BAIT AND SWITCH: HOW MEDICARE ADVANTAGE PLANS ARE SWINDLING MEDICARE-ELIGIBLE PERSONS AND THE FEDERAL GOVERNMENT

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I. Introduction

Fitness programs, over-the-counter medication credits, and hearing aid benefits, are just a few of the many benefits UnitedHealthcare offers to its Medicare Advantage Plan (Part C) enrollees.[1] Among those enrollees was 97-year-old, Paula Christopherson.[2] While under a UnitedHealthcare Medicare Advantage Plan, Ms. Christopherson suffered a severe fall, landing her in a skilled nursing facility for eleven days.[3] At the eleven day mark, her nurses and doctors knew she was not healthy enough to return home, but her insurers—individuals who had never laid eyes on her—told her further care was unnecessary and she needed to return home; they were no longer covering her health services at the facility.[4] In addition to the stress of recovery, the 97-year-old was forced to make a decision, return home and risk further injury or failed recovery, appeal the insurer's decision, or pay thousands of dollars out of pocket to stay in the skilled nursing facility.[5]

Unfortunately, Ms. Christopherson is not alone in her difficulties. In 2022, the U.S. Department of Health and Human Services (HHS) found private insurers improperly deny "medically necessary care" to tens of thousands of Medicare Advantage (MA) Plan enrollees every year.[6] Despite hundreds of thousands of claims being inappropriately denied, individuals are enrolling in MA Plans at seemingly exponential rates.[7] By expanding advertisement mediums to robo-calls, mailers, and television commercials, MA Plans are reaching a larger population than ever before.[8] These advertisements promise larger Social Security checks, increased benefits, and lower co-pays, incentivizing Medicare-eligible individuals to enroll in an MA Plan.[9] While the benefits seem unrefusable, these advertisements often fail to properly disclose the fine print conditions of these benefits, misleading and misinforming enrollees, perpetuating marketing abuse

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[1] UNITEDHEALTHCARE**,** https://www.uhc.com/medicare/shop/medicare-advantage-plans.html (last visited Apr. 12, 2023).
[2] Jaffe, Susan, *Nursing Home Surprise: Advantage Plans May Shorten Stays to Less Time Than Medicare Covers*, KFF HEALTH NEWS (Oct. 4, 2022, 8:00 AM), https://khn.org/news/article/nursing-home-surprise-medicare-advantage-plans-shorten-stays/.
[3] *Id*.
[4] *Id*.
[5] *Id*.
[6] U.S. DEPT. OF HEALTH AND HUM SERV. OFF. OF INSPECTOR GENERAL, SOME MEDICARE ADVANTAGE ORGANIZATION DENIALS OF PRIOR AUTHORIZATION REQUESTS RAISE CONCERNS ABOUT BENEFICIARY ACCESS TO MEDICALLY NECESSARY CARE (2022) [hereinafter HHS-OIG Report].
[7] STEVEN FINDLAY, GRETCHEN JACOBSON, FAITH LEONARD, *The Role of Marketing in Medicare Beneficiaries' Coverage Choices*, THE COMMONWEALTH FUND (Jan. 5, 2023), https://www.commonwealthfund.org/publications/explainer/2023/jan/role-marketing-medicare-beneficiaries-coverage-choices?utm_source=alert&utm_medium=email&utm_campaign=Improving+Health+Care+Quality (finding Medicare Advantage Plan enrollment is up nearly 36% from 2016, with over 28 million enrollees in 2022).
[8] U.S. COMM. ON. ON FIN., DECEPTIVE MARKETING PRACTICES FLOURISH IN MEDICARE ADVANTAGE: A REP. BY THE MAJORITY STAFF OF THE U.S. SENATE COMM. ON FIN. (2022) [hereinafter Finance Committee 2022 Report].
[9] Amanda Seitz, *Biden Administration Proposes Crackdown on Medicare Scam Ads*, Associate Press News (Dec. 14, 2022), https://apnews.com/article/health-medicare-government-and-politics 19ce28f3a5919d27cbff3dcb6d19c6e7.

of a vulnerable population.[10] In addition to the false and misleading advertising, MA Plans are facing scrutiny for overstating and falsifying enrollees' diagnoses and illnesses, resulting in substantial overpayments to the private insurers.[11]

Despite promising greater and more inclusive benefits, MA Plans have restricted healthcare access for participants, deceived Medicare-eligible individuals through advertisements, and inappropriately over collected payments at the expense of their plan participants.[12] Given the ongoing misbehavior of private organization's MA Plans, the current laws need to be changed to protect MA Plan participants from improper prohibition to healthcare access, mitigate aggressive and misleading MA Plan advertisements, and prevent overcompensation of Medicare Advantage Organizations (MAOs). The law should provide a streamlined, expedited process for MA denial appeals, implement harsher penalties for improper marketing, and require CMS to utilize mechanisms currently in place to reduce overpayments to MAOs.

II. The History of Medicare and Medicare Advantage Plans

In 1965, President Lyndon B. Johnson signed Title XVIII and XIX of the Social Security Act into law, creating what is now known as Original Medicare.[13] The first federally-funded health insurance, Original Medicare provided health insurance benefits to a majority of individuals 65 and older.[14] Original Medicare benefits only covered two categories of health services—Part A, hospital coverage, and Part B, physician and out service coverage.[15] Any individual who satisfied the basic qualifications, was automatically enrolled in Part A.[16] Any person enrolled in Part A was eligible to receive Part B coverage, but they had to select enrollment and pay a small premium for the benefits.[17] In less than a year, over 19 million individuals were enrolled in the original Medicare program.[18]

This expansive program is overseen by the HHS, and after the exponential enrollment, the Health Care Financing Administration (HCFA) subagency was formed to monitor, regulate, and oversee Medicare and Medicaid.[19] In 2001, the HCFA was renamed to Centers for Medicare and Medicaid Services (CMS), but its function of managing, maintaining, and regulating Medicare remained the same.[20]

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[10] U.S. Comm. On Fin., *supra* note 8.
[11] Amanda Seitz, *Feds Expect To Collect $4.7B In Insurance Fraud Penalties*, Associate Press News (Jan. 30, 2023), https://apnews.com/article/health-business-fraud-medicare-c17b938660ff8b211871b455b49cf8c9. The Biden Administration expects to recoup as much a $4.7 billion in overpayments over the next ten years.
[12] Fred Schulte, *Did Your Health Plan Rip Off Medicare?*, KFF News (Jan. 27 2022), https://khn.org/news/article/medicare-advantage-audits-investigation-cms-overpayment-recoup-billions/; Seitz, *supra* note 11.
[13] CENTERS FOR MEDICARE AND MEDICAID SERV., https://www.cms.gov/About-CMS/Agency-Information/History (last visited Apr. 12, 2023).; NAT'L ACAD. OF SOC. INS., https://www.nasi.org/learn/medicare/the-history-of-medicare/. (last visited Mar. 3, 2023).
[14] CENTERS FOR MEDICARE AND MEDICAID SERV., MILESTONES 1937-2015 (discussing how Medicare's funding comes from a federal tax collected on the earnings of employees and matched by employers).
[15] *Id.*
[16] NAT'L ACAD. OF SOC. INS., *supra* note 13 (finding that to qualify for Social Security, a person must be 65 years old and eligible for Social Security. Social Security eligibility requires a person work for at least forty quarters (ten years) throughout their life).
[17] *Id.*
[18] MILESTONES 1937-2015, *supra* note 14 at 3.
[19] HEALTH CARE FINANCE ADMINISTRATION, https://www.federalregister.gov/agencies/centers-for-medicare-medicaid-services (last visited Mar. 18, 2023).
[20] *Id.*

