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INFORMING THE DEBATE ABOUT CURBING MEDICARE ADVANTAGE OVERPAYMENTS

by Edwin Park

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As two House committees prepare to consider health legislation that is expected to include provisions to curb overpayments to private insurance plans that participate in the Medicare Advantage program, there is some confusion about these overpayments, the benefits that Medicare Advantage plans offer, who enrolls in those plans, and the marketing practices some of those plans employ. Adding to this confusion, some material on these matters being disseminated by the health insurance industry presents data very selectively and makes dubious claims.

This primer uses a question-and-answer format to clear up possible misunderstandings or confusion on various issues related to private plans that participate in the Medicare Advantage program. This primer is intended to help inform the debate as Congress considers reforms to Medicare Advantage in the months ahead.

1. Question: Do private plans cost more than it costs the regular Medicare program to cover the same beneficiaries?

Answer: Both the Medicare Payment Advisory Commission (MedPAC) — Congress’ expert advisory body on Medicare payment policy — and the Congressional Budget Office have found that private plans are paid *12 percent more*, on average, than it would cost traditional Medicare to cover the same beneficiaries.¹ According to an analysis by the Commonwealth Fund, these overpayments currently are estimated to average about \$1,000 for each beneficiary enrolled in a private plan.²

The private plans and the Administration have attempted to cast some doubt on these estimates, contending they may be inflated.³ Such claims do not have merit. Peter Orszag, director of the Congressional Budget Office, recently testified that “such claims are simply inaccurate.”⁴ MedPAC similarly dismissed such claims in its most recent report to Congress in June 2007.⁵

Moreover, according to CBO, the overpayment per beneficiary is likely to *rise* in the future because enrollment growth in the private plans is concentrating in geographic areas with the highest overpayment rates.⁶

2. Question: How do Medicare Advantage overpayments affect Medicare’s finances?

Answer: CBO estimates that setting payments to private plans at the same level it would cost traditional Medicare to serve the same beneficiaries would save \$54 billion over the next five years and \$149 billion over ten years. These are the amounts by which the private plans are overpaid.⁷

¹ Medicare Payment Advisory Commission, “Report to the Congress: Promoting Greater Efficiency in Medicare,” June 2007 and Peter Orszag, “The Medicare Advantage Program: Enrollment Trends and Budgetary Effects,” Testimony before the Senate Finance Committee, Congressional Budget Office, April 11, 2007.

² Brian Biles, Lauren Hersh Nicholas, Barbara Cooper, Emily Adrion and Stuart Guterman, “The Cost of Privatization: Extra Payments to Medicare Advantage Plans— Updated and Revised,” The Commonwealth Fund, November 2006. See also Brian Biles and Emily Adrion, “The Cost of Privatization: Extra Payments to Medicare Advantage Plans; Updated Tables for 2007,” George Washington University, May 1, 2007.

³ America’s Health Insurance Plans, “AHIP Raises Concerns about New MedPAC Report and its Potential Impact on Beneficiaries,” March 1, 2007; Scott Serota, “Statement on MedPAC Report,” Blue Cross and Blue Shield Association; and Centers for Medicare and Medicaid Services, “Medicare Advantage in 2007,” April 20, 2007.

⁴ Mary Agnes Carey, “Cuts to Medicare Private Fee-for-Service Plans Would Yield Modest Savings,” CQ Healthbeat News, June 28, 2007.

⁵ Medicare Payment Advisory Commission, *op cit*.

⁶ See Edwin Park and Robert Greenstein, “Private Plan Overpayments Weaken Medicare’s Financing and Hasten the Program’s Insolvency,” Center on Budget and Policy Priorities, April 20, 2007 (discussing testimony of Peter Orszag, CBO Director, before the Senate Finance Committee on April 11, 2007). See also Medicare Payment Advisory Commission, *op cit*.

⁷ Peter Orszag, “The Medicare Advantage Program,” Testimony before the House Budget Committee, Congressional Budget Office, June 28, 2007.

