

Note

Modernizing Medicare: Protecting America's Most Vulnerable Patients from Predatory Health Care Marketing Through Accessible Legal Remedies

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Seventy-four-year-old T.W. Aldridge of Mississippi woke up one day to discover that his Medicare health plan was switched from a government-insured plan to a private Medicare Advantage plan.¹ An insurance salesman forged Mr. Aldridge's signature to collect a \$300 commission, thereby enrolling Mr. Aldridge in a health plan that his doctors would not accept.² Mr. Aldridge, ailing and in need of medical care, accrued over \$40,000 in out-of-pocket expenses while enrolled in a private Medicare Advantage plan.³ He spent months trying to get off the private plan by continually telephoning and submitting letters to Medicare and the insurance company.⁴ After his long struggle, Mr. Aldridge's plan was finally switched back to original Medicare—unfortunately, the change came eleven days after he died.⁵

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1. Armen Keteyian, *Trapped in the Private Medicare Maze*, CBS NEWS, July 17, 2007, http://www.cbsnews.com/stories/2007/07/17/cbsnews_investigates/printable3067330.shtml.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

Disturbingly, stories like Mr. Aldridge's are becoming increasingly common throughout the United States.⁶ In California, insurance agents made an unscheduled visit to a subsidized housing complex where they enrolled elderly Chinese-Americans with limited English proficiency in private Medicare plans.⁷ Forty-four of these residents were enrolled in private plans without understanding that neither their doctors nor the county hospital accepted the private plans.⁸ In other instances, agents enrolled mentally disabled persons without consulting their guardians and even signed up deceased persons for private Medicare plans.⁹ Tens of thousands of Medicare beneficiaries have been victimized by the deceptive sales tactics of insurers running Medicare's huge private plan options.¹⁰ Recent audits of the Medicare program document widespread violations of patients' rights and consumer protection standards.¹¹ Such violations directly impact the health of patients by delaying access to urgently needed medications¹² or denying coverage of medical treatments.¹³

6. See, e.g., Robert Pear, *For Recipients of Medicare, the Hard Sell*, N.Y. TIMES, Dec. 17, 2007, at A1 (describing the persistent problem of aggressive Medicare marketing throughout the country).

7. Robert Pear, *Hard Sell Cited as Insurers Push Plans to Elderly*, N.Y. TIMES, May 7, 2007, at A18.

8. See Letter from Clare Crawford & Michael Keys, Staff Attorneys, Bay Area Legal Aid, to Leslie V. Norwalk, Acting Adm'r, Ctrs. for Medicaid & Medicaid Servs. (Mar. 9, 2007), available at http://www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391/article.2007-03-13.2062873155/at_download/attachment.

9. *Insurers Suspend the Marketing of Some Medicare Plans*, N.Y. TIMES, June 16, 2007, at C2.

10. Robert Pear, *Medicare Audits Show Problems in Private Plans*, N.Y. TIMES, Oct. 7, 2007, at A1.

11. *Id.*; see also OFFICE OF INSPECTOR GEN., DEPT OF HEALTH & HUMAN SERVS., NO. OEI-01-05-00130, MEDICARE ADVANTAGE MARKETING MATERIALS FOR CALENDAR YEAR 2005, at 12 (2006), available at <http://oig.hhs.gov/oei/reports/oei-01-05-00130.pdf> (concluding from audits in fiscal year 2005 that some private plans were not in compliance with federal marketing regulations).

12. Pear, *supra* note 10.

13. See, e.g., *Predatory Sales Practices in Medicare Advantage: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 110th Cong. (2007) [hereinafter *Oversight & Investigations Hearing*] (hearings audio file) (statement of Brenda Clegg-Boodram, Resident, D.C. Housing Authority Property for Senior and Disabled People of Low Income), http://energycommerce.house.gov/cmte_mtgs110-oi-hrg.062607.MedicareAdvantage.shtml (describing how a fellow resident was denied medical treatment for multiple sclerosis while enrolled in a Medicare Advantage plan).

Medicare Advantage and Part D prescription drug plans are private health-benefit options approved by Medicare but sold and administered by private insurance companies.¹⁴ Although these plans are not administered by the government, they are still considered part of the Medicare program, and companies who sell them must be approved by the federal government.¹⁵ The programs were created as part of the Medicare Modernization Act of 2003,¹⁶ and coverage became effective on January 1, 2006.¹⁷ Since that time, abuse of seniors has grown.¹⁸ This problem is not limited to a few rogue insurance agents, as companies offering the plans frequently intimate.¹⁹ Rather, insurers provide lucrative incentives to producers who sell private Medicare products²⁰ and often fail to appropriately train or supervise their agents.²¹

Abusive marketing problems are aggravated by insufficient regulations and federal enforcement failures.²² Current Medi-

14. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., MEDICARE & YOU 37–38 (2007), <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

15. See 42 U.S.C. § 1395w-27 (2000 & Supp. V 2007) (delineating the requirements for federal contracts with insurers offering Medicare Advantage plans); *id.* § 1395w-112 (providing the requirements for federal contracts with prescription drug plan sponsors).

16. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C.).

17. See 42 U.S.C. § 1395w-101.

18. Compare Robert Pear, *Insurers' Tactics in Marketing Drug Plan Draw Complaints*, N.Y. TIMES, Nov. 27, 2005, at 33 (quoting a federal official who stated there had been about one hundred reported complaints of aggressive marketing of prescription drug plans before the benefit went into effect), with Pear, *supra* note 10 (indicating that by the fall of 2007 “tens of thousands” of beneficiaries were victims of predatory marketing).

19. See Robert Pear, *Oklahoma Chides Insurer in Medicare Marketing Case*, N.Y. TIMES, May 15, 2007, at A14 (quoting an executive from an insurance organization as saying, “[a] few bad apples have been behaving unethically”).

20. See, e.g., *Medicare Advantage Marketing and Sales: Who Has the Advantage?: Hearing Before the S. Spec. Comm. on Aging*, 110th Cong. 19 (2007) [hereinafter *Aging Hearing*] (statement of Sean Dilweg, Insurance Comm'r, Wisconsin) (noting that an insurer paid agents commissions ranging from \$50 to \$250 for private Medicare plan sales).

21. Pear, *supra* note 19.

22. See 153 CONG. REC. S10,153 (daily ed. July 26, 2007) (statement of Sen. Kohl) (explaining that the exclusive authority of the Centers for Medicare and Medicaid Services to investigate and discipline the marketing and selling of private Medicare plans has left a “sizeable enforcement gap” that has exacerbated marketing abuses).

care marketing guidelines lack comprehensive protections for beneficiaries.²³ Unfortunately, these weak regulations preempt stronger state law protections.²⁴ Inaction by federal regulatory agencies, coupled with broad preemption of state law creates a legal fissure in which vulnerable Medicare patients are pitted against wealthy private insurers without accessible legal avenues for relief.

This Note offers solutions to the weak regulation and enforcement gaps that facilitate marketing abuse. Current legislative proposals to predatory marketing problems fall short in providing the appropriate relief needed by victimized Medicare beneficiaries.²⁵ This Note does not engage in the political debate over the validity of privatizing Medicare's benefit packages.²⁶ Rather, it contends that as long as Medicare offers private benefits, government authorities are responsible for protecting patients from unscrupulous marketing behavior. Part I of this Note examines the development of the Medicare program, the movement to privatize benefits, and the expansive preemption of state authority under the Medicare law. Part II analyzes the current law and discusses legislation introduced to remedy the abusive marketing crisis, ultimately arguing that the measures do not offer enough protection for beneficiaries. Part III draws from the strengths of consumer protection theories to recommend legislative reforms. Specifically, this Note proposes delegating enforcement authority to states, employing existing state consumer protections, creating

23. Under current regulations, insurers may engage in sales practices generally considered inappropriate for senior citizens, such as cold-calling and cross-selling unrelated insurance products. See *Aging Hearing*, *supra* note 20, at 19–20 (statement of Sean Dilweg, Insurance Comm'r, Wisconsin).

24. 42 U.S.C. §§ 1395w-26(b)(3), -112(g) (Supp. V 2007) (preempting all state laws and regulations related to private Medicare plans).

25. See Accountability and Transparency in Medicare Marketing Act of 2007, S. 1883, 110th Cong. (2007); Accountability and Transparency in Medicare Marketing Act of 2007, H.R. 4790, 110th Cong. § 1 (2007); Preventing Medicare Seniors from Being Confused Due to Abusive Marketing (Prevent Medicare SCAMs) Act of 2007, H.R. 2307, 110th Cong. § 1 (2007).