In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) was passed, creating the foundation for MA Plans.[21] TEFRA allowed Medicare to contract with private health insurance providers, making the private insurers responsible for enrolled participants, in exchange Medicare paid the insurer capitated payments.[22] In 1997, the Balanced Budget Act (BBA) formally recognized the at-risk contracting, naming it Medicare+Choice, and allowed providers to offer different types of plans, including preferred-provider organizations (PPO), provider-sponsored organizations (PSO), and private-fee-for-service plans (PFFS).[23] In passing the BBA, Congress sought to reduce the exponentially growing Medicare costs by contracting with private insurers.[24] However, this original intent proved to be incredibly off-base, as current MA Plans cost the government approximately $321 more per person than Traditional Medicare (TM).[25]

Since 1982, several other Parts of Medicare have formed, giving Medicare-eligible individuals options for health care coverage and prescription drug coverage.[26] However, the foundations of coverage options remain the same—eligible persons may elect Traditional Medicare (TM), whose healthcare coverage is provided by the government, or a Medicare Advantage (MA) Plan, in which a private insurer provides healthcare coverage.[27]

III. Understanding Medicare Advantage Plans

When an individual elects to enroll in an MA Plan, they pay the elective Part B premium to Medicare, as well as any supplemental premium required by the private health insurance provider.[28] Each month, the private companies receive a fixed payment from Medicare, in addition to any supplemental premium paid by the plan participant.[29] Because the programs are federally supervised and partially funded by the government, MA Plans are required to maintain minimum benefits which are reflective of Original Medicare, Part A and Part B.[30] Thus, to compete with TM and other plans, private insurers use supplemental benefits to incentivize participants.[31] Though the programs are required to provide health care services in line with those of TM, they

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[21] THOMAS MCGUIRE, JOSEPH NEWHOUSE, & ANNA SINAIKO, *An Economic History of Medicare Part C*, 89 THE MILBANK QUARTERLY (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270

[22] *Id*. (Explaining that this allowed Medicare-eligible individuals to select a private plan as opposed to traditional Medicare).

[23] *Id*.

[24] *Id*.

[25] JEANNIE BINIEK, JULIETTE CUBANSKI, & TRICIA NEUMAN, *Higher and Faster Growing Spending Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges*, KFF News (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 (Finding CMS spent an additional $7 billion on MA Plan spending, compared to Traditional Medicare).

[26] MEDICARE, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices (last visited Mar. 23, 2023) (noting, since 1982, Part D has been added which provides prescription drug coverage, and Medigap policies now exist to provide supplemental benefits for Parts A and B).

[27] *Id*.

[28] THOMAS MCGUIRE, JOSEPH NEWHOUSE, & ANNA SINAIKO, *supra* note 21, at 4 (stating that not all MA plans require an additional premium); MEREDITH FREED, JEANNIE BINIEK, ANTHONY DAMICO, & TRICIA NEUMAN, *Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings*, KFF News (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/) (finding 69% of MA Plans do not require supplemental premium).

[29] THOMAS MCGUIRE, JOSEPH NEWHOUSE, & ANNA SINAIKO, *supra* note 21 (finding capitations paid by Medicare are risk-based, fixed payments. Medicare uses formal risk adjustment to set a "per-member-per-month" payment price for each participant using demographics like age, gender, Medicaid eligibility, institutional status, and geographic location).

[30] *Id*.

[31] *Id*. (Noting MA Plans originally only offered supplemental benefits like: dental coverage for cleanings; vision coverage for eyeglasses and eye exams; and reduced premiums, co-payments, and out-of-pocket costs. These supplemental benefits have now extended to both health non-health related benefits like, fitness club memberships, credits for groceries, pet food, transportation to appointments, and increased Social Security payments).

are permitted to regulate how a participant receives health services and charge different costs for services, out-of-pocket expenses, and deductibles.[32] While those enrolled in TM may receive health services from any physician or facility that accepts Medicare, MA Plans often restrict participants' coverage to "in-network" physicians and facilities, require prior authorizations or referrals, and/or limit supplemental coverages, like drug benefits.[33] These limitations may result in a smaller pool of treatment facilities, physicians, and providers. [34]

MA Plans typically also come with geographical restrictions, limiting enrollees to coverage within their plan's service area.[35] While TM travels with enrollees anywhere within the confines of the United States, MA Plans typically only provide coverage for health services within the Plan's service area.[36] Service areas vary based on the Plan, some may be restricted to a single county, while others may provide nationwide coverage.[37] Location, namely zip code, will impact the plan options offered to a participant, network of physicians and facilities, participant's premium costs, supplemental benefits, and covered service area.[38]

Although they are not permanent, a participant may not drop or switch an MA Plan at any time.[39] A majority of MA plans prohibit unenrollment for one calendar-year after joining the MA Plan.[40] Even after the one-year period has expired, MA Plan participants may only drop or switch their MA Plan during two periods a year: Open Enrollment Period, which runs from October 15-December 7, or Medicare Advantage Open Enrollment Period, which runs from January 1-March 3.[41] Thus, it is crucial MA Plan participants inquire as to whether their providers are in-network, understand the offered supplemental benefits and their limitations, and consider other potential prohibitors, before enrolling in a MA Plan.[42]

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[32] U.S. DEPT. OF HEALTH AND HUM. SERV. CENTERS FOR MEDICARE AND MEDICAID SERV., UNDERSTANDING MEDICARE ADVANTAGE PLANS (2022).

[33] Anna Porretta, *Know The Pros & Cons of Medicare Advantage Plans*, EHEALTH (Aug. 4, 2022), https://www.ehealthinsurance.com/medicare/parts/what-are-the-pros-and-cons-of-switching-to-a-medicare-advantage-plan (noting "in-network" refers to a group of physicians and facilities who have contracted with the private insurer to provide services at a lower cost to the insurance company).

[34] GRETCHEN JACOBSON, MATTHEW RAE, TRICIA NEUMAN, KENDAL ORGERA, AND CRISTINA BOCCUTI, *Medicare Advantage: How Robust Are Plans' Physician Networks?*, KFF News (Oct. 5, 2017), https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/ (finding in 2017, KFF's survey of 391 MA plans in twenty counties found Medicare Advantage networks included less than half (46%) of all physicians in a county, on average).

[35] U.S. DEPT. OF HEALTH AND HUM. SERV. CENTERS FOR MEDICARE AND MEDICAID SERV., *supra* note 32 at 5.

[36] UNITEDHEALTHCARE INSURANCE COMPANY, https://www.uhc.com/medicare/medicare-education/medicare-advantage-plans.html (last visited Apr. 14, 2023).

