents Submitted by the Alliance for Community Health Plans**
  - A. ACHP Comments on MA Marketing Letter
  
- VIII. **Documents Submitted by the National Association of Insurance Commissioners**
  - A. 2021 Benefits Information Mailer – Utah
  - B. CGM Letters – New Mexico
  
- IX. **Document Submitted by the National Organization of Rheumatology Management**
  - A. NORM Letter to CMS
  
- X. **Documents Submitted by Beneficiaries**
  - A. Letter to a Patient



## Appendix B. Summary of Key Stakeholders Involved in Medicare Advantage Marketing

Enrollment in the MA program continues to grow rapidly and with this growth comes increasing pressure for health plans to attract beneficiaries. A cottage industry has formed dedicated to MA marketing. According to a recent Boston Consulting Group study, “The allure of such a large and growing market is obvious.”<sup>63</sup>

CMS delegates the majority of Third Party Marketing Organization (TPMO) oversight responsibilities to the health plans. There is often considerable overlap in activities across different entity types, such as field marketing organizations, agencies, brokerages, lead generators, and other marketing stakeholders. TPMO is a catch-all term to encompass these different stakeholders.

Activities are often subcontracted out multiple times, creating a web of organizations interacting with beneficiaries and placing health plans at “arm’s length” away from lead generators and other marketing entities. There are strong financial incentives for TPMOs to market aggressively and generate leads with only minimal compliance standards.

### Key Stakeholders

**Insurance Carriers:** In the context of this report, insurance carriers are the health insurance companies that have a contractual relationship with CMS also known as Medicare Advantage Organizations (MAOs) and offer health insurance plans, in this case MA plans.

**Third Party Marketing Organizations (TPMOs):**<sup>64</sup> TPMOs are a regulatory term created by CMS that encompasses agents, brokers, field marketing organizations, lead generators or any other third party that may be involved in marketing or communications on behalf of an MA organization. TPMO means 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 (FDR), but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR.

**First Tier, Downstream, or Related Entities (FDR):**<sup>65</sup> First tier entity means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program. A downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization or First Tier Entity.

**Field Marketing Organizations (FMOs):** An organization that sits in between a carrier and agents/brokers, and typically have a subcontractor relationship with the agents/brokers. An FMO typically markets, contracts, and distributes a variety of health and life products to licensed agents; they also may conduct lead generation activities. FMOs typically provide a

<sup>63</sup> “Understanding Customers in a Crowded Medicare Advantage Market.” Boston Consulting Group (2022) <https://www.bcg.com/publications/2022/understanding-customer-in-crowded-medicare-advantage-market>

<sup>64</sup> 42 CFR §§ 422.2

<sup>65</sup> Ibid.

suite of services for agents, from marketing to training to acting as an intermediary for agents to contract with carriers. Sometimes known as Insurance Marketing Organizations (IMOs) and National Marketing Organizations (NMOs) in other types of insurance classes.

**Captive Agencies:**<sup>66</sup> Captive agencies are similar to an FMO in that the organization sits in between the carrier and marketing agents. However, captive agencies have more of an employer/employee relationship with their agents, whereas an FMO has more of a subcontractor type relationship.

**Agents:** A health insurance agent is a licensed professional who can help individuals select a health insurance plan. Agents usually sell insurance products for a single carrier and may be independent, employed by a carrier, work for an agency, or be in a contractual relationship with an FMO.

**Brokers:** A health insurance broker is a licensed professional who can help individuals select a health insurance plan. Brokers usually sell insurance products for multiple carriers.

**Lead Generators:**<sup>67</sup> These entities fall under the definition of TPMO and can be independent or subcontract with many of the entities defined in this section. Many agencies and brokerages conduct their own lead generation activities.

FMOs and other agency structures help insurance carriers recruit large teams of independent agents who are interested in selling for multiple carriers without having to set terms for each person. FMOs help carriers overcome the challenges of contracting with independent agents individually.

To sell for an insurance carrier, agents need a contract, specifications of their duties, agreed upon commissions, and pre-agreed upon terms. While some carriers offer contracts to independent agents, carriers will typically work with a third party. Agents typically access a carrier's products through two avenues: either join the carrier as a captive agent that only sells the given carrier's policies or join a third party with one of these contracts (often an FMO).

FMOs, captive agencies, and other similar TPMOs generate revenues based on the agents' commissions from sales of an insurance product. Captive agencies provide services such as a book of business, office space, and branding for their agents. Captive agencies often keep a significant percentage of an agent's commissions given the range of services they provide, whereas FMOs often provide fewer services and therefore take a smaller percentage of commissions. FMOs and other similar TPMOs may have fairly exclusive relationships with a single carrier, but it is more common for them to work with many carriers in the same market.

<sup>66</sup> In 42 CFR §§ 422.2274, CMS requires the MA organization to report if it intends to use employed, captive, or independent agents or brokers in the upcoming plan year and the specific rates or range of rates the plan will pay independent agents and brokers

<sup>67</sup> CMS defines TPMOs in §§ 422.2260 and 423.2260 as being organizations that are compensated to perform lead generation [and other activities]. CMS references lead generation 12 times in 87 Fed. Reg. 27704, 27704-27902 (May 9, 2022).

Lead generation is a specific function focused on identifying individuals for targeting the sale of products. This function often sits within a TPMO, which conducts its own lead generation activities. There are also specific firms that focus exclusively on lead generation. Lead generation often entails pulling public information on sales targets (e.g., census data, voter registration files, data aggregator files), sending out mass mailers, and, increasingly, establishing online methods for lead generation. The case study on Aggressive Lead Generation covers some deceptive lead generation tactics identified through this investigation.