The Chief Actuary at the Centers for Medicare and Medicaid Services has testified that the overpayments advance the date when the Medicare Hospital Insurance Trust Fund will become insolvent by two years, from 2021 to 2019.⁸ Because of the overpayments, restoring solvency will require substantially larger benefit cuts and/or tax increases than would otherwise be needed. In testimony before the Health Subcommittee of the House Ways and Means Committee earlier this year, Glenn Hackbarth, the MedPAC chairman, warned that Medicare faces “a very clear and imminent risk from this overpayment that will put this country in an untenable position.”⁹

3. Question: How do Medicare Advantage overpayments affect beneficiary premiums?

Answer: Under Medicare Part B, beneficiaries are charged a monthly premium equal to 25 percent of the costs of Part B-related services, which include physician visits and other types of outpatient care. Because private-plan overpayments increase Medicare costs under both Part A (hospital and nursing home services) and Part B, they increase the Part B premiums that beneficiaries must pay. According to both MedPAC and the Chief Actuary at the Centers for Medicare and Medicaid Services, the Medicare Advantage overpayments have raised the Part B premiums by \$2 per month per person, or \$48 a year for a couple, in 2007.¹⁰

This means that the 35 million seniors and people with disabilities enrolled in regular Medicare are charged higher premiums every month in order to help subsidize the cost of the overpayments related to the approximately 8 million beneficiaries who are enrolled in private plans. (Approximately 7 million of the 35 million beneficiaries charged the higher premiums are low-income beneficiaries whose premiums are paid for them by the Medicaid program; the costs of the higher Medicare premium for these individuals are borne by the federal government and the states, which jointly fund Medicaid.)

4. Question: Did the private plans once take the position that they should be paid at the same levels as regular Medicare?

Answer: Private plans were originally brought into the Medicare program on the theory that they could deliver Medicare services at lower cost. Plan payment rates were initially set at *95 percent* of the cost of traditional Medicare. Private plans at that time called for payment increases to pay them at *100 percent* of the cost of Medicare fee-for-service. The private plans said that reimbursing them at levels equal to those under regular Medicare would close a “fairness gap” and “create a level playing field between [private plans] and fee-for-service.”¹¹

⁸ BNA Health Care Policy Daily, “CMS Actuary Says Medicare Funding Warning Likely Not Needed if Managed Care Pay Cut,” April 26, 2007.

⁹ BNA Health Care Policy Daily, “Growth of Managed Care Plans Threaten Program’s Finances, MedPAC Chairman Says,” March 2, 2007.

¹⁰ Glenn Hackbarth, “The Medicare Advantage Program and MedPAC Recommendations,” Testimony before the Senate Finance Committee, Medicare Payment Advisory Commission, April 11, 2007 and BNA Health Care Policy Daily, “CMS Actuary Says Medicare Funding Warning Likely Not Needed if Managed Care Pay Cut,” April 26, 2007.

¹¹ See, for example, Karen Ignagni, Testimony before the Senate Finance Committee, American Association of Health Plans, May 27, 1999.

Today, however, as a result of provisions written into the 2003 Medicare prescription drug law that throw billions of dollars at the plans, the plans are paid substantially *more* than it costs to treat the same patients under regular Medicare. As noted above, they are paid 12 percent more on average (or 112 percent of Medicare fee-for-service costs). Now that MedPAC has recommended for a number of years that Congress equalize payments between the private plans and regular Medicare to create a level playing field — the very position the plans themselves took in the late 1990s — the plans are adamantly opposing it.

5. Question: If private plans were paid at 100 percent of fee-for-service, would a significant risk remain that Medicare Advantage plans still would be overpaid to some degree?

Answer: When private plan payments were set at 95 percent of Medicare fee-for-service in the 1990s, many private plans still received excessive payments. This occurred because the plans enrolled Medicare beneficiaries who were healthier, on average — and thus less costly to treat — than beneficiaries in the traditional Medicare fee-for-service program. An effective “risk adjustment” system had not been developed to lower plan payments if plan enrollees were healthier. As a result, Medicare ended up overpaying many of the private plans.¹²

If Congress enacted the MedPAC recommendation to “level the playing field” by paying private plans at 100 percent of Medicare fee-for-service costs, there would still be a risk of overpayments if the plans continue enrolling beneficiaries who are healthier than average and the improved risk adjustment system developed in recent years (and only now being fully implemented) is less than fully effective in adjusting payments downward based on how much healthier these enrollees are. (MedPAC recently reported that private plan enrollees continue to be healthier, on average, than those in regular Medicare.¹³) Given that both CBO and leading experts in the field have said that *no* risk adjustment system has yet been developed that fully captures all differences in health status, it is very likely that private plans would continue to be overpaid to some extent even if the MedPAC recommendation were adopted.¹⁴