26. For discussions on the values and demerits of privatizing Medicare benefits, see Susan Adler Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will It Be Good Medicine for U.S. Health Policy?*, 14 ELDER L.J. 237, 241–45 (2006) (critiquing privatization), and Mark Schlesinger & Jacob S. Hacker, *Secret Weapon: The "New" Medicare as a Route to Health Security*, 32 J. HEALTH POL. POL'Y & L. 247, 282–84 (2007) (arguing that Medicare's public-private hybrid gives the program flexibility).

a private cause of action for consumer redress, and enhancing violation penalties.

I. THE CREATION, REFORM, AND REGULATION OF MEDICARE

Medicare is the largest public health care program in the United States.²⁷ Since its inception in 1965, Medicare has provided health coverage for our nation's most vulnerable patients.²⁸ Originally modeled on the Social Security benefit and European social welfare programs,²⁹ Medicare recently expanded private plan options in a shift towards market-based health care.³⁰

A. "SOCIALIZED MEDICINE" AND THE RISE OF GOVERNMENT-SPONSORED HEALTH INSURANCE

Notably demonized by opposition groups as "socialized medicine,"³¹ the enactment of Medicare reflected the culmination of an epochal political struggle that raged across the country for more than a generation.³² The Medicare Act was finally passed in 1965.³³ Medicare continues to come under sharp criticism,³⁴ but the program remains considerably popular among Americans.³⁵

27. See MARILYN MOON, *MEDICARE: A POLICY PRIMER* 1 (2006) (stating that Medicare is also one of the fastest growing programs in the national budget).

28. According to the Centers for Medicare and Medicaid Services (CMS), the federal agency charged with administering Medicare, over 42 million elderly and disabled persons received Medicare benefits in 2005. See Ctrs. for Medicare & Medicaid Servs., *Medicare Enrollment: All Beneficiaries as of July 2005*, <http://www.cms.hhs.gov/MedicareEnRpts/> (follow "2005 and All" hyperlink) (last visited Mar. 11, 2008).

29. See Bruce C. Vladeck, *The Struggle for the Soul of Medicare*, 32 J.L. MED. & ETHICS 410, 411 (2004).

30. See Remarks by the President at the Signing of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 2 PUB. PAPERS 1694, 1696-97 (Dec. 8, 2003) (praising the new Medicare legislation for providing beneficiaries with choices between private plans).

31. See RICHARD HARRIS, *A SACRED TRUST* 2 (1966).

32. See *id.* at 2-3 (noting that opposition forces spent almost \$50 million in national campaigns); MONTE M. POEN, *HARRY S. TRUMAN VERSUS THE MEDICAL LOBBY* 1-28 (1979) (detailing conflicts over health security beginning in 1915).

33. Health Insurance for the Aged Act (Medicare Act), Pub. L. No. 89-97, 79 Stat. 290 (1965).

34. See, e.g., Richard A. Epstein, *Introduction* to DAVID A. HYMAN, *MEDICARE MEETS MEPHISTOPHELES*, at xi, xii (2006) (criticizing Medicare as a

Medicare has achieved substantial success in providing health care to some of America's most vulnerable citizens.³⁶ Medicare improved access to health care.³⁷ Before Medicare, only about half of all older Americans had health insurance³⁸ and senior citizens were increasingly harmed by the rising costs of health care.³⁹ Medicare almost immediately doubled the share of elderly citizens with insurance.⁴⁰ Medicare's benefit package has changed little since 1965,⁴¹ although private insurance companies have gained increased prominence in the program.⁴²

"multi-trillion-dollar mistake that encapsulates all that is wrong with the modern social welfare state").

35. See MOON, *supra* note 27, at 2 (stating that Medicare is one of the most popular public programs and gets higher marks from its beneficiaries than most private health insurance companies serving the younger population); Vladeck, *supra* note 29, at 410–11 (noting that Medicare remains popular among Americans of all ages and socioeconomic status).

36. Persons eligible for Medicare include patients age sixty-five and over, persons with disabilities, and end-stage renal disease patients. See 42 U.S.C. § 1395c (2000).

37. Medicare played an important role in desegregating medical facilities. See Robert M. Ball, *Reflections on How Medicare Came About*, in MEDICARE: PREPARING FOR THE CHALLENGES OF THE 21ST CENTURY 27, 27–28 (Robert D. Reischauer et al. eds., 1998) (stating that when the author was the Medicare Commissioner during the program's first seven years, not only were hospitals required to submit desegregation plans, but Medicare inspectors would investigate facilities to determine whether integration was actually occurring).

38. MOON, *supra* note 27, at 2.

39. See RASHI FEIN, MEDICAL CARE, MEDICAL COSTS: THE SEARCH FOR A HEALTH INSURANCE POLICY 53 (1986) (noting that elderly Americans often had low incomes, faced higher health insurance premiums, lacked employer contributions, and required more medical attention).

40. By 1970, ninety-seven percent of older Americans were enrolled in the Medicare program, and that proportion has remained steady since. MOON, *supra* note 27, at 2.

41. BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 364 (5th ed. 2004) (explaining that the Medicare benefits package still closely resembles the standard package available in the mid-1960s).

42. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified in scattered sections of 42 U.S.C.) (creating private managed care options); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C.) (creating private prescription drug plans and expanding private managed care options).

B. MEDICARE REFORM AND INCREASED PRIVATIZATION OF THE PROGRAM

Medicare is divided into four parts. Part A covers the cost of hospital care⁴³ and Part B pays for physician services and outpatient care.⁴⁴ Parts A and B are incorporated in the traditional fee-for-service program, or “Original Medicare,” in which the government serves as the insurer.⁴⁵ In 1997, Congress added Part C, initially known as the “Medicare+Choice” program⁴⁶ and now recognized as “Medicare Advantage.”⁴⁷ Part C plans are approved by Medicare and offer the same coverage available under Parts A and B.⁴⁸ However, Part C plans are managed and administered by private companies.⁴⁹ Part D is the prescription drug program created in 2003.⁵⁰ Part D is also administered entirely by private companies.⁵¹

1. Private Plan Options

Medicare has a history of cooperation with private insurers.⁵² Introduced to expand plan choices,⁵³ private plans were

43. See 42 U.S.C. § 1395c (2000) (describing Part A hospital coverage).

44. See *id.* § 1395k (describing the scope of benefits under Part B).

45. Under Original Medicare, the federal government acts as an insurance company by bearing the risk for the costs of the basic benefit package. MOON, *supra* note 27, at 3. Part A is funded by payroll taxes and a portion of the taxation of Social Security benefits. *Id.* at 4. Similarly, Part B is funded by beneficiary-paid premiums and general revenues that mostly come from personal income taxes. *Id.* at 3–4.

46. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified in scattered sections of 42 U.S.C.).

47. See 10 U.S.C. § 1108 (2000 & Supp. V 2007) (noting that references to “Medicare+Choice” refer to “Medicare Advantage or MA” as provided in section 201(b) of the Medicare Prescription Drug, Improvement, and Modification Act of 2005 and set out as a note under 42 U.S.C. § 1395w-21 (2000 & Supp. V 2007)).

48. See, e.g., 42 U.S.C. § 1395w-22 (detailing benefits available under Part C).

49. See, e.g., *id.* § 1395w-27 (describing guidelines for contracting with organizations to offer Part C plans); see also CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 14, at 38.

50. Part D provisions of the Act are codified in 42 U.S.C. § 1395w.

51. See, e.g., 42 U.S.C. § 1395w-111 to -112 (codifying bid submission rules, contract regulations, and other general requirements for insurers offering Part D prescription drug plans).

52. See Michael J. Jackonis, Jr., *Considerations in Medicare Reform: The Impact of Medicare Preemption on State Laws*, 13 ANNALS HEALTH L. 179, 185 (2004) (explaining that Medicare has offered coverage through managed care organizations since 1972).

53. See Geraldine Dallek et al., *Lessons from Medicare+Choice for Medi-*

intended to hold down treatment expenses by incorporating managed care components and reducing premiums through private competition.⁵⁴ Under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982,⁵⁵ integrated health systems offering Medicare managed care plans were paid on a full-risk basis and required savings to be passed on to beneficiaries in the form of increased benefits or reduced cost sharing, used for future benefits, or refunded to Medicare.⁵⁶ A significant effort to expand enrollment in private plans occurred with the passage of the Balanced Budget Act of 1997, which created the Medicare+Choice program.⁵⁷

The Medicare+Choice program encountered many problems, including overly complicated options that hindered beneficiaries' ability to make informed choices.⁵⁸ Unstable health provider participation also caused many private companies to leave the Medicare program.⁵⁹ Despite the intent of the program to reduce costs, the private plans were more expensive for the government than traditional Medicare.⁶⁰ These problems led to legislative reform of the program.

