COMMENTARY

Addressing the Marketing Practices of Medicare Advantage Plans

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The Medicare Advantage (MA) Program, home to nearly half of the eligible Medicare population, has recently come under increased scrutiny. Recent investigations conducted by the United States Senate Committee on Finance and Centers for Medicare & Medicaid Services (CMS) have uncovered marketing practices of MA insurance agents that "were not complying with current regulation and unduly pressuring beneficiaries, as well as failing to provide accurate or enough information to assist a beneficiary in making an informed enrollment decision." These findings come at a time in which MA programs are under investigation for denials of prior authorization requests that fall within Medicare guidelines for covered health services. In this Commentary we consider the backdrop for the growing scrutiny of the MA program and the implications thereof to its future trajectory. (J Am Board Fam Med 2024;37:494–496.)

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Medicare Advantage Programs (MAPs) constitute an alternative Medicare option available to seniors wherein private insurers contract with Medicare to provide benefits to enrollees. MAPs have experienced enormous growth in the past decade in that 30.8 million seniors, more than half of all eligible Medicare enrollees, are presently covered by a MAP.[1] Despite this growth, MAPs have come under heavy scrutiny by the federal government for multiple issues related to noncompliant prior authorization (PA) denials and, more recently, specious marketing practices in which seniors were unduly pressured to enroll into MAPs under false pretenses.

Unlike Medicare proper, MAPs require PAs for an extensive range of health services. By law, MAPs must abide by the clinical coverage rules set by Medicare in their PA decision making. Of the roughly 2 million PA denials last year, however, only 11% were appealed, yet 82% of these appeals were either completely or partially overturned, casting doubt on the legitimacy of these denials.[2] With the wave of growth in artificial intelligence (AI), the problem of PA denials is likely to worsen in that recent Senate probes into MAPs revealed the use of AI algorithms in the MAP decision making processes.[2] While insurers have utilized computerized algorithms in the past, federal guidelines mandate that these proprietary algorithms can only be used to help guide rather than dictate PA decision making. Both UnitedHealth and Cigna are facing lawsuits alleging the use of automated tools to deny PAs. One report even states that Cigna denied over 300,000 claims over a 2 month timespan, equating to approximately 1.2 seconds spent in the review of each claim.[3] Although the use of AI technology has likely increased the efficiency of PA decision making, the relatively high rates of successful PA appeals call into question the efficacy of the reliance on AI for such decision making.[4]

Despite this scrutiny, private insurance companies entering the MA market have proven financially successful. Findings from the past 8 years reveal that MAPs consistently enjoy the highest gross margins, a measure of an insurance company's profitability, among all other health insurance markets.[5] In 2021, MAPs recorded an average gross margin of $1730 per enrollees, a $962 increase compared with the average gross margins of $768 for enrollees in a traditional Medicare program.[5] These prospects have driven some companies, such as Humana Inc. to

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announce plans to exit the employer-sponsored health insurance market altogether in pursuit of increasing their stake in the MAP market.[5]

Despite these drawbacks, the number of enrollees in MAPs continue to grow year after year.[6] While MAPs have an obvious incentive to increase enrollment, with insurers such as UnitedHealth alone profiting $14.4 billion last year, the increasing willingness of consumers to enroll in a MAP is not as clear. In an October 19, 2022 memo from the Centers for Medicare & Medicaid Services (CMS), Director Kathryn A. Coleman notes that, potentially specious marketing practices that "overstate the available benefits, as well as use words and imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government" are a likely the culprit for the rise in MA enrollment.[7] Director Coleman further reveals that her agency received thousands of complaints from beneficiaries about the marketing tactics of MAPs while citing the use of "confusing, misleading and/or inaccurate" information to persuade consumers to join.[7] To investigate this issue further, CMS made use of a practice known as "secret shopping" wherein CMS employees, posing as prospective enrollees, called the numbers listed on MAP advertisements.[7] Marketing agents for these advertisements "were not complying with current regulation and unduly pressuring beneficiaries, as well as failing to provide accurate or enough information to assist a beneficiary in making an informed enrollment decision."[7] In the wake of the aforementioned memo, an investigative report by the Majority Staff of the United States Senate Committee on Finance discovered "egregious" and "predatory" MAP marketing practices that supported Director Coleman's claims.[6] The findings revealed the MAPs to use misleading materials with designs intent on mimicking official documents from Federal agencies. MAP marketers also proved overly aggressive in their tactics with claims that would pressure seniors at their local grocery stores to switch to a MAP. Other findings of this investigation reported that insurance agents from various MAPs would call individuals over 65 more than 20 times a day during open enrollment periods.

As a result of the aforementioned findings, CMS as of January 2023 no longer allows misleading advertisements to be shared on television. CMS has also enacted more stringent review criteria for the approval process of all MAP marketing material. In addition, CMS expressed a commitment to directing their regulatory efforts at any and all known offenders in marketing.[7]

These findings are especially concerning for members of marginalized communities in that studies show that "people from racial and ethnic minority groups, such as Blacks and Hispanics, were noted to have lower financial/health literacy than White non-Hispanics in the US."[8] This means that these groups may have been the target of exploitative practices by MAP marketers. Racial minorities are also more likely to encounter financial barriers in accessing health care meaning issues related to the denial of PAs have likely disproportionately affected these communities, further calling into question issues of equity as they relate to health care.[8]

Since family medicine physicians deliver the bulk of the nation's primary care services, these clinicians often have longstanding relationships with patients. As such, they have a unique understanding of their patients' specific health needs and are in a position to educate patients about the recent issues related to MAPs to assist them in making an informed enrollment decision. In addition, family physicians should be aware of the issues of PA denials for MAPs and encourage patients to appeal decisions that the clinician believes were made in error.

While the increased scrutiny and regulation from government agencies constitute an encouraging step forward toward addressing misleading marketing practices, continued, robust oversight will be required to ensure that MAPs are compliant with current guidelines. In addition, efforts should be taken on multiple fronts to increase public awareness of the current issues plaguing MAPs as many seniors who fell victim to previous noncompliant marketing tactics may still be unaware of these problems. CMS could also consider a nationwide mandate for MAPs to communicate the recent findings of their investigation to their enrollees concurrent with the option of a special enrollment period for all current MAP enrollees. This action would allow seniors who enrolled into MAPs under the influence of misleading marketing practices the option to re-enroll in a traditional Medicare program. Fraud and violation of contract constitute grounds for an enrollee to qualify for a special enrollment period. Considering the findings from the Senate and the CMS investigations that have proven widespread fraud and breach of contract with the MAP insurers, this proposal is reasonable. In

addition, this action could increase self-regulation within the MAP industry to hold each other accountable to comply with CMS guidelines and prevent future transgressions. Although allowing current MAP enrollees the option to switch to Medicare proper would likely be widely unpopular among MAPs, it would ensure that access to care and enrollee decision making is prioritized.

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