6. Question: Can private plans reduce existing Medicare benefits, as well as offer some additional benefits?

Answer: A portion of the overpayments that private plans receive goes to provide additional benefits to enrollees, such as services that Medicaid otherwise does not cover or lower cost-sharing than Medicare otherwise charges. (The rest of the overpayments go to administrative costs, marketing, and profits.) What is not widely understood, however is that the private plans

¹² See, for example, June Gibbs Brown, “Adequacy of Medicare’s Managed Care Payments After the Balanced Budget Act of 1997,” Office of Inspector General, U.S. Department of Health and Human Services, September 18, 2000; General Accounting Office, “Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits, May 1997; and General Accounting Office, “Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem,” November 1995.

¹³ Medicare Payment Advisory Commission, “Report to the Congress: Promoting Greater Efficiency in Medicare,” *op cit.*

¹⁴ Thomas Rice and Katherine Desmond, “The Distributional Consequences of a Medicare Premium Support Proposal,” *Journal of Health Politics, Policy, and Law*, December 2004 and Congressional Budget Office, “Designing a Premium Support System for Medicare,” December 2006.

not only have the flexibility to offer additional benefits but also the discretion to *scale back* existing Medicare benefits, so long as the actuarial value of their *overall* benefit package is not less than the value of the package under traditional Medicare.¹⁵

Some private insurers evidently use this flexibility to design the benefits packages they offer to entice healthy Medicare beneficiaries, who are less costly to treat, while deterring sicker and more costly beneficiaries from enrolling.¹⁶ For example, some private plans scale back certain Medicare benefits used primarily by sicker individuals; they may impose substantially higher co-payment charges for days in the hospital or costly treatments like chemotherapy. Some beneficiaries in poorer health consequently can wind up significantly worse off if they enroll in Medicare Advantage.

Analyses by the Medicare Rights Center, the Commonwealth Fund, the Kaiser Family Foundation, and MedPAC all have found that, to some extent, Medicare Advantage beneficiaries who need hospital care, home health care, and other specialty services may end up paying more for such services, or receiving less of a covered service, under the benefits packages the private plans offer.¹⁷ (Even CMS has acknowledged this problem and recently stated it will scrutinize cost-sharing levels among Medicare Advantage plans for certain services like physician-administered chemotherapy drugs and dialysis services.¹⁸)

7. **Question: Do private plans disproportionately enroll low-income and minority beneficiaries?**

Answer: Despite the claims of private plans to the contrary,¹⁹ low-income and minority beneficiaries generally do not enroll disproportionately in Medicare Advantage plans.²⁰ Beneficiaries with incomes below \$10,000 enroll in Medicare Advantage to a lesser degree than other beneficiaries do, and African-American beneficiaries enroll in Medicare Advantage to about the same degree as other Medicare beneficiaries do. Moreover, for every racial/ethnic group, the number of Medicare beneficiaries who are enrolled in *regular* Medicare rather than in Medicare Advantage plans — and who consequently are charged higher Medicare premiums to

¹⁵ See, for example, Brian Biles, Lauren Hersch Nicholas and Stuart Guterman, “Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?” The Commonwealth Fund, May 2006.

¹⁶ While Medicare generally prohibits Medicare Advantage plans from discriminating on the basis of health status, an analysis by the Commonwealth Fund found that that “compliance with this broad policy is not carefully defined and enforced by CMS....” Biles et al., *op cit*.

¹⁷ Medicare Rights Center, “Too Good to Be True: The Fine Print in Medicare Private Health Plan Benefits,” April 2007; Biles et al., *op cit*; Medicare Payment Advisory Commission, “Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans,” December 2004; and Patricia Neuman, “Medicare Advantage: Key Issues and Implications for Beneficiaries,” Testimony before the House Budget Committee, Kaiser Family Foundation, June 28, 2007.

¹⁸ Centers for Medicare and Medicaid Services, “2008 Call Letter,” April 19, 2007.