In 2003, Congress reformed the troubled Medicare+Choice program by passing the Medicare Modernization Act⁶¹ (MMA), which renamed the program "Medicare Advantage."⁶² The Act expanded managed care and established a system of managed competition between private insurers and the government.⁶³ Medicare Advantage plans, administered by private companies,

care Reform, COMMONWEALTH FUND, June 2003, at 1, 1, available at http://www.commonwealthfund.org/usr_doc/Dallek_lessonsM+C_658.pdf?section=4039.

54. MOON, *supra* note 27, at 111–12.

55. Pub. L. No. 97-248, 96 Stat. 324 (codified as amended at 42 U.S.C. § 1395 (2000 & Supp. V 2007)).

56. Jackonis, *supra* note 52, at 187.

57. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified in scattered sections of 42 U.S.C.).

58. See Dallek et al., *supra* note 53, at 4–5.

59. Between 1999 and 2003, more than 2.4 million beneficiaries were affected by plan withdrawals and overall enrollment in Medicare+Choice managed care plans dropped by 1.4 million beneficiaries. *Id.* at 3.

60. See *id.* at 6–7.

61. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C.).

62. 10 U.S.C. § 1108 (2000 & Supp. V 2007).

63. Melissa M. Ostrowski, Recent Development, *Medicare Advantage Private Fee-for-Service Plans: What Privatization Means for Today's Beneficiaries*, 8 MARQ. ELDER'S ADVISOR 375, 378 (2007).

provide hospital and primary care coverage, and many plans offer additional benefits not available under the government-insured Medicare plans.⁶⁴ Unlike its predecessor, the Medicare Advantage program offers no appearance of cost control.⁶⁵ In fact, the MMA provides a series of financial subsidies designed to attract private insurers to the Medicare market.⁶⁶

The MMA also created a long-awaited prescription drug program⁶⁷ available to all Medicare beneficiaries, known as Part D.⁶⁸ Enamored with market approaches to health care coverage and perhaps eager to protect the interests of heavy political contributors such as drug manufacturers, insurance companies, and managed care organizations,⁶⁹ lawmakers designed the Part D prescription drug benefit as a program entirely administered by private insurers.⁷⁰

2. Profitability for the Private Health Care Industry

Private insurers have an opportunity to make a lot of money off Medicare plans. Rather than encouraging plans to offer more benefits at less cost,⁷¹ the government now pays private plans more than the traditional government-sponsored plan.⁷²

64. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 14, at 33, 35, 38 (describing extra benefits such as coverage for vision, hearing, dental, and general wellness programs).

65. Jonathan Oberlander, *Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act*, 32 J. HEALTH POL. POL'Y & L. 187, 204 (2007).

66. See 42 U.S.C. § 1395w-23 (2000 & Supp. V 2007).

67. In the wake of rising drug costs, Judge Selya criticized Medicare's lack of prescription drug coverage, noting that "[i]f social programs are meant to furnish a safety net, Medicare is a notoriously porous one. A main cause of this porosity is that most outpatient prescription drugs are not covered." *Mass. Ass'n of Health Maint. Orgs. v. Ruthardt*, 194 F.3d 176, 177 (1st Cir. 1999).

68. See 42 U.S.C. § 1395w-101 to -152.

69. See FURROW ET AL., *supra* note 41, at 367; see also Remarks Following a Meeting on Prescription Drug Benefits, 43 WEEKLY COMP. PRES. DOC. 511 (Apr. 23, 2007) (highlighting the success of the MMA by praising the principles of competition incorporated in the program).

70. See, e.g., 42 U.S.C. § 1395w-112 (articulating the requirements for contracts with prescription drug plan sponsors).

71. Roger Feldman & Bryan Dowd, *Structuring Choice Under Medicare*, in *MEDICARE: PREPARING FOR CHALLENGES OF THE 21ST CENTURY*, *supra* note 37, at 75, 76-77 (describing the competitive health care delivery system encouraged under TEFRA that emphasized cost savings for the government and greater benefits for patients).

72. Marsha Gold, *Private Plans in Medicare: Another Look*, 24 HEALTH AFF. 1302, 1303 (2005) (stating that on average, a Medicare Advantage plan will receive about 108% of what Medicare pays for the same beneficiary in the

“Under the Medicare Advantage program, the government pays insurers an average of \$9,000 a year for each person enrolled in a private plan.”⁷³ Medicare payments to private health plans increased by a record 10.6% in 2004, in an effort to persuade the plans to enter the expanded Medicare market.⁷⁴ Federal officials and members of Congress said they hoped that the increase, five times as large as the typical annual increase, would stop private plans from deserting the Medicare program.⁷⁵ High payments to insurers offering private Medicare plans continue today.⁷⁶ Private plans have an incentive to enter the Medicare market and to do well within it. However, the government is ultimately responsible for overseeing the operation of Medicare.⁷⁷

C. GOVERNMENT RESPONSIBILITY FOR MEDICARE MARKETING

1. Federal Oversight and Regulation of Private Medicare Plans

Private health plans are not considered public actors for the purposes of the procedural due process clause,⁷⁸ but are still subject to government oversight. Federal statutes provide for the coordinated administration of the Medicare Prescription Drug and Medicare Advantage programs by the Centers for Medicare & Medicaid Services (CMS).⁷⁹ Private plans are required to submit all marketing materials to CMS for review,⁸⁰ and the agency has established detailed marketing guide-

traditional fee-for-service program).

73. Pear, *supra* note 6.

74. See Robert Pear, *Private Health Plans to Receive Record Increase from Medicare*, N.Y. TIMES, Jan. 20, 2004, at A1 (noting that the Bush administration wanted to triple enrollment in private plans within three years of passing the MMA).

75. *Id.*

76. See *Medicare Participants Face a 3% Rise in Premiums*, STAR TRIB. (Minneapolis, Minn.), Oct. 1, 2007, <http://www.startribune.com/484/story/1458330.html> (noting that high payments to private insurers in October 2007 contributed to premium increases for beneficiaries).

77. See 42 U.S.C. § 1395b-9 (Supp. V 2007) (describing the administration of Medicare).

78. See *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 43–44, 60 (1999) (holding that private health plans are not state actors for the purposes of the Due Process Clause).

79. See 42 U.S.C. § 1395b-9.

80. 42 C.F.R. §§ 422.80, 423.50 (2006) (regulating the approval of marketing materials and enrollment forms for Medicare Advantage and Part D plans).

lines.⁸¹ Part D plans, for example, are prohibited from certain specific marketing activities such as inducing enrollment through remunerations, soliciting Medicare beneficiaries door-to-door, and engaging in activities that could mislead or confuse Medicare beneficiaries.⁸² Similar requirements exist for Medicare Advantage plans.⁸³

In the spring of 2007, CMS announced that seven insurance companies voluntarily suspended marketing their private Medicare health plans.⁸⁴ The decision came after increased reports that insurance agents tricked elderly customers into buying policies they could not afford.⁸⁵ Three months later, the biggest private providers of Medicare coverage were cleared to resume marketing their Medicare Advantage plans.⁸⁶ CMS has begun imposing fines on insurers,⁸⁷ but senior citizen advocates continue to question the agency's commitment to protecting beneficiaries.⁸⁸

Commentators criticize CMS for not adequately protecting patients against marketing abuses.⁸⁹ In particular, critics are

81. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE MARKETING GUIDELINES FOR MEDICARE ADVANTAGE PLANS, MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS, PRESCRIPTION DRUG PLANS, 1876 COST PLANS (2d rev. 2006), available at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf>.

82. 42 C.F.R. § 423.50(f).

83. See *id.* § 422.80.

84. See *Insurers Suspend the Marketing of Some Medicare Plans*, N.Y. TIMES, June 16, 2007, at C2.

85. See *id.*

86. See *Medicare Advantage Marketing OK'd*, STAR TRIB. (Minneapolis, Minn.), Sept. 24, 2007, available at <http://www.startribune.com/535/story/1443559.html> (noting that UnitedHealth Group Inc., Humana, Inc., Blue Cross-Blue Shield of Tennessee, and Aon Corporation's Sterling Life Insurance Co. had all been approved to market their Medicare Advantage plans).