[37] DEPT. OF MGMT. SERV., 2023 CONTRACTED ADVANTAGE & PRESCRIPTION DRUG (MA-PD) PLAN SERVICE AREAS (2023) (describing visual aid representing the service coverage areas for the Medicare Advantage and Prescription Drug (MA-PD) Plan Service Areas of the two HMOs and PPO offered by the Division of State Group Insurance in 2023. One HMO program offered limits its service area to seven counties in the Panhandle of Florida. The second HMO program extends its service area throughout forty-three Florida counties, sporadically covering counties from the western-most point through the southeastern coast. Seventeen counties do not qualify as a service area for any HMO offered by the Division of State Group Insurance. A third option, and the only PPO, provides nationwide coverage, including all sixty-seven Florida counties).

[38] U.S. DEPT. OF HEALTH AND HUM. SERV. CENTERS FOR MEDICARE AND MEDICAID SERV., *supra* note 32, at 5.

[39] *Id*. at 14.

[40] *Id*. (Stating that enrollees may only drop MA Plans within three months if they enrolled during their initial enrollment period. The initial enrollment period is only offered once a person's lifetime, it begins three months before the enrollee's 65th birthday and extends three months after their 65th birthday. If a person enrolls during this period, they may drop the MA Plan within three months of enrollment).

[41] U.S. DEPT. OF HEALTH AND HUM. SERV. CENTERS FOR MEDICARE AND MEDICAID SERV., *supra* note 32, at 13 (noting participants who change plans will not be switched over until January 1st of the upcoming year. During the Open Enrollment Period, any Medicare-eligible person may drop, add, or switch their plan between TM and MA Plans. During the Medicare Advantage Enrollment Period, only MA Plan participants may drop or switch their MA Plan. MA Plan participants are also limited to one change during this MA Open Enrollment Period, thus if a person switches from MA Plan X to MA Plan Y, they may not switch to a different MA Plan, nor drop the plan for TM.

[42] UNDERSTANDING MEDICARE ADVANTAGE PLANS, *supra* note 32.

IV. Improper Denials

In 99% of MA Plans, the Plan participant must receive prior authorization from their plan provider before receiving health care services.[43] So, if a patient requests authorization for medical services, but the insurer denies or delays approval of the service, that patient is left with limited options: (1) pay for the service out of pocket with the risk of not receiving reimbursement, (2) forego the health service, or (3) appeal the denial.[44] In 2021 alone, more than two million MA Plan participants were denied authorization for medical or health services.[45] Approximately 220,000 of those denials were appealed; of those appealed, over 82% were overturned and authorized.[46] In its 2022 Report[47], the HHS Office of the Inspector General (HHS-OIG)[48] found an estimated 1,631 requests were improperly denied in a one-week span—projecting nearly 85,000 improper denials that year.[49] Through its investigation, the HHS-OIG found MA Plan providers were "applying…clinical criteria that are not contained in Medicare coverage rules," thus making it unreasonably burdensome for participants to receive authorization for health services.[50]

Among these denials was Patient X, a 76-year-old plan participant who requested a walker due to disabilities caused by post-polio syndrome. Despite Patient X's medical history and risk of falling, coupled with the doctor's notes deeming the walker medically necessary, Patient X's MA Plan denied the request.[51] The Medicare Advantage Organization (MAO)[52] stood by its denial, claiming the participant received a cane in the five years prior and was only entitled to one

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[43] MEREDITH FREED, JEANNIE BINIEK, ANTHONY DAMICO, & TRICIA NEUMAN, *supra* note 21.
[44] JILL HALLORAN, *CAN MY MEDICARE ADVANTAGE PLAN DENY MY COVERAGE?*, EHEALTH (JAN. 17, 2023), https://www.ehealthinsurance.com/medicare/parts/can-my-medicare-advantage-plan-deny-my-coverage/.
[45] JEANNIE BINIEK & NOLAN SROCZYNSKI, OVER *35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021*, KFF News (Feb. 2,2023), https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/.
[46] *Id*. (Determining the rate of overturned denials is up 5% from the 75% overturn rate in the 2014-2016 audit conducted by HHS-OIG).
[47] HHS-OIG REPORT, *supra* note 6, at 2 (clarifying the audit **"**sampled 250 denials of prior authorization requests and 250 payment denials issued by 15 of the largest MAOs during June 1−7, 2019.").
[48] STATEMENT OF ORGANIZATION, FUNCTIONS, AND DELEGATIONS OF AUTHORITY, 83 FED. REG., 55553 (Nov. 6, 2023) (explaining that as the federal agency overseeing Medicare, HHS has created the Office of Inspector General (OIG) to "carry out the mission of preventing fraud and abuse and promoting economy, efficiency, and effectiveness of HHS programs and operations." In achieving this mission, the OIG is tasked with supervising operations, conducting investigations and audits, and detecting "wrongdoers and abusers of HHS programs[….]so appropriate remedies…including imposing administrative sanctions against providers of health care under Medicare[…]who commit certain prohibited acts.").
[49] HHS-OIG REPORT, *supra* note 6, at 13 (explaining that MA Plans are required, at minimum, to provide the same coverage Traditional Medicare would provide, and they must follow the national and local coverage determinations provided by TM. MAOs may implement requirements like prior authorizations and coverage for in-network providers only, but they may not develop criteria "more restrictive than [Traditional] Medicare's national and local coverage policies." In its report, the HHS-OIG deemed denials improper for the heightening the treatment requirements set forth in the national and local coverage determinations. By imposing stricter clinical criteria, the MA Plans improperly denied coverage that would have been provided through TM).
[50] *Id*. at 10 (Stating that in its report, the HHS-OIG found an MA Plan improperly denied a patient's prior authorization request for a follow-up MRI because the patient's lesion was less than two centimeters in length. Eight months prior to the denied request, the patient received an MRI to examine adrenal lesions; after eight months, the doctors wished to perform a second MRI of the non-cancerous lesions. The patient's MA Plan denied the prior authorization because the lesion was under two centimeters and any lesions under two centimeters only permitted coverage for one MRI per year—a clinical criteria outside of Medicare coverage rules).
[51] *Id*. at 14.
[52] CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE DIABETES PREVENTION PROGRAM (2022) (explaining that "[a]n MAO is the legal entity that has a contract with the Medicare program to provide coverage.").

assistive-walking device every five years.[53] After reviewing the denial, the HHS-OIG found the Plan's reasoning in violation of local coverage requirements and found the ambulatory device medically necessary, as the patient "could not walk safely with only a cane."[54]

Though Patient X's quality of life was deeply hindered, other victims of denial might consider her a "lucky one", since her condition was not as time sensitive as other denials for service requests like cancer treatment.[55] Patient D421, an 81 year-old woman, faced substantial delays in her endometrial cancer treatment when her MA Plan denied coverage for a Computed Tomography Scan (CT Scan) to determine the progression of the cancer.[56] The MAO supported their denial by citing their clinical criteria requiring "information to support that the disease had spread[…]or that the tumor was advanced."[57] More than five weeks later, the HHS-OGI's investigating physicians found the CT Scan was medically necessary and deemed the Plan's denial improper for creating stricter clinical than the local and national coverage determinations.[58]

For patients suffering from critical, aggressive, and/or time sensitive health issues, these denials may result in adverse outcomes, including permanent disabilities and death.[59] The delays brought on by improper denials are not just a burden, they are a danger for patients receiving medical care.[60] While some patients are fortunate enough to have their improper denial overturned in just five weeks, like Patient D421, few see such quicks responses, as less than 3% of improper denials are overturned within ninety days.[61]