¹⁹ See, for example, America’s Health Insurance Plans, “Low-Income and Minority Beneficiaries in Medicare Advantage Plans,” February 2007.

²⁰ See Edwin Park and Robert Greenstein, “Low-Income and Minority Beneficiaries Do Not Rely Disproportionately on Medicare Advantage Plans,” Center on Budget and Policy Priorities, Revised April 12, 2007.

help cover the cost of the Medicare Advantage overpayments — is about three to seven times greater than the number enrolled in Medicare Advantage.

For low-income and minority beneficiaries, the most common form of supplemental coverage (i.e., coverage that supplements Medicare) is *Medicaid*, not Medicare Advantage.

- Nearly half (48 percent) of all Medicare beneficiaries with incomes below \$10,000 were enrolled in Medicaid in 2004, nearly five times the proportion enrolled in Medicare Advantage plans.
- Minority beneficiaries also are much more likely to be enrolled in Medicaid than Medicare Advantage. In 2004, most Asian-American Medicare beneficiaries (58 percent) and a plurality of African-American (30 percent) and Hispanic beneficiaries (34 percent) received supplemental coverage through Medicaid. By contrast, the percentages of minority beneficiaries enrolled in private plans — 14 percent of Asian Americans, 13 percent of African Americans and 25 percent of Hispanics — were considerably smaller.

African American and Asian American beneficiaries make up the same or a smaller proportion of Medicare Advantage enrollment than they do of the overall Medicare population. Hispanics are modestly more likely to enroll in Medicare Advantage, but this simply reflects where they live.²¹ Half of all Hispanic Medicare Advantage enrollees live in California and Florida. In those states, the proportion of people enrolled in managed care plans — through employer-based coverage as well as through Medicare — is higher than in other parts of the country.²²

8. Question: What is the most efficient approach to help low-income and minority Medicare beneficiaries afford health care?

Answer: Private insurance companies participating in Medicare Advantage offer some benefits not available through regular Medicare. As noted above, however, the additional benefits are not the only, or necessarily the primary, place that the overpayments go. For example, MedPAC has found that among “private fee-for-service” plans — the type of Medicare Advantage plan that receives the largest overpayments and is growing the fastest — *half* of the revenue from the overpayments goes to profits, marketing, and administrative costs (which are much higher than under regular Medicare), rather than to additional benefits.²³

A more targeted, effective, and less costly way to aid low-income Medicare beneficiaries would be to expand and improve three existing programs, known as the “Medicare Savings Programs,” that help low- and moderate-income beneficiaries pay their Medicare premiums and cost-sharing.²⁴ MedPAC and other have specifically suggested such an approach. MedPAC has

²¹ Park and Greenstein, *op cit*.

²² Neuman, *op cit* and Park and Greenstein, *op cit*.

²³ Mark Miller, “The Medicare Advantage Program and MedPAC Recommendations,” Testimony before the House Budget Committee,” Medicare Payment Advisory Commission, June 28, 2007 and Glenn Hackbarth, Oral Testimony before the Senate Finance Committee, April 11, 2007.

²⁴ The three programs are the Qualified Medicare Beneficiary program (QMB), the Specified Low-Income Medicare Beneficiary program (SLMB), and the Qualifying Individual program (QI-1). QMB pays all Medicare premiums and

noted that “if the justification for higher payments to [private] plans is that extra payments are being provided to low-income beneficiaries who choose such plans, there are less costly and more efficient ways to achieve this result,” such as by improving the Medicare Savings Programs or strengthening the low-income subsidy in the Medicare prescription drug benefit.²⁵

9. Question: Do private plans disproportionately enroll rural beneficiaries?

Answer: Although a quarter of all Medicare beneficiaries live in rural areas,²⁶ only eight percent of Medicare Advantage enrollees did in 2006,²⁷ and only seven percent of all rural beneficiaries were enrolled in such plans.²⁸ While enrollment among rural beneficiaries in Medicare Advantage plans has grown significantly of late, enrollment in private plans remains disproportionately low in rural areas.