87. See CTRS. FOR MEDICARE & MEDICAID SERVS., ENFORCEMENT ACTIONS AGAINST MEDICARE ADVANTAGE ORGANIZATIONS AND PRESCRIPTION DRUG SPONSORS: JANUARY 2006–JANUARY 2008 (2008), http://www.cms.hhs.gov/MCRAdvPArtDENrolData/Downloads/Enforcement_Actions_Web.pdf (listing all enforcement actions by CMS since January 2006, which include two instances of fines levied against plans for marketing violations).

88. See, e.g., DAVID LIPSCHUTZ ET AL., CAL. HEALTH ADVOCS., THE RELUCTANT REGULATOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES' RESPONSE TO MARKETING MISCONDUCT BY MEDICARE ADVANTAGE PLANS 2 (2007), http://www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Regulator-2007-07.pdf.

89. See, e.g., Letter from John D. Dingell, Henry Waxman, Charles Rangel, Sherrod Brown, & Pete Stark, Representatives, United States Congress, to Dr. Mark B. McClellan, Adm'r, Ctrs. for Medicare & Medicaid Servs. (Sept. 7, 2006), available at http://www.naic.org/documents/committees_b_senior_

concerned that generous payments to private plans encourage predatory sales practices because every enrollee is a potential source of profit for private plans.⁹⁰ Others note that CMS lacks the resources necessary to respond to widespread marketing abuses.⁹¹ State regulators express concern that the current federal marketing guidelines, crafted by CMS, permit certain high-pressure sales tactics that are generally considered inappropriate for senior citizens, such as cold calls and cross-selling.⁹² Insurance commissioners explain that once agents start talking to seniors about Medicare plans, they often try to sell unrelated and sometimes unsuitable insurance products such as annuities, life insurance, and funeral policies.⁹³

In light of such accusations, the National Association of Insurance Commissioners (NAIC) requested that CMS require plan sponsors to restrict how the companies market non-Medicare products in conjunction with Medicare products, otherwise referred to as “cross-selling.”⁹⁴ However, CMS refused to place cross-selling restrictions on plan sponsors,⁹⁵ stating that since it does not regulate the sale of non-Medicare insurance products, the creation of restrictions on cross-selling would be an “indirect way of regulating products and activities that are regulated by other governmental entities and, therefore, it is inappropriate for CMS to create such restrictions.”⁹⁶ As referenced by this statement, states are usually the government

issues_House_letter_to_McClellan.pdf (expressing concern about abusive marketing of prescription drug plans).

90. See Pear, *supra* note 6 (describing high government payments to insurers for each private plan enrollee and noting that agent commissions range as high as \$600 for each sale).

91. *E.g.*, *Aging Hearing*, *supra* note 20, at 47 (statement of Kim Holland, Insurance Comm’r, Oklahoma).

92. See *id.* at 18–21 (statement of Sean Dilweg, Insurance Comm’r, Wisconsin).

93. See *id.* at 19.

94. *Winter 2006 National Meeting*, 2006 NAIC PROC. 4TH QTR. 747, 757–58 (Nat’l Ass’n of Ins. Comm’rs, Kansas City, Mo.).

95. CMS responded to concerns about cross-selling by noting, “We do not want to restrict beneficiaries from receiving materials about health-related and non-health-related services that may be of benefit to them in managing their health or payments for health care.” Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4224 (Jan. 28, 2005).

96. See Nat’l Ass’n of Ins. Comm’rs, *supra* note 94, at 757 (citing Letter from Abby L. Block, Dir. of the Ctr. for Beneficiary Choices, Ctrs. for Medicare and Medicaid Servs., to Jorge Gomez, Chair, Senior Issues Task Force and Comm’r, Wis. Dep’t of Ins., Nat’l Ass’n of Ins. Comm’rs (Dec. 9, 2006)).

agencies responsible for regulating the sales of most insurance products.⁹⁷

2. State Protection of Beneficiaries

Abusive marketing of private Medicare plans is a growing concern for state governments. State insurance commissioners note that the lack of federal enforcement has created “virtual lawlessness.”⁹⁸ According to a survey conducted in April 2007 by the NAIC, forty-one states reported receiving complaints about misrepresentations in the marketing and sales of private Medicare plans.⁹⁹ Thirty-three states received complaints about cross-selling non-Medicare products, and thirty-nine states reported complaints about inappropriate or confusing marketing practices that led beneficiaries to enroll in plans they did not understand.¹⁰⁰ States use a complaint system as one of the tools to regulate the insurance industry and protect consumers.

Many states enacted insurance suitability laws requiring sales agents and insurance companies to determine whether a particular insurance product is appropriate for a consumer before selling the product.¹⁰¹ Some suitability laws only apply to senior citizen sales,¹⁰² while others do not specify application to

97. See 15 U.S.C. § 1012(a) (2000) (“The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.”).

98. See *Aging Hearing*, *supra* note 20, at 46–47 (statement of Kim Holland, Insurance Comm’r, Oklahoma).

99. NAT’L ASS’N OF INS. COMM’RS SENIOR ISSUES TASK FORCE, STATE SURVEY ON MEDICARE MARKETING ISSUES: PRELIMINARY RESULTS 2007, at 1 (2007), http://www.naic.org/documents/committees_b_senior_issues_0706_medicare_advantage_marketing_survey.pdf (noting that surveys were received from forty-six state departments of insurance and that results differed widely as many states did not track complaints because their authority is preempted by the Medicare Modernization Act).

100. *Id.*

101. See, e.g., MINN. STAT. § 60K.46, subdiv. 4 (2006) (requiring agents selling long-term care, annuity, life-endowment, or Medicare supplement insurance to have “reasonable grounds for believing that the recommendation is suitable for the customer” by making “reasonable inquiries to determine suitability” including looking into the customer’s income, need for insurance, and the values, benefits, and costs of the customer’s existing insurance program, when compared to that same qualities of the recommended policy); *id.* § 72A.20, subdiv. 34 (applying similar suitability requirements to insurance companies).

102. See, e.g., FLA. STAT. § 627.4554 (2007); WIS. STAT. § 628.347 (2004 & Supp. 2007). A pending bill to amend the Wisconsin statute would remove the “senior” limitation. S. 294, 2007 Leg., 98th Sess. (Wis. 2007).

a particular class of persons.¹⁰³ Suitability laws may have specific requirements for certain insurance products, such as long-term care insurance¹⁰⁴ or annuities.¹⁰⁵ Although beneficiaries currently seek help from their state governments that have mechanisms to regulate abusive behavior, state authorities are struggling to find ways to protect senior citizens in light of the MMA's broad preemption of state laws.

3. Preemption of State Law

Historically, states exercised their police powers¹⁰⁶ to protect the health and safety of their citizens,¹⁰⁷ and played a primary role in the regulation of health care and insurance.¹⁰⁸ In 1945, Congress passed the McCarran-Ferguson Act¹⁰⁹ to ensure continued state authority over the insurance industry in the wake of a 1944 Supreme Court decision that recognized insurance as an element of interstate commerce.¹¹⁰ Although the McCarran-Ferguson Act grants states broad powers to regulate insurance, Congress reserved the right to supersede state law.¹¹¹ In fact, the Supreme Court recognized that the federal government has played an "increasingly significant role" in the "protection of the health of our people."¹¹²

Federal intervention into the domain of commercial activities traditionally regulated by the States poses "perhaps our

103. See, e.g., ALA. CODE § 482-1-137 (2007); OKLA. ADMIN. CODE § 365:25-17-7 (2007).

104. E.g., HAW. REV. STAT. § 431:10H-231 (2005 & Supp. 2007).

105. E.g., MONT. CODE ANN. § 33-20-805 (2007); TEX. INS. CODE ANN. § 1115.001 (Vernon 2007).

106. *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (noting that, when Congress legislates in an area traditionally regulated by states, "we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress").

107. The Supreme Court has noted that the states "traditionally have had great latitude" to legislate as to the "protection of the lives, limbs, health, comfort, and quiet of all persons." See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756 (1985) (citing *Slaughter House Cases*, 83 U.S. (16 Wall.) 36, 62 (1873)).

108. Jackonis, *supra* note 52, at 201 (explaining that states have historically regulated health care and insurance).

109. 15 U.S.C. §§ 1011–1015 (2000).

110. See *United States v. Se. Underwriters Ass'n*, 322 U.S. 533, 541–46, 553 (1944).

111. 15 U.S.C. § 1012(b).

112. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) (referencing the federal statutes regulating food and drug safety).

oldest question of constitutional law.”¹¹³ The Supremacy Clause of the U.S. Constitution provides that federal law shall be the “supreme Law of the Land; . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.”¹¹⁴ Courts have noted that although the power to preempt is “absolute,” its exercise is “not to be lightly presumed.”¹¹⁵ Rather, courts start with the assumption that the historic powers of the states are not to be superseded by federal law unless preemption is the clear and manifest purpose of Congress.¹¹⁶

The MMA “significantly altered” the preemption analysis for private Medicare programs,¹¹⁷ reversing the presumption that state laws were not preempted unless specific conditions were met.¹¹⁸ Instead, the MMA provides, “The standards established under this [part] shall supersede any State law or regulation,” other than State licensing laws or State laws relating to plan solvency, “with respect to MA [Medicare Advantage] plans which are offered by MA organizations under this part.”¹¹⁹ These same standards apply to the Part D prescription drug program.¹²⁰ The MMA’s legislative history supports broad preemption, indicating that the Medicare Advantage program is a federal program “operated under Federal rules” and state laws, “do not, and should not apply,” with the exception of state licensing or plan solvency laws.¹²¹

113. *New York v. United States*, 505 U.S. 144, 149 (1992) (“The constitutional question is as old as the Constitution: It consists of discerning the proper division of authority between the Federal Government and the States.”).

114. U.S. CONST. art. VI, cl. 2.

115. *E.g.*, *Mass. Ass’n of Health Maint. Orgs. v. Ruthardt*, 194 F.3d 176, 177–79 (1st Cir. 1999).

116. *See Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).

117. *See Jennifer L. Weaver et al., Courts, Regulators Wrestle with Scope of Part D Preemption*, HEALTH LAW., Feb. 2007, at 18, 18 (noting that before the enactment of the MMA, the presumption was that state law was not preempted if it did not conflict with a Medicare+Choice requirement and did not fit into one of four specified categories where preemption was presumed).

118. The MMA amended section 1856(b)(3) of the Social Security Act and significantly broadened the scope of federal preemption of state law. *See Medicare Program; Medicare Prescription Drug Benefit*, 70 Fed. Reg. 4588, 4663 (Jan. 28, 2005) (codified at 42 C.F.R. pts. 417 and 422).

119. 42 U.S.C. § 1395w-26(b)(3) (Supp. V 2007).

120. *See id.* § 1395w-112(g) (stating that the preemption provisions of §§ 1395w-24(g), 1395w-26(b)(3) also apply to prescription drug plans).

121. H.R. REP. NO. 108-391, at 557 (2003), *as reprinted in* 2003 U.S.C.C.A.N. 1808, 1926.

CMS similarly asserts that the MMA broadly preempts state law.¹²² Because Medicare Advantage and Part D incorporate the same preemption provision, CMS notes that Congress clearly intended the programs to operate in the same manner—that is—the programs are to be regulated solely by federal and not state rules.¹²³ In guidance documents for states, CMS maintains that federal laws preempt state laws applicable to marketing abuse.¹²⁴

Despite the sweeping preemption provisions advocated by CMS, many states have taken action to protect their citizens. For example, the New York State Insurance Department issued an opinion in 2007 stating that the MMA does not preempt all of New York's insurance laws.¹²⁵ In May 2007, the Oklahoma insurance commissioner conducted the first major investigation into Medicare marketing, documenting widespread misconduct by insurance agents and ordering an insurance company to take corrective action to protect consumers against high-pressure sales practices.¹²⁶ However, any actions states currently take against insurers depend on the cooperativeness of the plans themselves since, if raised, a preemption defense will likely defeat state enforcement actions.¹²⁷ While states struggle to negotiate ways to protect their citizens,¹²⁸ individual beneficiaries have challenged the MMA's preemption in court.

122. See, e.g., Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4588, 4664 (Jan. 28, 2005) (stating that under current federal preemption authority, states are limited in applying only those requirements that are directly related to agent licensing laws and may not regulate health plans); Letter from Abby L. Block, *supra* note 96 (asserting broad federal authority and limited state jurisdiction).

123. Weaver et al., *supra* note 117, at 18 (citing Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4319 (Jan. 28, 2005) (codified in 42 C.F.R. § 423) and Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4588, 4664 (Jan. 28, 2005) (codified in 42 C.F.R. § 422)).

124. Ctrs. for Medicare & Medicaid Servs., Questions and Answers on Preemption, <http://www.cms.hhs.gov/States/Downloads/QnAonPreemption.pdf> (last visited Mar. 11, 2008).

125. Medicare Prescription Drug Program, Use of Adjusters, 20 Op. N.Y. Ins. Dep't 07-07-20 (July 24, 2007), available at <http://www.ins.state.ny.us/ogco2007/rg070720.htm> (stating that, in addition to being subject to federal regulations, when a producer solicits and sells private Medicare plans in the state the agent is also required to follow state laws and regulations).

126. Pear, *supra* note 19.

127. See *Aging Hearing*, *supra* note 20, at 87 (statement of Heidi Margulis, Senior Vice President, Humana, Inc.) (asserting that Humana is not subject to Oklahoma state law under the MMA despite its willingness to comply with the state insurance commissioner's investigation).

128. See, e.g., Nat'l Ass'n of Ins. Comm'rs, Medicare Private Plans Sub-

Lawsuits brought by beneficiaries against health plan companies have largely been impeded by MMA preemption. In *Uhm v. Humana, Inc.*, a group of senior citizens brought suit against an insurance company offering a Part D prescription drug plan.¹²⁹ The plaintiffs alleged that the company violated various state laws by fraudulently inducing seniors to sign up for its prescription drug plan through the use of deceptive marketing tactics.¹³⁰ The court dismissed the lawsuit, holding that the plaintiffs' state law claims were preempted by the MMA.¹³¹ Citing the statutory language¹³² and legislative history,¹³³ the court also relied on the "comprehensive standards" for marketing materials promulgated by CMS to conclude that the MMA preempted state law.¹³⁴ A federal district court in Alabama used the same reasoning to dismiss a claim brought by seniors alleging that they were duped into joining a Medicare Advantage plan.¹³⁵ Similarly, the court noted that legislative history and congressional intent establish that the MMA was intended to preempt state law in the area of marketing regulation.¹³⁶

The First Circuit is the only federal appellate court that has addressed the preemptive effect of the MMA.¹³⁷ Although the court ultimately determined that the health plan at issue was actually part of the state Medicaid program and thus outside the scope of the Medicare preemption provision,¹³⁸ the court did discuss the congressional intent behind the preemption clause.¹³⁹ Without reaching the issue of whether the MMA preempts state law, the First Circuit analyzed the plain statutory language and legislative history of the MMA, noting that express preemption occurs when Congress "unmistakably or-

group, http://www.naic.org/committees_b_senior_issues_medicare_private_plans.htm (last visited Mar. 11, 2008) (providing links to recent testimony and debates regarding state regulation of private Medicare products).

129. *Uhm v. Humana, Inc.*, No. C06-0185-RSM, 2006 WL 1587443, at *1 (W.D. Wash. June 2, 2006).

130. *Id.*

131. *Id.* at *4.

132. *Id.* at *2.

133. *Id.* at *4.

134. *Id.* at *2.

135. *Dial v. HealthSpring of Ala., Inc.*, 501 F. Supp. 2d 1348, 1353-54 (S.D. Ala. 2007).

136. *Id.* at 1355-56.

137. *See* First Med. Health Plan, Inc. v. Vega-Ramos, 479 F.3d 46, 51-52 (1st Cir. 2007).

138. 42 U.S.C. § 1395w-26(b)(3) (Supp. V 2007).

139. *See Vega-Ramos*, 479 F.3d at 51.

dains” that its enactments alone are to regulate a particular subject matter and that “state laws regulating that subject must fail.”¹⁴⁰ Few courts have interpreted the MMA’s preemption clause, but the scope of federal preemption has been a particular concern for states, beneficiaries, and insurers.¹⁴¹

Courts will likely continue to grapple with state law preemption under the MMA as beneficiaries push for marketing abuse remedies.¹⁴² However, given the likelihood that the expansive preemption provisions in the plain language of current Medicare law will obstruct legal actions, there is little chance that state laws will be recognized as valid enforcement tools. Preemption of state law, coupled with federal inaction to protect beneficiaries from predatory marketing, creates a legal void in which victimized patients are left without sufficient recourse.