Despite the hundreds of thousands of improper denials, these private insurers fail to face any serious repercussions.[62] In February 2022, CIGNA Corp., the third largest insurance company in America—worth more than $150 billion—was fined $126,988 for failing to properly provide coverage to its MA Plan participants.[63] Less than one month later, CIGNA was fined another $85,436 for "fail[ing] to comply with Medicare requirements."[64] Together, these civil monetary punishments cost CIGNA less than .00004% of its annual profit, and less than .0000015% of its total wealth.[65] Because of these inconsequential monetary punishments imposed by CMS, third-parties, like American Optometric Association (AOA), are calling upon the Department of Justice (DOJ) to take action against Medicare Advantage Organizations (MAOs) for illegally denying and

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[53] HHS-OIG REPORT, *supra* note 6, at 10.
[54] *Id*. (Noting that MA plans cannot implement additional treatment requirements not set forth by the national and local coverage determinations. The HHS-OIG found requiring five years to pass before a participant could receive an additional ambulatory device exceeded the requirements laid out in traditional Medicare and therefore violated the local coverage determination, making the criteria overly burdensome and improper).
[55] MEGAN BROOKS, '*Bane of My Existence:' The Burden of Medicare Advantage* Denials, MEDSCAPE (May 10, 2022), https://www.medscape.com/viewarticle/973718?reg=1.
[56] HHS-OIG REPORT, *supra* note 6, at 38.
[57] *Id*.
[58] *Id*.
[59] AMERICAN MEDICAL ASSOCIAT'N, *2022 AMA Prior Authorization (PA) Physician Survey* (2022) (finding that "34% of physicians reported that prior authorization led to a serious adverse event for a patient in their care, including hospitalization, medical intervention to prevent permanent impairment, and even disability or death.").
[60] *Id*.
[61] HHS-OIG REPORT, *supra* note 6, at 31 (finding less than 3% of denials of prior authorization requests that met Medicare coverage rules and were reversed within three months).
[62] DIANE ARCHER, *Government Rules Will Not Curtail Medicare Advantage Bad Acts Without Stiff Penalties*, JUSTCARE (Dec. 21, 2022), https://justcareusa.org/government-rules-wont-curtail-medicare-advantage-bad-acts-without-stiff-penalties/.
[63] DEPMT. OF HEALTH & HUM. SERV. CENTERS FOR MEDICARE & MEDICAID SERVICES, NOTICE OF IMPOSITION OF CIVIL MONEY PENALTY FOR MEDICARE ADVANTAGE-PRESCRIPTION DRUG CONTRACT NUMBERS: H0354, H0439, H1415, H2108, H3949, H4407, H7020, H9460, AND H9725 (2022).
[64] DEPMT. OF HEALTH & HUM. SERV. CENTERS FOR MEDICARE & MEDICAID SERVICES, NOTICE OF IMPOSITION OF CIVIL MONEY PENALTY FOR MEDICARE-MEDICAID PLAN CONTRACT NUMBERS: H0354, H0672, H1415, H2108, H3949, H4407, H4513, H7020, H7787, H7849, H9725, S5617, S5660 (2022).
[65] FORBES, https://www.forbes.com/companies/cigna/?sh=3faeffea9742 (last visited Apr. 3, 2023).

improperly restricting plan participants' "access to medically necessary care."[66] Groups like the AOA are rightfully advocating, for without proper and significant punishments, MAOs will continue to improperly deny coverage and restrict participants' health care access, as evidenced by the increase from an estimated 84,000 improper denials in 2019[67] to approximately 180,000 in 2021.[68]

V. Misleading, Abusive, and False Marketing

Pet food, carpet shampooing, acupuncture, pest control, and gym memberships are a few of the supplemental benefits MA Plans may offer for their participants.[69] Originally, MA Plans were only permitted to provide supplemental benefits which were primarily health related.[70] However, in 2018, CMS elected to reinterpret the definition of "primarily health related" and extended the scope to include "item[s] or service[s] … used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduce[] avoidable emergency and healthcare utilization."[71] So, while MA Plans may market these lavish services to all enrollees, participants are only entitled to services which are "recommended by a licensed medical professional" and directly benefit their health. [72] Thus, pet food and other animal-related expenses may only be covered for participants who have a service animal, while the pest control may only be provided for participants whose condition is aggravated by bugs, pests, or rodents.[73]

In 2019, CMS once again extended supplemental benefits to allow MA Plans to offer non-health related supplemental benefits like: meals, transportation to and from grocery stores, food and produce to improve nutritional intake, structural home modifications, and social club memberships, for chronically ill Plan participants only.[74] While these supplemental benefits are attractive to all, they only apply to *chronically ill* enrollees.[75] Yet despite this barrier to qualification, MA Plans advertise these benefits to all without drawing attention to the requirements; as a result, consumers enroll in MA Plans seeking supplemental benefits for which they do not qualify for and thus never receive.[76] In a survey conducted by The Commonwealth

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[66] AMERICAN OPTOMETRIC ASSOCIATION, https://www.aoa.org/news/advocacy/third-party/medicare-advantage-claim-denials?sso=y (last visited Apr. 16, 2023).
[67] HHS-OIG REPORT, SUPRA note 6, at 9 *(*finding in just one week 1,631 improper denials occurred, resulting in an estimated 84,812 improper denials in the 2019 service year).
[68] JEANNIE BINIEK & NOLAN SROCZYNSKI, *supra* note 45 (determining MAOs denied over 2 million prior authorization requests, only 11% were appealed, and 82% of the appeals resulted in a partial or full overturning of the denial).
[69] JON BLUM, *Pet Food, Pest Control, A Ride to Church: Medicare Advantage Has Expanded Benefits, but Will They Make People Healthier?*, ARNOLDVENTURES (Feb. 24, 2020), https://www.arnoldventures.org/stories/pet-food-pest-control-a-ride-to-church-medicare-advantage-has-expanded-benefits-but-will-they-make-people-healthier).
[70] DEPMT. OF HEALTH & HUM. SERV. CENTERS FOR MEDICARE & MEDICAID SERVICES, REINTERPRETATION OF "PRIMARILY HEALTH RELATED" FOR SUPPLEMENTAL BENEFITS (2018).
[71] *Id*.
[72] STEVE ISRAEL, *Medicare Plans: Be Wary of Joe Namath, Other Celebrity Pitchmen*, TIMES HERALD-RECORD (Nov. 5, 2021), https://www.recordonline.com/story/opinion/2021/11/05/steve-israel-celebrities-pitching-medicare-plans/6297275001/.
[73] PAIGE MINEMYER, *Insurance Coverage For Pest Control and Dog Food? Anthem Unveils 2020 MA Supplemental* Benefits, FIERCE HEALTH (Oct. 2, 2019), https://www.fiercehealthcare.com/payer/anthem-unveils-slate-ma-supplemental-benefits-for-2020-including-pest-control-coverage.
[74] DEPMT. OF HEALTH & HUM. SERV. CENTERS FOR MEDICARE & MEDICAID SERVICES, IMPLEMENTING SUPPLEMENTAL BENEFITS FOR CHRONICALLY ILL ENROLLEES (2019).
[75] *Id*.
[76] LINDSEY COPELAND, *Report Examines Complaints About Medicare Advantage* Marketing, MEDICARE RIGHTS CENTER (Nov. 10, 2022), https://www.medicarerights.org/medicare-watch/2022/11/10/report-examines-complaints-about-medicare-advantage-marketing.