10. Question: Do private plans offer quality of care that is higher, the same, or lower than under regular Medicare?

Answer: Some plans have sought to justify the overpayments they receive as promoting better quality of care relative to traditional Medicare. MedPAC, however, has reported that while it is difficult to assess differences in the quality of care between Medicare Advantage and fee-for-service due to the lack of comparative quality measures, levels of beneficiary satisfaction were relatively similar, and fee-for-service beneficiaries were less likely to report problems accessing specialists.²⁹

The quality of care appears to vary widely across private plans.³⁰ The Congressional Budget Office has concluded “though Medicare Advantage plans cost more than care under the FFS program does, on average, they would be more cost-effective if they delivered a sufficiently higher quality of care. The limited [quality] measures available suggest that Medicare Advantage plans are *not* more cost-effective than the FFS program” (emphasis added).³¹

cost-sharing for poor beneficiaries; the other two programs pay Medicare premiums (but not cost-sharing) for beneficiaries with incomes up to 135 percent of the poverty line

²⁵ Miller, *op cit.* The Medicare Part D drug benefit includes a separate subsidy for low-income Medicare beneficiaries that pays for Part D premiums and/or Part D deductibles and cost-sharing.

²⁶ In 2004, 24 percent of Medicare beneficiaries lived in rural areas. See Kaiser Family Foundation, “Medicare Chartbook,” July 2005.

²⁷ Timothy McBride, Tanchica Terry and Keith Mueller, “Rural Enrollment in Medicare Advantage Is Concentrated in Private Fee-for-Service Plans,” RUPRI Center for Rural Health Policy Analysis, April 2007.

²⁸ Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2007.

²⁹ Medicare Payment Advisory Commission, “Issues in a Modernized Medicare Program,” June 2005.

³⁰ See, for example, Medicare Payment Advisory Commission, “Promoting Great Efficiency in Medicare,” *op cit.*

³¹ Peter Orszag, “The Medicare Advantage Program,” *op cit.*

11. Question: Do the abusive marketing practices of some Medicare Advantage plans bear similarities to past marketing abuses associated with Medigap policies or the EITC health insurance tax credit of the early 1990s?

Answer: Over the past year, numerous media reports and several Congressional hearings have documented a pattern of misleading and abusive marketing practices by some insurance agents who seek to entice Medicare beneficiaries to enroll in Medicare Advantage plans (particularly private fee-for-service plans).³² A January 2007 analysis by the Medicare Rights Center and California Health Advocates provides extensive documentation of such practices.³³

In addition, in a survey recently conducted by the National Association of Insurance Commissioners, 37 of the 43 states responding reported complaints about inappropriate or confusing marketing practices that led Medicare beneficiaries to enroll in private plans without understanding how the plans differed from traditional Medicare in such areas as benefits and provider availability. The state insurance commissioners reported complaints of high-pressure sales tactics, including complaints of agents and brokers conducting door-to-door sales and portraying themselves as government representatives from Medicare or Social Security.³⁴

The overpayments now being made to the private insurance companies have clearly contributed to these marketing abuses. Because private plans receive a 12-percent overpayment, on average, for each Medicare beneficiary they enroll (with overpayments to private fee-for-service plans averaging 19 percent), private plans have a significant incentive to maximize enrollment. As a result, many private plans have established lucrative commission structures for their insurance agents, providing as much as \$500 per new enrollee, as well as free trips and other financial inducements.

In addition, because each Medicare Advantage plan has its own benefits package that may differ substantially from traditional Medicare and from the offerings of other private plans, and each plan also may have its own provider network, vulnerable seniors and people with disabilities can be confused by the array of plans. Lack of proper oversight by the federal government has exacerbated these problems.³⁵

³² See, for example, Robert Pear, "Hard Sell Cited as Insurers Push Plans to Elderly," *New York Times*, May 7, 2007; Victoria Colliver, "Medicare plans under scrutiny: Complaints are adding up from seniors upset with private health care packages," *San Francisco Chronicle*, January 26, 2007; and Milt Freudenheim, "Luring Customers from Medicare," *New York Times*, September 22, 2006.

³³ See David Lipschutz, Paul Precht, and Bonnie Burns, "After the Goldrush: The Marketing of Medicare Advantage and Part D Plans," California Health Advocates and the Medicare Rights Center, January 2007.