II. THE FEDERAL MEDICARE LAW FAILS TO PROTECT VULNERABLE BENEFICIARIES

Victims of marketing abuse need an effective remedy, particularly since patients unknowingly enroll in plans that limit their access to necessary medical care.¹⁴³ Section A of this Part argues that current federal marketing regulations do not provide enough protection against abuse. However, even if federal marketing rules are substantively improved, Section B contends that CMS is not an effective law enforcer because of its conflicted interest in promoting private plans. Finally, Section C analyzes legislative proposals to remedy the status quo, and

140. *See id.* (citing *Mass. Ass’n of Health Maint. Orgs. v. Ruthardt*, 194 F.3d 176, 179 (1st Cir. 1999)).

141. *Weaver et al.*, *supra* note 117, at 18 (noting that a common concern is the extent to which the MMA preempts state consumer protection statutes, insurance laws, and pharmacy regulations).

142. For instance, a federal court in Alabama found that beneficiaries’ common-law fraud claims arising from the sale of private Medicare plans were not completely preempted by federal law. *Harris v. Pacificare Life & Health Ins. Co.*, 514 F. Supp. 2d 1280, 1288 (M.D. Ala. 2007). However, the court only found that there was no federal question basis for removal, and it explicitly recognized that preemption may still be a defense in state court. *See id.* at 1294; *see also* *Lassiter v. Pacificare Life & Health Ins. Co.*, No. 2:07-cv-583-MEF, 2007 WL 4404051 (M.D. Ala. Dec. 13, 2007).

143. *See, e.g., Oversight & Investigations Hearing*, *supra* note 13 (statement of Brenda Clegg-Boodram, Resident, D.C. Housing Authority Property for Senior and Disabled People of Low-Income) (describing the consequences of denied medical treatment as a result of being misled into joining a Medicare Advantage plan).

concludes that a more comprehensive solution is needed to protect beneficiaries' individual rights.

A. FEDERAL MARKETING REGULATIONS ARE FLAWED

Existing federal marketing guidelines allow insurers to use confusing and aggressive sales tactics. Under current regulations, insurers may cross-market other insurance products while selling private Medicare plans.¹⁴⁴ Cross-marketing increases the likelihood that beneficiaries will be led to believe that unsuitable insurance products are endorsed by the Medicare program, or even required to receive health benefits.¹⁴⁵ Insurers eagerly take advantage of the unique cross-selling opportunities the MMA creates within the "senior market."¹⁴⁶ For example, commentators note that cross-marketing encourages financial service firms, such as banks, to sponsor private Medicare plans,¹⁴⁷ which may increase risks of federal privacy law violations.¹⁴⁸ However, even if cross-selling is eliminated, other activities that are currently permissible under federal marketing regulations are similarly troubling.

Federal regulations permit certain sales tactics that may be appropriate under other circumstances, but are not suitable for Medicare patients. For example, under the current regulations, insurers and their agents may cold-call Medicare-eligible

144. See, e.g., Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4224 (Jan. 28, 2005) (supporting cross-selling).

145. *Harris*, 514 F. Supp. 2d at 1284–85 (explaining the plaintiffs' claim that they were misled into joining a Medicare Advantage plan because they believed it was required to receive prescription drug coverage). *But see* 42 C.F.R. § 422.80(e)(iv) (2006) (prohibiting insurers from claiming that private plans are recommended or endorsed by the government).

146. Lindsay R. Resnick, *Turn Medicare Advantage into Sales Advantage*, NAT'L UNDERWRITER, Jan. 9, 2006, at 2, available at <http://lindsayresnick.typepad.com/Articles/MedicareTrends.pdf> (explaining that prescription drug plans can be leveraged as an entryway into selling other plans: "[i]f marketers and advisors give seniors a reason to trust them, they'll have a customer for life").

147. See *CNBC: "Street Signs"—Medicare Extreme Makeover* (CNBC television broadcast July 26, 2004), available at http://www.mbproject.org/media_center.php (linking to a rebroadcast of a CNBC story on cross-marketing opportunities for financial institutions).

148. Major sectors of the financial service industry take the position that they are exempt from the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), thereby jeopardizing beneficiaries' health information. See Joy Pritts, Health Pol'y Inst., *Marketing and Privacy Issues: An Analysis of the MMA and Proposed Regulations 10* (2004), <http://www.kff.org/medicare/upload/Marketing-and-Privacy-Issues-An-Analysis-of-the-MMA-and-Proposed-Regulations.pdf>.

individuals for the purpose of selling their private plans.¹⁴⁹ In many instances it is difficult for seniors to determine whether a call is legitimate or fraudulent.¹⁵⁰ Some commentators suggest that beneficiaries must adapt to the changing Medicare program by learning to “deal skeptically with people they have generally trusted in the past” and interpret “complex information about plans and providers.”¹⁵¹ Perhaps it is sensible for beneficiaries to view themselves as consumers in the private Medicare market.¹⁵² However, Medicare patients are senior citizens and chronically ill individuals who often have limited incomes,¹⁵³ and therefore are more susceptible to promises related to medical care. It is unreasonable to require beneficiaries to sort through convoluted Medicare information and determine whether a plan’s marketing materials are deceptive. Unfortunately, state protections that inhibit insurers from unfairly taking advantage of beneficiaries are displaced by the weak federal regulations.

Congress should not have preempted stronger state laws with federal regulations that permit aggressive marketing. The MMA’s broad preemption facilitates abusive marketing practices because it impedes other methods of law enforcement.¹⁵⁴ All of the states already provide avenues for remedying the harmful effects of predatory marketing.¹⁵⁵ Existing local infrastruc-

149. 42 C.F.R. §§ 422.80, 423.50 (2006) (detailing marketing regulations but not prohibiting cold-calling).

150. *E.g.*, Press Release, Better Business Bureau, Med Provision Asking Personal Questions (Sept. 25, 2007), *available at* http://www.spokane.net/stay_connected/PressReleases.aspx?prid=980 (describing deceptive cold-calls to senior citizens).

151. Stan Jones, *The Medicare Beneficiary as Consumer*, in *MEDICARE: PREPARING FOR CHALLENGES OF THE 21ST CENTURY*, *supra* note 37, at 61, 68.

152. *Id.* at 68–69.

153. *See, e.g.*, Dawn E. Havrda et al., *Impact of the Medicare Modernization Act on Low-Income Persons*, 143 *ANNALS OF INTERNAL MED.* 600, 604 (2005) (describing Medicare patient characteristics).

154. *See* 153 CONG. REC. S10,152 (daily ed. July 26, 2007) (statement of Sen. Kohl) (noting that under current law, CMS has “exclusive authority to investigate and discipline the marketing and selling of Medicare advantage products” and states have “only been permitted to examine and enforce violations against individual insurance agents,” which has “left a sizable enforcement gap that has exacerbated the problems” of abusive marketing).

155. *See, e.g.*, *Aging Hearing*, *supra* note 20, at 15 (statement of Sean Dilweg, Insurance Comm’r, Wisconsin) (noting that under other circumstances abusive marketing practices are either “prohibited by State laws or unfair or deceptive practices in the business of insurance or would be questioned by watchful State regulators and controlled by the State regulatory structure,”

tures offer faster and more responsive remedies, although critics are likely to respond that forcing insurance companies to comply with differing state regulations creates an unnecessary burden.¹⁵⁶

Uniform regulations may facilitate insurer compliance, but this is not a reason to preempt state law. Admittedly, there are difficulties in requiring plans to comply with fifty different state insurance regulations.¹⁵⁷ Diverse regulations increase the likelihood that insurers will be unaware of, and therefore not in compliance with, each state's nuanced rules.¹⁵⁸ Such difficulties have been cited as a reason to rely solely on preemptive federal regulations.¹⁵⁹ However, this argument fails since insurers already abide by the laws of each state in which they sell their other insurance products, including Medicare supplemental insurance (Medigap).¹⁶⁰ Requiring plans to observe state law will not create an unreasonable burden for the companies, as insurers are already accustomed to adhering to state standards.¹⁶¹ While uniform marketing standards have value, preemption would be more justified if the federal government also implemented sufficient protective regulations that were well en-

however, in cases involving Medicare Advantage and Medicare Part D, "our hands are tied as it relates to the companies").

156. See, e.g., *Aging Hearing*, *supra* note 20, at 87 (statement of Heidi Margulis, Senior Vice President, Humana, Inc.) (advocating for uniform rules).