Fund, one in four of MA Plan participants indicated they elected to enroll in an MA Plan because of the "extended benefits and limits on out-of-pocket costs."[77]

The most recent supplemental benefit being pushed is the increased Social Security check.[78] Brokers, agents, and telemarketers are using "bait and switch" tactics to mislead Medicare-eligible individuals to enroll into MA Plans.[79] The marketers promise an increased Social Security check when the MA Plan "buys down" the enrollee's Medicare Part B premium.[80] However, they typically fail to inform the enrollee that the lower Part B premiums may not be offered by plans in their location, their current providers will not be covered by the plan, and/or items like prescription drugs may not be covered by the plan.[81] As a result, the enrollees may receive a small boost in their Social Security check, but they are often economically harmed or unduly burdened by the MA Plan's restrictions.[82] This was the case for an Oregon resident who selected to enroll in a MA Plan after a broker informed him he would receive an additional $135 on his Social Security check if he enrolled.[83] The broker failed to mention the terms of the plan, and did not disclose this new MA Plan would not cover his prescription drugs, a prescription he had been taking for an extended period.[84] After enrolling in the MA Plan, the man went to his pharmacy to pick up his prescription drugs, but upon arrival, the pharmacist informed him his prescription drugs were not covered by his new insurance. [85] Any prescription drugs would require an out-of-pocket payment—the plan did not cover any prescription drugs.[86]

In an effort to protect Medicare-eligible individuals from misleading and abusive marketing, CMS enacted the Medicare Improvement for Patient and Providers Act of 2008 (MIPPA).[87] Among other things, MIPPA prohibits MA Plans from making unsolicited direct contact, like cold calling, with prospective enrollees, thus preventing MA Plans from directly soliciting prospective enrollees, unless the prospective enrollee reaches out first.[88] As a result, MA Plans have developed strategies to work around these rules using third-party marketing organizations (TPMOs), companies which serve solely to generate leads.[89] Because TPMOs' only purpose is to generate leads, they "fall[] outside the definition of solicitation under the National Association of Insurance Commissioners (NAIC) Producer Licensing Model Act"; thus, they are not subject to the rules and regulations of insurers which would require they submit all marketing

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[77] FAITH LEONARD, GRETCHEN JACOBSON, LAUREN HAYNES, & SARA COLLINS, *Traditional Medicare or Medicare Advantage: How Older Americans Choose and* Why, THE COMMONWEALTH FUND (Oct. 17, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.

[78] FINANCE COMMITTEE 2022 REPORT, *supra* note 8, at 2.

[79] *Id*. at 7.

[80] *Id*. at 6.

[81] *Id*. at 9 (noting that Medicare Advantage plans are permitted to buy down a participant's Medicare Part B premium, meaning they will pay a portion or all of the participant's premium. Because the government automatically garnishes a Medicare-eligible person's Social Security check to cover this premium, it appears to the plan participant that they are receiving additional funds in their Social Security check).

[82] *Id*. at 12 (explaining that the Committee's inquiry revealed a complaint from a 94-year-old woman living in a rural area. She was essentially coaxed into enrolling in an MA plan but was not informed she would not be able to see her current doctors. The only doctors and providers within her network were located several miles outside of her town).

[83] *Id*. at 7.

[84] *Id*.

[85] *Id*.

[86] *Id*.

[87] Medicare Improvements for Patients and Providers Act of 2008, H.R.6331, 110th Cong.§103 (2008).

[88] *Id*.

[89] FINANCE COMMITTEE 2022 REPORT, *supra* note 8, at 11.

materials to CMS for approval, follow all Medicare marketing guidelines, and comply with the respective state's insurance laws.[90]

In response to the growing concerns surrounding MA Plan marketing, the Senate Finance Committee Majority Staff (Committee) launched an inquiry into the misleading, false, and over-aggressive marketing tactics.[91] Based on the evidence gathered from fourteen states, the Committee determined MA Plan marketing is not monitored closely enough, and bad actors are not being held accountable for their bad acts.[92] While some insurers used misleading tactics, others blatantly broke MIPPA rules and lied to enrollees.[93] Using the work around of a TPMO, an insurance agency in Arizona sent out mailers resembling tax documents from the IRS and official documents from CMS.[94] Upon receiving what appear to be time-sensitive government forms, prospective enrollees contact the numbers, websites, and emails.[95] Once the potential enrollee has made contact, MIPPA no longer applies and the prohibited marketing tactics are fair game for MA Plan brokers, agents, and salespeople.[96] The Committee's inquiry also revealed complaints of insurers completely disregarding MIPPA, CMS regulations, and state law regulations by lying to Medicare-eligible individuals, telling them their current treating physicians and providers would be covered in the new plan.[97] These enrollees switched plans then found out months later their doctors were not in-network and any visits to these providers would be an out-of-pocket expense.[98] Thousands of complaints also cited misleading websites, overly-aggressive marketing, and inappropriate marketing to individuals with diminished capacity.[99]

Reacting to the MAO's egregious circumvention of CMS rules, CMS developed new rules which expand the definition of marketing to include TPMOs.[100] Under 42 CFR § 422.2261, the new interpretation requires "all marketing materials, election forms, and certain designated communications materials … including those used by third-party and downstream entities … be

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[90] *Id*.

[91] *Id*. at 2 (Describing a seemingly exponential increase in marketing complaints to CMS. In 2020, CMS reported receiving 15,497 complaints regarding false, misleading, or inappropriate marketing. In 2021, that number more than doubled and CMS received 39,617 complaints from January-November).

[92] *Id*. at 3.

[93] *Id*.

[94] *Id*. at 11 (Describing the MA Plan marketing materials in which the form copied stylistic characteristics of official tax documents, like bolded numbers and letters in the corner. Where a tax form may have a bolded and capitalized "W-2" in the top left-hand corner, these mailers had "T-2" bolded and enlarged in the top left-hand corner. The title was centered on the top of the document and read "Medicare Savings Program". In the top right hand corner, the mailer read "2022" with the 20 being thinner, not bolded, and outlined numbers (the numbers were not filled in and had no background), while the 22 was bolded in a similar font to the T-2. This copies the format used on federal IRS documents. Under the title, a textbox read "**Do you qualify** to have your Medicare Part B premium paid for by the state?? **If you do qualify, you will receive $170.10 back into your Social Security check.** 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, and Hearing, Transportation, and FREE over the counter Health Products? **Return this inquiry card today. This is a FREE service to you, PLEASE READ.**" Under the text, only a box indicating interest in the benefits listed above was provided. Next to the text box, the mailer requested the following information: Name, Age, Spouse's Name, Spouse's Age, Street Addresses (no PO boxes), and Phone Number with Area Code. Under this box, in nearly illegible font, the mailer read "Not affiliated with or endorsed by any government agency." In the same fine print font, the card informed the recipient they could opt out of mailings by calling a number and entering a 9-digit code).

[95] *Id*.

[96] *Id*.

[97] *Id*. at 2.

[98] *Id*.

