Statement of Cobi Blumenfeld-Gantz, CEO and Co-Founder of Chapter, for the Senate Finance Committee on October 18, 2023

"Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences"

Introduction

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

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

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

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

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

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

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

***

Chapter's Approach

Before I highlight some of the significant challenges impacting consumers navigating Medicare, I want to share our unique approach to providing Medicare guidance. This work has afforded us insight into what consumers are up against. Unlike other insurance agencies, we did not start working on Medicare as just another offering to complement other insurance products. We built Chapter to focus specifically on issues related to Medicare and retirement, and we designed our model around the distinct needs of this consumer group and the unique characteristics of Medicare plans.

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

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

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

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

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

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

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

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

***

Improving plan data availability

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

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

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

Consider a consumer who has three doctors and wants to determine the network status of their doctors across local plans. Because of the large number of Medicare Advantage plans locally available to the average consumer, this consumer might need to conduct over one hundred separate searches across each insurance company's website and track the comparisons independently. It is not reasonable to expect a

typical consumer to do this, and it is no surprise that many consumers may not fully understand the network status of their doctors across each plan.

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

***

Eliminating deceptive marketing

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

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

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

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

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

Deceptive marketing is even more problematic when Medicare plan information is less accessible to consumers and industry participants. Without the ability to easily compare benefits across plans, it is

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

challenging for consumers and well-intentioned brokers alike to make informed coverage decisions based on that marketing.

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

***

Putting consumers' interests first

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

Brokers should be held to a higher standard of conduct and accountability. There are policy pathways for accomplishing this. For example, brokers could be required to consider all plans when making recommendations, and agencies could ensure that their salespeople are not incentivized to push plans that pay higher commissions. We would support such a higher standard that prioritizes consumers' interests.

***

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

- **Consumer-first standard: Any trusted guide used by a consumer should be obligated to place consumers' interests first**. There are thousands of Medicare plans available across a variety of plan types. This diversity of options means that consumers can find truly excellent coverage, but they often need a trusted guide to help them through the process.

- **Information across all types of Medicare plans: Consumers deserve to be informed about all types of Medicare plans that are available to them.** These include Medicare Supplement Plans, standalone Part D prescription plans, coverage under Original Medicare, Medicare

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

Advantage Plans, and Special Needs plans for people with both Medicare and Medicaid or people who have qualifying chronic conditions, for example.

- <u>Complete coverage search</u>**: Any trusted guide – whether a broker or another entity – should be obligated to search among all options available to the consumer**. Consumers should never receive a limited set of options or a sub-optimal recommendation simply because a broker works with a limited number of carriers.

- <u>Transparent and accessible plan data</u>**: Consumers and their trusted guides must be able to easily search and compare plans based on their full features.** These include plans' provider networks, formularies of covered drugs, ancillary benefits, and the premiums, out-of-pocket limits, and costs of each service, prescription, and benefit. The complexity of Medicare plans requires clear transparency on the specific differences between plans, and consumers cannot reasonably be expected to wade through hundreds of pages of Summaries of Benefits or Evidences of Coverage to understand these items.

- <u>Transparency in advertisements</u>**: Third party marketing and lead generators should be required to clearly identify who they are and the specific organization that will contact the consumer – or which the consumer is being prompted to contact.**

I am grateful to the Committee for your on-going work to improve the Medicare navigation and enrollment experience for Americans.

Cobi Blumenfeld-Gantz
CEO & Co-Founder
Chapter