157. *Hearing on the Regulation of Medicare Private Plans Before the Senior Issues Task Force*, Nat'l Ass'n of Ins. Comm'rs 5 (2007), http://www.naic.org/committees_b_senior_issues_medicare_private_plans.htm [hereinafter NAIC Hearing] (follow "BCBS of Minnesota" hyperlink) (written testimony of Lois Wattman, Senior Policy Counsel, Blue Cross-Blue Shield of Minnesota) (explaining that approval by CMS and local officials is likely to create delays).

158. *Id.* at 4 (noting that increased state regulation would "make it impossible" to meet the requirements of a product uniformly administered across the entire region).

159. *Id.* ("Blue Cross believes that the implications of increased oversight and authority for state regulators in a Medicare multi-state regional plan would make it extraordinarily difficult for the regional plan to meet its statutory and regulatory requirements."); see also NAIC Hearing, *supra* note 157, at 3-4 (follow "BCBS of Michigan" hyperlink) (written testimony of Catherine Schmitt, Vice President of Federal Programs, Blue Cross-Blue Shield of Michigan) (arguing that "dual regulation" may lead to "conflicts and inconsistencies in state oversight and Plan operations").

160. For an example of state regulations for marketing Medicare supplemental insurance, see CAL. HEALTH & SAFETY CODE § 1358.20 (West 2006).

161. See NAIC Hearing, *supra* note 157, at 5-6 (follow "California Health Advocates" hyperlink) (written testimonies of Bonnie Burns, Training & Policy Specialist, and David Lipschutz, Staff Attorney, California Health Advocates) (describing state insurance regulation and analogizing past marketing abuse of Medigap plans that led to state enforcement delegation).

forced. However, as described below, the current enforcement structure is not working.

B. THE FEDERAL GOVERNMENT INADEQUATELY ENFORCES MARKETING REGULATIONS

Ultimately, Medicare's private plans are government-funded programs, therefore the government is responsible for protecting beneficiaries. This Section argues that the federal government's interest in promoting private Medicare plans obstructs its effectiveness as a law enforcer, which is evidenced by CMS's reluctance to sanction abusive private plans.

1. The Federal Government's Conflicts of Interest Prevent Effective Law Enforcement

Federal authorities are interested in preserving the Medicare program through private administration.¹⁶² CMS has acted more as a cheerleader for the private programs than an enforcement agency,¹⁶³ and was slow to respond to initial reports of marketing abuses.¹⁶⁴ Substantial federal payments to private plans¹⁶⁵ make federal agencies a suspicious enforcer.

Perhaps indicative of CMS's investment in private plan success, the agency only regulated insurance companies when

162. See Remarks Following a Meeting on Prescription Drug Benefits, 43 WEEKLY COMP. PRES. DOC. 511 (Apr. 30, 2007) (“[W]hen you trust people to make decisions in their lives, when you have competition, it is likely you’ll get lower price and better quality. It is the spirit of this reform that needs to be now extended to Medicare overall.”).

163. See, e.g., *Aging Hearing*, *supra* note 20, at 3 (statement of Abby L. Block, Director, Ctr. for Beneficiary Choices, Ctrs. for Medicare & Medicaid Servs.) (“Medicare Advantage is a valued, important option for millions of people with Medicare.”); *Oversight & Investigations Hearing*, *supra* note 13 (statement of Abby L. Block, Director, Ctr. for Beneficiary Choices, Ctrs. for Medicare & Medicaid Servs.) (emphasizing that the Medicare Advantage program offers an “affordable, high value choice for all Medicare beneficiaries” and that “enrollment is at an all-time high” with plans available in every state and many rural areas).

164. CMS responded to reports of marketing abuses in early 2007 by noting that such problems are “few” and “to be expected,” further emphasizing that “[w]ith any program of this size, you will always be able to find a few people that are dissatisfied.” See LIPSCHUTZ ET AL., *supra* note 88, at 2 (quoting CMS spokesperson Aaron Hase).

165. See *Oversight & Investigations Hearing*, *supra* note 13 (statement of Chairman Bart Stupak) (“Before MMA, the government was paying the private plans 95% of the cost of traditional Medicare. Now, the government is paying them 112% to 119% of traditional Medicare. ‘Medicare Advantage’ is aptly named—it’s richly funded to out-compete or privatize traditional Medicare.”).

faced with public pressure. In 2006, CMS released information about plans' compliance status only after prompted by media pressure.¹⁶⁶ In May 2007, CMS proposed new regulatory changes to its oversight and enforcement of marketing guidelines, but the proposed revisions came after media reports of misconduct and fraud problems.¹⁶⁷ As pressure from advocates, states, and Congress mounted in the last few months, CMS has taken a series of steps to address the deceptive marketing of Medicare Advantage "Private Fee-for-Service" (PFFS) plans.¹⁶⁸ An enforcement authority that only acts when faced with negative publicity is unsustainable and dangerous. CMS is not preventing marketing abuse. Instead, CMS reacts only after patients have already been significantly harmed. As the sole enforcer of private Medicare marketing, CMS's ad hoc and discretionary enforcement behavior jeopardizes patient health and safety.

2. CMS Weakly Exercises Its Enforcement Authority

Of the compliance actions CMS reports taking, few are actually enforcement actions as defined in the regulations, such as civil penalties or bans on marketing.¹⁶⁹ For example, in

166. TOBY S. EDELMAN, CTR. FOR MEDICARE ADVOCACY, INC., OVERSIGHT AND ENFORCEMENT OF MEDICARE PART D PLAN REQUIREMENTS: FEDERAL ROLE AND RESPONSIBILITIES 12 (2006), <http://www.kff.org/medicare/upload/7558.pdf> (noting that although CMS stated in its final regulations that it would not publicly release ongoing information about plans' compliance status, it released such information five days after the *New York Times* reported that the federal government was having difficulties regulating federal marketing standards).

167. See Medicare Program; Revisions to the Medicare Advantage and Part D Prescription Drug Contract Determinations, Appeals, and Intermediate Sanctions Processes, 72 Fed. Reg. 29,368 (May 25, 2007); LIPSCHUTZ ET AL., *supra* note 88, at 3.

168. Medicare Advantage Private Fee-for-Service (PFFS) plans are the most lucrative private plans for insurers. See MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 244 (Mar. 2007), http://www.medpac.gov/chapters/Mar07_Ch04.pdf. For examples of recent actions taken to address PFFS plan marketing problems, see *Insurers Suspend the Marketing of Some Medicare Plans*, *supra* note 84 (noting voluntary suspension), and Letter from Cynthia Tudor, Dir., Medicare Drug Benefit Group, Ctrs. for Medicare and Medicaid Servs., to Medicare Advantage-Prescription Drug Orgs., Cost-Based Plans, Stand-Alone Prescription Drug Plans, Employer/Union-Sponsored Group Health Plans (May 14, 2007), *available at* <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf> (issuing updated expectations for private plans).

169. Compare 42 C.F.R. § 422.750 (2006) (describing kinds of sanctions), *with id.* § 422.756 (detailing procedures for imposing sanctions).

2006, CMS issued only “warning notices” to plans violating marketing standards.¹⁷⁰ Without compelling penalties, insurers have no reason to change the abusive practices from which they profit. Although CMS is authorized to conduct on-site audits to determine plans’ compliance,¹⁷¹ CMS employs an oversight structure based on complaint processing, and will not conduct focused or targeted audits unless “questionable findings” are first identified in complaints.¹⁷² Oversight by complaint tracking alone fails to capture the full scope of abusive marketing and perversely places the burden on beneficiaries to navigate their way through complex bureaucratic grievance procedures.¹⁷³ In many instances, these complaints are first filtered through the plans themselves.¹⁷⁴

CMS relies too much on plan self-regulation.¹⁷⁵ The agency gives private plan sponsors considerable authority to monitor and correct their own behavior,¹⁷⁶ indicating that CMS will limit its civil enforcement activities only to “large, repeat and/or egregious” violations.¹⁷⁷ Depending on plans to self-police themselves is a dangerous strategy on its face and does not work in practice. The Department of Health and Human Ser-

170. CMS reported issuing “warning letters” and “notices of non-compliance,” which are merely written notices required by the regulations before an enforcement action can occur. *Compare* Press Release, Ctrs. for Medicare & Medicaid Servs., Medicare Details Steps Taken to Improve Customer Service by Drug Plans: Data Shows Improvements in Plan Call Center Wait Times (June 29, 2006), available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1890> (reporting the issuance of written notices), with 42 C.F.R. § 422.750 (detailing the types of applicable sanctions), and *id.* § 422.756 (detailing procedures for imposing sanctions).

171. 42 C.F.R. § 423.505(e)(ii).