[99] *Id*. at 7-8 (Demonstrating misleading marketing when a company physically advertised its website, "MedicareBus.com" on a red, white, and blue bus. The website title never mentions Advantage Plan, or Part C, and the website was a decoy website, meaning when a prospective enrollee visited the "MedicareBus.com" website, they were immediately redirected to the website of an independent insurance agent. No notice of the redirect was ever provided).

[100] AIP MARKETING ALLIANCE, https://aipma.com/media/aipma-blogs-articles/understanding-medicare-marketing-rules-for-third-party-marketing-organizations/ (last visited Apr. 7, 2023).

submitted to CMS for review."[101] As a result, TPMOs will not be permitted to contact prospective enrollees, market Plans prior to October 1st, or use decoy websites without alerting users they are being redirected.[102] TPMOs are also required to record all calls, in their entirety, between the TPMO and enrollees, both prospective and active.[103] The new CMS rule works to minimize misleading promises of unapplicable benefits by requiring the following 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."[104]

The federal government has also taken action to combat the extreme rise in misleading MA Plan marketing.[105] In response to the Committee's alarming and egregious findings, the Biden Administration enacted laws which require all MA Plan marketing materials to indicate the MAO which they represent, prohibit marketing benefits and plans that are not available to people in the marketed area, and limit the scope in which "the Medicare name, logo, and Medicare card" may be used.[106] These new rules aim to reduce any confusion on who the Plan provider is and boost the transparency of benefits provided to enrollees.[107] Together, these federal actions are taking a step in the right direction to protect a population being exploited by marketing abuse.

VI. Overpayments from CMS to Medicare Advantage Plans

Once a person enrolls in an MA Plan, CMS agrees to pay the private insurance company a capitated payment based on the "risk" the insurer is taking.[108] Thus, when an MA Plan enrolls a sicker individual with numerous, severe diagnoses, the federal government will pay out additional funds for the medical treatments of that person.[109]

Sicker enrollees, means a higher risk score, a higher risk score means a higher payment, and higher payments mean more money in MAOs' pockets.[110] Given their financial motive, it is no surprise MA Plan enrollees tend to have a 9.5% higher risk score than TM enrollees.[111] As a

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[101] 42 C.F.R. § 422.2261 (2022).
[102] 42 C.F.R. § 422.2263 (2022). (working to prohibit TPMOs from using decoy websites, which have no content of their own and merely serve to redirect users' browser from the website they originally visited to the website of an independent agency. No alert is given to the user that they are being redirected from the original website to a new website. This may lead to confusion on who the Plan provider is).
[103] AIP MARKETING ALLIANCE, *supra* note 100.
[104] *Id*.
[105] FINANCE COMMITTEE 2022 REPORT, *supra* note 8 at 6 (stating of the 14 states surveyed by the Finance Committee of the Senate, only one state saw a decrease in the number of misleading advertisement complaints. However, this decrease was substantially outweighed by the increase in the others which collected data on the issue, "[m]ost notably Arizona [which] saw a 614% increase" in complaints from 2020-2021).
[106] Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly**,** 88 Fed. Reg. 22120, 22122 (proposed Apr. 12, 2023) (to be codified at 42 C.F.R. pts. 417, 422, 423, 455, & 460).
[107] JACQUELINE HOWARD, *Biden Administration Finalizes Rule to Target 'Misleading' Medicare Advantage Ads*, CNN (Apr. 5, 2023, 6:34 PM), https://www.cnn.com/2023/04/05/health/hhs-medicare-advantage-ads/index.html.
[108] BETTER MEDICARE ALLIANCE, *Medicare Advantage Payment Structure*, (2017), https://www.bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_OnePager_Payment_Structure_2017_10_18-Final.pdf (explaining CMS considers a patient's, "[diagnoses, [s]ex, [working [a]ged [s]tatus, Medicaid [s]tatus, [d]isabled [s]tatus" when determining their risk to the insurer. Section 1853(a)(1)(C) of the Social Security Act requires CMS to risk-adjust payments made to MAOs).
[109] THOMAS MCGUIRE, JOSEPH NEWHOUSE, & ANNA SINAIKO, *supra* note 21 at 309.
[110] MARTHA HOSTETTER, *Taking Stock of Medicare Advantage Risk Adjustment*, THE COMMONWEALTH FUND (Feb. 7, 2022), https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-risk-adjustment.
[111] ALISON BINKOWKSI, JEFF STENSLAND, DAN ZABINSKI, LEDIA TABOR & BRIAN O'DONNELL, *The Medicare Advantage Program: Status Report and Mandated Report on Dual-Eligible Special Needs Plans,* MEDPAC (Jan. 13, 2021), (https://www.medpac.gov/meeting/january-13-14-2022/).

result of these increased risk scores, CMS paid out an additional $12 billion to MA Plans in 2020 alone.[112] To combat these ulterior motives, CMS applies a coding intensity adjustment to account for the higher risk scores.[113] This adjustment cuts MA Plan payments by a set percentage, with a minimum adjustment of 5.9%.[114] Although it has the power to increase the adjustment percentage, CMS has not increased the adjustment percentage over the federal minimum since its implementation in 2018.[115] While the average risk score for MA Plan enrollees continues to grow, CMS fails to offset the costs by increasing the coding intensity adjustment.[116] Without increasing the 5.9% code intensity adjustment, studies suggest MA Plan payments may be "$413 billion higher over the 2023-2030 period," as MA Plans continue to inflate enrollees' risk scores by overstating and falsifying enrollees' conditions.[117]

Under the Payment Integrity Information Act of 2019 (PIIA), the HHS OIG is required to annually review and report any improper payments of their agencies, including payments for falsified and unsupported conditions.[118] In recent years, HHS has conceded its failure to comply with PIIA, citing over $15 billion in overpayments to insurers for MA Plan beneficiaries in the 2021 fiscal year alone.[119] This may come as a potential result of the miniscule ninety audits over the past decade,[120] despite the nearly 4,000 MA Plans that exist nationwide.[121] Even more staggering, independent analysis of MA billing data suggests CMS overpaid more than $106 billion to the private insurers from 2010-2019, with a vast majority of these overpayments coming from overstated sicknesses, false diagnoses, and improper billing for conditions enrollees did not have.[122]

Among these bad actors is a Florida Humana Plan, audited in April 2021 ("April 2021 Audit").[123] In conducting its audit, the HHS-OIG used "a medical review contractor to review the medical records" of the 200 randomly selected enrollees, to determine whether their conditions and diagnoses were consistent with those reported by the Humana Plan.[124] Out of the sample's