³⁴ Sean Dilweg, Wisconsin Insurance Commissioner, "Testimony of Sean Dilweg, Wisconsin Insurance Commissioner, before the United States Special Committee on Aging Regarding Medicare Advantage Marketing and Sales," Testimony before the Senate Special Committee on Aging, May 16, 2007. See also Kim Holland, Oklahoma Insurance Commissioner, "Senate Special Committee on Aging Testimony for 5/16/07," Testimony before the Senate Special Committee on Aging, May 16, 2007 and Sherry Mowell, "Remarks before the Senate Committee on Aging: Sherry Mowell, Special Agent, Georgia Insurance and Safety Fire Commissioner John Oxendine," Testimony before the Senate Special Committee on Aging, May 16, 2007.

³⁵ Until CMS and the Medicare Advantage plans offering private fee-for-service plans voluntarily suspended the marketing of such plans in June 2007, there had been little effort by CMS to rein in marketing abuses by private plans and their agents. See Holland, *op cit* and Lipschutz, Precht and Burns, *op cit*.

In a number of respects, these abusive marketing practices bear a striking similarity to what occurred in the marketing of supplemental Medigap plans in the 1970s and 1980s, as well as in the marketing of the short-lived refundable health insurance tax credit for children's health insurance in the early 1990s. In both cases, unsuspecting individuals and families were initially left to their own devices in a highly profitable "wild west" health insurance market, with little government oversight to reduce confusion among potential enrollees or curtail misleading sales practices and outright fraud.

With regard to Medigap policies, for example, some Medicare beneficiaries were sold multiple plans or plans that duplicated their employer-based retiree coverage. Many beneficiaries were baffled by the number of plans, each with its own benefit structure. In addition, some plans provided coverage of little value. As a consequence, Congress enacted legislation in 1980, 1990 and 1994 that, in conjunction with greater state oversight, regulated Medigap marketing, standardized the benefits packages that could be offered, ensured that a significant portion of premium costs would be devoted to medical coverage (rather than to plan profits or administrative costs), and established key consumer protections such as open enrollment periods and limits on exclusions for pre-existing health conditions. These improvements helped stabilize the Medigap market and substantially reduced beneficiary complaints about marketing abuses.³⁶

In a similar vein, after Congress established a refundable tax credit for the purchase of health insurance for low-income children in 1990, with few standards involved, Congress had to revisit that issue. The tax credit proved to be a failure of such a scope that Congress repealed the tax credit in 1993. The decision to repeal the credit came after investigations by the IRS and the Oversight Subcommittee of the House Ways and Means Committee found that many low-income families were being sold flimsy insurance policies of little merit. Some insurers sold policies for children that covered only cancer, heart attacks, strokes, and other diseases that few children have. Other policies imposed restrictions such as the exclusion of pre-existing conditions and/or austere benefit limits, such as a limit of one outpatient visit per year. The investigations also uncovered extensive evidence of insurance agents using misleading, high-pressure sales tactics and, in some cases, posing as government officials.³⁷

The Medigap experience is instructive for how to address the marketing abuses in Medicare Advantage. Reducing the excessive payments to Medicare Advantage plans could help bring these marketing abuses under control by reducing the financial incentives for such practices. Increased federal and state regulation and oversight of the marketing of such plans would also be of value. Unfortunately, the 2003 Medicare drug law moved in the opposite direction, taking the unwise step of significantly limiting *state* regulation of private Medicare plans. Restoring states' ability to investigate and penalize plans and their agents for improper marketing practices would be an important step in curbing abusive marketing.

As with Medigap, plan benefits also could be better standardized in order to reduce beneficiary confusion. For example, plans could be barred from scaling back benefits that are offered

³⁶ Jim Hahn, "Standardized Choices: Medigap Lessons for Medicare Part D," Congressional Research Service, March 8, 2006.

³⁷ "Report on Marketing and Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit," Subcommittee on Oversight of the House Ways and Means Committee, June 1, 1993.

under traditional Medicare. Preventing private plans from charging higher cost-sharing for certain Medicare services, such as chemotherapy and hospital care, would not only prevent private-plan enrollees from facing higher costs in Medicare Advantage plans but also would reduce plans' ability to entice healthier beneficiaries while discouraging enrollment by those who are in poorer health.