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[112] *Id.* (Finding based on 2020 data, CMS would have saved $12 billion in payments if MA Plan enrollees held the same risk score of TM enrollees).
[113] COMM. FOR A RESPONSIBLE FED. BUDGET, REDUCING MEDICARE ADVANTAGE OVERPAYMENTS (2021).
[114] *Id*.
[115] *Id*.
[116] *Id*.
[117] RICHARD KRONICK & MICHAEL CHUA, *INDUSTRY-WIDE AND SPONSOR-SPECIFIC ESTIMATES OF MEDICARE ADVANTAGE CODING INTENSITY* (November 11, 2021).
[118] U.S. DEPT. OF HEALTH AND HUM SERV. OFF. OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES MET MANY REQUIREMENTS, BUT IT DID NOT FULLY COMPLY WITH THE PAYMENT INTEGRITY INFORMATION ACT OF 2019 AND APPLICABLE IMPROPER PAYMENT GUIDANCE FOR FISCAL YEAR 2021 (2021) (explaining that CMS classifies any payment "that should not have been made or that was made in an incorrect amount" as an improper payment).
[119] U.S. DEPT. OF HEALTH AND HUM SERV, FY 2021 HHS AGENCY FINANCIAL REPORT (2021).
[120] Fred Schulte &Holly Hacker, *Hidden Audits Reveal Millions in Overcharges by Medicare Advantage Plans*, NPR (NOV. 21, 2022), https://www.npr.org/sections/health-shots/2022/11/21/1137500875/audit-medicare-advantage-overcharged-medicare (noting CMS only conducted 90 audits from 2011-2022).
[121] Meredith Freed, Anthoony Damico & Tracia Neuman, Medicare Advantage 2022 Spotlight: First Look, KFF (Nov. 2, 2021), https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/ (stating in 2022, there were 8,384 MA Plans available for enrollment).
[122] Fred Schulte, *Researcher: Medicare Advantage Plans Costing Billions More Than They Should*, KFF HEALTH NEWS (Nov. 11, 2021),
https://kffhealthnews.org/news/article/medicare-advantage-overpayments-cost-taxpayers-billions-researcher-says/
[123] U.S. DEPT. OF HEALTH AND HUM SERV. OFF. OF INSPECTOR GENERAL, MEDICARE ADVANTAGE COMPIANCE AUDIT OF DIAGNOSIS CODES THAT HUMANA, INC., (CONTRACT H1036) SUBMITTED TO CMS (2021) (finding in April 2021, the HHS OIG audited contract H1036's 2015 service year. H1036 is a plan which serves approximately 485,000 enrollees, located primarily in South Florida. Of the 485,000 enrollees, the OIG randomly selected 200 enrollees for sampling. In total, this group of 200 enrollees accounted for $3,522,179 of the $5.6 billion, less than 7%, of payments to Humana for this coverage).
[124] *Id*.

1,525 conditions and diagnoses, 203 were invalidated, meaning the medical records did not support the claim.[125] Review of one enrollee's records indicated annual overpayment of $4,380 due to the diagnoses of "malignant neoplasm of the larynx," which coded the patient as having a form of a major cancer.[126] However, the patient was never "monitored, evaluated, or treated" for that diagnosis in the 2015 service year.[127] Another enrollee's medical records revealed the overstating of their diabetes, resulting in overpayments of $1,956 annually.[128] Contrastingly, Humana failed to report, or misreported, fifteen conditions to CMS; these would have resulted in a higher risk score for the respective enrollee.[129] After accounting for CMS's underpayments for those fifteen unreported or misreported conditions, the HHS-OIG found CMS still overpaid Humana $249,279 for those 200 enrollees and "estimated…at least $197,720,651 of net overpayments in 2015."[130]

In response to private insurers' fraudulent activities, like those evidenced by the April 2021 Audit, several lawsuits have launched under the False Claims Act (FCA).[131] CIGNA, Independent Health, Keiser Permanente, and UnitedHealth Group are four insurers currently involved in pending litigation after DOJ investigations revealed the companies knowingly falsified diagnoses.[132] The outcome of these lawsuits will likely determine the trajectory of MAOs moving forward, as each insurer could face tens of millions of dollars in judgments.[133]

Separate from pending litigation, CMS has proposed Risk Adjustment Data Validation (RADV) audit rules which will result in approximately $4.7 billion in repayments to the federal government.[134] These rules will allow CMS to extrapolate RADV findings and apply them across the entire MA Plan.[135] As a result, Plans are expected to pay back an estimated $4.7 billion from 2023-2032,[136] less than 4.5% of the estimated overpayments from 2010-2019.[137] Though they face some adverse repercussions in the future, CMS relieved previously-audited MAOs of nearly $1.96

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[125] *Id*. at 5 (Explaining twenty of the invalidated conditions were invalidated because the OIG "identified 22 other [categories] for more and less severe manifestations of the diseases).
[126] *Id*.
[127] *Id*.
[128] *Id*. at 8 (Finding that the diagnosis reported by Humana was "'Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled.'" The enrollee's medical records indicated the enrollee had Diabetes without complications, a "less severe manifestation[]" of the condition, which would have resulted in a lower risk score and in turn a lower payment to Humana).
[129] *Id*.
[130] *Id*. at 5.
[131] U.S. DEPARTMENT OF JUSTICE, UNITED STATES INTERVENES AND FILES COMPLAINT IN FALSE CLAIMS ACT SUIT AGAINST HEALTH INSURER FOR SUBMITTING UNSUPPORTED DIAGNOSES TO THE MEDICARE ADVANTAGE PROGRAM (2021) (describing under 31 U.S.C. 3729(a)(1)(G), any person who receives an overpayment under the Medicare Act is required to "report and return" the overpayment within 60 days of the overpayment being identified. The FCS prohibits anyone from perpetuating fraud against federally funded programs by knowingly submitting false claims).
[132] U.S. DEPARTMENT OF JUSTICE, FALSE CLAIMS ACT SETTLEMENTS AND JUDGMENTS EXCEED $2 BILLION IN FISCAL YEAR 2022 (2023).
[133] *Id*.
[134] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, *supra* note 109 (explaining that an RDAV is an audit that reviews a randomly selected sample population from an MA Plan to check for improper reports. The auditor cross-references the diagnoses and treatments reported by the Plan with the enrollee's medical records to determine whether the Plan properly reported an enrollee's condition. Auditors then determine whether the Plan was properly paid, underpaid, or overpaid, for the coverage they provided. The new rule allows the HHS-OIG to continue performing its standard RADV audits, which review a sample population's health data as opposed reviewing all enrollees' medical records, to calculate over and under payments to MA Plans. The error rate from the RADV audit, the sample population, will then be applied to the plan as a whole.
[135] *Id*.
[136] *Id*.
[137] COMM. FOR A RESPONSIBLE FED. BUDGET, REDUCING MEDICARE ADVANTAGE OVERPAYMENTS, *supra* note 118.

billion in paybacks by only extrapolating RADV overpayments from 2018 and on.[138] CMS also plans to implement changes to capitation rates and payments, which will decrease the amount of money CMS pays MAOs for diagnoses that appear to be manipulated and over abused by MA Plans.[139] Contrary to initial CMS plans, these capitations and decreased payments will be phased in over a three-year period, resulting in continued federal funding for payments "Medicare officials do not consider appropriate."[140]

VII. Recommendations

Given the consistent misbehavior of MA Plans, new processes, harsher punishments, and changed protocols should be implemented to protect MA enrollees and limit the overspending of taxpayer dollars.

To ensure MA Plan enrollees receive adequate medical treatment, an expedited administrative court should be created for MA Plan healthcare service denials. Rather than waiting over three months for an appellate body's decision, MA Plan enrollees should have the opportunity to immediately appeal a prior authorization denial with an Administrative Law Judge (ALJ), as opposed to the MAO.[141] However, unless a party shows egregious bias or bribery, the ALJ's decision shall be final and binding. Thus, patients who are appealing a denial with uncertainty are encouraged to proceed with the current appeals process. Due to the nature of the issues at hand, an enrollee's hearing shall take place within three business days of the filing. Enrollees should provide the ALJ all medical documentation provided to the MAO for prior authorization, while the MAO shall be required to cite their reasoning for denial. An ALJ will then review the evidence at hand to determine whether the denial was proper or failed to comply with Medicare policies. To fund the program, any MAO who wishes to contract with CMS must contribute a pro-rated amount, based on the number of enrollees within their Plans, to a fund which will be used to pay out all MA Plan ALJ's salaries. This pro-rated calculation will be determined by dividing the sum of the ALJs' salaries by the number of MA enrollees. MAOs must contribute this dollar amount per enrollee to contract with CMS.

In addition to the marketing rules and regulations recently mandated by the Biden Administration and CMS, harsher punishments, like a "Three Strikes Rule," should be created to punish MAOs for continuous, improper bad marketing acts. Under such a rule, MA Plans would be prohibited from contracting with CMS after receiving three warnings for improper marketing. With catastrophic repercussions on the line, MA Plans may be incentivized to further scrutinize their marketing materials, including those designed and distributed by TPMOs. Under the Three Strikes Rule, MA Plans will be required to abide by all CMS regulations, federal laws, and state laws that both restrict marketing and require specific disclaimers. Since recently enacted regulations require all MA Plans to disclose themselves on any marketing materials, any complaints received by CMS should require the complainant to disclose the named Plan. Once a

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[138] *Id*. (explaining if CMS began extrapolation in 2011, MA Plans would owe an estimated $2 billion for improper payments. Under the proposed rule, MA Plans will only pay an estimated $41.1 million for improper payments).
[139] Margot Sanger-Katz, Reed Abelson, *Medicare Delays a Full Crackdown on Private Health Plans*, New York Times (Mar. 31, 2023), https://www.nytimes.com/2023/03/31/health/medicare-overbilling-insurance.html (finding that "[a]ltogether, Medicare estimates that Medicare Advantage plans will be paid 3.32 percent more next year than this year. Under the original limits proposed by the administration, that increase would have been around 1 percent.").
[140] *Id*.
[141] HHS-OIG REPORT, *supra* note 64.

Plan has received 150 complaints, CMS should open an investigation into the Plan's marketing materials. If found in violation of the regulations and rules, the violating Plan will receive a warning for improper marketing. Upon their third violation, the Plan's contract with CMS will be voided, and the Plan will not be permitted to contract with CMS for one full enrollment period. Thus, if a Plan receives a third violation on July 15, 2025, they will not be permitted to contract with CMS until October 1, 2027. Any enrollees adversely affected by the dropped contract will receive TM until the next Open Enrollment Period begins. Should any Plan's contract be voided three times throughout the Plan's existence, it will be prohibited from ever contracting with CMS. This rule serves to toughen marketing rules and mitigate the number of repeat offenders in the market.

The final recommendation aims to minimize federal MA Plan spending by requiring CMS to increase or decrease the code intensity adjustment every year, with respect to the annual MA payment percentage.[142] Though different models of determining a proper code intensity adjustment exist, CMS should reserve the authority to determine the adjustment's magnitude.[143] However, CMS should be required to modify the adjustment percentage by at least 25% of the annual MA payment percentage. With risk-scores acting as the crux of MA payments, an annual adjustment of the coding intensity adjustment will result in at least some offset of increased costs. While unfavorable audit reports and FCA judgments encourage MAOs to properly report enrollees' diagnoses, taking direct action against the source guarantees a reduction in improperly inflated MA Plan payouts. Changing the coding intensity adjustment annually will result in a reactive system that protects taxpayer dollars and minimizes the effects of MAOs' financially motivated, false statements.

Collectively, these recommendations work in conjunction with the rules and regulations already set forth by CMS, federal statutes, and executive declarations to expedite the appeals process for MA Plan participants, provide appropriate and transparent marketing to Medicare-eligible people, and minimize funds paid by CMS to MA Plans for improper, exaggerated claims.

VIII. Conclusion

With enrollment skyrocketing and reports of misbehavior increasing at a similar rate, MA Plans' misbehavior is a growing concern for Medicare-eligible people and the federal government.[144] MA Plans continue to improperly deny healthcare treatment for thousands of enrollees each year, but with minimal repercussions, few incentives exist for MA Plans to properly consider prior authorizations.[145] MA Plans' misbehavior is not limited to its current enrollees, but extends into the community, affecting prospective enrollees who are victims of misleading, false, and abusive marketing.[146] Using the "bait and switch" tactic, MA Plans are swindling prospective enrollees, leading them to believe they will receive incredible supplemental benefits.[147] Yet, the Plans' marketers often fail to disclose the fine print which restricts who these benefits apply to,

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[142] Author suggests, if the annual MA payment percentage increases, CMS will be required to increase the code intensity adjustment by the minimal percentage. If the annual MA payment percentage decreases, CMS will be required to decrease the code intensity adjustment by the minimal percentage.
[143] RICHARD KRONICK, MICHAEL CHUA, *supra* note 120.
[144] STEVEN FINDLAY, GRETCHEN JACOBSON, FAITH LEONARD, *supra* note 7; FINANCE COMMITTEE 2022 REPORT *supra note 8.*
[145] NOTICE OF IMPOSITION OF CIVIL MONEY PENALTY FOR MEDICARE ADVANTAGE-PRESCRIPTION DRUG CONTRACT NUMBERS: H0354, H0439, H1415, H2108, H3949, H4407, H7020, H9460, AND H9725, *supra* note 66 (noting CIGNA received a fine of $126,988 in February 2022 followed by another fine of $85,436 for improper coverage of MA Plans).
[146] *See generally*, FINANCE COMMITTEE 2022 REPORT, *supra* note 8.
[147] *Id*. at 2.

commonly disqualifying the enrollee at hand.[148] Given the continuance of these misbehaviors, coupled with the failure to correct after being penalized, new procedures and stricter punishments should be implemented to curb the bad acts of MA Plans which negatively affect enrollees.

MA Plans' bad acts also have negative impacts on the federal government, costing over $100 billion in the past decade, with projections expecting an additional $400 billion in overspending over the next decade.[149] MA Plans notoriously overstate enrollees' conditions and treatments, resulting in the implementation of a coding intensity adjustment—an adjustment which cuts all MA Plan payments by a fixed percentage.[150] However, CMS has failed to maintain the adjustment, keeping the adjustment percentage stagnant over the past five years.[151] While the government may seek recourse for overpayment through the FCA and audits, stronger actions should be taken to cauterize the issue at its source. Enacting laws that require CMS to adjust the code intensity rate in relation to the change in annual percentage of MA Plan costs would cut federal overspending on MA Plans.

Taking actions to eliminate and correct the misbehavior of Medicare Advantage Plans is crucial to the future of healthcare for MA Plan enrollees and federal spending. Thus, the law should create an expedited administrative process for MA Plan prior authorization denials, implement stricter, more significant punishments for misleading marketing, and require CMS use existing mechanisms to reduce payments to MAOs.

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[148] *Id*. at 5.
[149] FRED SCHULTE, *supra* note *126;* RICHARD KRONICK, MICHAEL CHUA, *supra* note 120.
[150] REDUCING MEDICARE ADVANTAGE OVERPAYMENTS, *supra* note 116.
[151] *Id*.