172. CTRS. FOR MEDICARE & MEDICAID SERVS., PART D OVERSIGHT STRATEGY FOR CONTRACTORS/INDUSTRY 3 (2005), http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/OversightStrategy_10.24.05.pdf.

173. *Cf.* Pear, *supra* note 6 (reporting that the extent of marketing problems “almost surely exceeds” official data because many victims never file complaints).

174. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 172, at 6 (noting that CMS will receive data from plans and then “will develop reports and related intervention metrics to serve as the triggers to ad hoc data mining and reporting”).

175. *See id.* at 2 (explaining that contractor management activity is based on analysis of self-reported, unaudited plan data from Part D contractors).

176. *See* Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4334 (Jan. 28, 2005) (codified in 42 C.F.R. pts. 400, 403, 411, 417, and 423) (eliminating a mandatory requirement that plan sponsors report “violations of law, regulation, or other wrongdoing on the part of the organization or its employees/officers”).

177. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 172, at 2.

vices' Office of the Inspector General discovered that many private plan sponsors failed to develop policies to ensure internal compliance with CMS regulations, including those governing marketing.¹⁷⁸ While some private plan providers voluntarily agreed to suspend marketing after reported abuses,¹⁷⁹ the structure remains ripe for abuse as long as private companies are allowed to determine their own violations and penalties. Representative Pete Stark noted that permitting the companies to determine "which crimes they'll plead to and which sentences they'll serve" does "virtually nothing to protect Medicare beneficiaries" and the voluntary marketing suspension is only "a pathetic attempt to preempt congressional action."¹⁸⁰ Although other members of Congress have also acknowledged some of the flaws in the current regulatory structure,¹⁸¹ proposed legislative solutions to the marketing abuse crisis do not include enough protections for Medicare patients.

C. PENDING LEGISLATION LACKS COMPREHENSIVE SOLUTIONS TO PROTECT BENEFICIARIES

In response to the growing problem of abusive marketing, congressional leaders have proposed legislation to address predatory Medicare marketing. Senator Herb Kohl remarked that it is "clear that a major disconnect in oversight exists" and that it is "simply unacceptable to leave our seniors unprotected."¹⁸²

178. See OFFICE OF THE INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., NO. OEI-01-05-00130, MEDICARE ADVANTAGE MARKETING MATERIALS FOR CALENDAR YEAR 2005, at 12 (2006), available at <http://oig.hhs.gov/oei/reports/oei-01-05-00130.pdf> (concluding, after audits of Medicare Advantage plans in fiscal year 2005, that marketing materials lacked CMS-required information essential for beneficiaries to make informed plan choices and plans used unclear and technical language in their marketing materials).

179. See, e.g., *Insurers Suspend the Marketing of Some Medicare Plans*, supra note 84; see also Kendra Casey Plank, *Internal Auditors Should Be Key Part of Compliance for Medicare Rx Plans*, HEALTH CARE FRAUD REP., Jan. 2008, at 1, 16 (2008), available at <http://pubs.bna.com/ip/bna/HFR.NSF/eh/a0b5n2z7w5> (stating that insurers are advocating for internal compliance audits).

180. John Reichard, *CMS: Seven Private Fee-for-Service Plans to Suspend Marketing*, CONG. Q. HEALTHBEAT NEWS, June 15, 2007, <http://public.cq.com/docs/hb/hbnews110-000002533208.html> (quoting California Representative Pete Stark).

181. E.g., Press Release, U.S. Rep. Bart Stupak, Stupak Leads Investigation into "Medicare Advantage" Marketing Abuses (June 26, 2007), available at http://www.house.gov/list/speech/mi01_stupak/MedicareAdvantage062607.html.

182. Press Release, U.S. Sen. Special Comm. on Aging, Kohl Bill Gives State More Power to Regulate Sales and Marketing of Medicare Advantage

On July 26, 2007, Senator Kohl introduced the Accountability and Transparency in Medicare Marketing Act of 2007.¹⁸³ This bill calls for standardized marketing of prescription drug and Medicare Advantage plans and specifically prohibits cross-selling of non-Medicare products, telemarketing, and offering rebates to induce enrollment.¹⁸⁴ While certain prohibited activities are enumerated in the bill, the legislation also calls for the NAIC to develop standardized marketing requirements.¹⁸⁵

The House has taken similar steps. A House bill inserted a provision into the “Children’s Health and Medicare Protection Act of 2007,” which delegated authority to the NAIC to develop marketing standards.¹⁸⁶ However, the version that eventually passed in the House and Senate lacked any provisions related to Medicare marketing.¹⁸⁷ Another House bill was introduced to provide “broader and more informed protection” to Medicare-eligible individuals from abusive marketing practices of Medicare prescription drug plans.¹⁸⁸ However, this proposal only applies to the sales of prescription drug plans offered under Part D or drug plans that are part of a Medicare Advantage product—it does not even attempt to regulate marketing of most Medicare Advantage plans.¹⁸⁹ The bill also fails to delegate any authority to states,¹⁹⁰ and therefore does not acknowledge federal enforcement problems.

While this legislative activity is a significant step in reining in the problem of abusive marketing, the proposed bills fall short in developing comprehensive solutions. Senator Kohl’s

Plans (July 26, 2007), available at <http://aging.senate.gov/record.cfm?id=279942>.

183. S. 1883, 110th Cong. § 1 (2007). A bill with the same provisions was also introduced in the House on December 18, 2007. See H.R. 4790, 110th Cong. § 1 (2007).

184. S. 1883, § 2.

185. See *id.* § 2(c)(1), (4).

186. H.R. 3162, 110th Cong. § 411 (2007) (providing for the NAIC’s development of marketing, advertising, and other protections related to private Medicare plans).

187. See Children’s Health Insurance Program Reauthorization Act of 2007, H.R. 976, 110th Cong. (as passed by House and Senate, Sept. 27, 2007). President Bush vetoed the Act on Oct. 3, 2007. *Bush Vetoes Child Health Insurance Plan*, MSNBC.COM, Oct. 3, 2007, <http://www.msnbc.msn.com/id/21111931>.

188. See Preventing Medicare Seniors from Being Confused Due to Abusive Marketing (Prevent Medicare SCAMs) Act of 2007, H.R. 2307, 110th Cong. § 1 (2007).

189. See *id.* §§ 2–4.

190. See *id.*

proposal is the best of the pending bills because it attempts the broadest solution. The proposal should be commended for granting states the authority to enforce marketing requirements,¹⁹¹ prohibiting cold-calling, and eliminating cross-selling.¹⁹² However, new uniform regulations from the NAIC may be inadequate and inadvertently supplant more protective existing state laws that could be used immediately.¹⁹³ The benefits of standardized regulations are acknowledged and discussed above, but the development of uniform marketing requirements as proposed in this bill may be unnecessarily time-consuming,¹⁹⁴ given that state laws are readily applicable.

In addition to waiting for the NAIC to develop new and potentially inadequate regulations, Senator Kohl's bill leaves beneficiaries powerless. The lack of a private right of action¹⁹⁵ means that beneficiaries would continue to depend on government enforcers to take up their cause, or risk judicial dismissal.¹⁹⁶ As demonstrated by other model rules it developed, the NAIC appears unlikely to support private enforcement rights.¹⁹⁷ The government should ensure that beneficiaries are protected from abusive marketing to the greatest extent possible, including provision for direct access to judicial remedies.

Congressional attention to abusive Medicare marketing is an important step towards controlling predatory marketing problems, but the current proposals are not strong enough. It is important to improve the substance of the federal regulations and allow states to enforce the regulations, as Senator Kohl's

191. See S. 1883, 110th Cong. § 2(c)(2)(B) (2007) (letting states enforce federal marketing rules).

192. *Id.* § 2(c)(1)(B).

193. See *id.* § 2(c)(1)–(2) (providing that only uniform federal standards will be used to regulate plans).

194. For example, if the NAIC does not submit a report articulating standardized marketing requirements, the duty falls to the Secretary of Health and Human Services to promulgate such regulations. *Id.* § 2(c)(2). Even if the NAIC does develop regulations, they must still be considered and approved by the Secretary. *Id.*

195. The bill does not provide beneficiaries with a private cause of action. See S. 1883.

196. See *Dial v. Healthspring of Ala., Inc.*, 501 F. Supp. 2d 1348 (S.D. Ala. 2007) (dismissing private action as a violation of the MMA); *Uhm v. Humana, Inc.*, No. C06-0185-RSM, 2006 WL 1587443, at *5 (W.D. Wash. June 2, 2006) (preventing individuals' suit under state law).

197. See Nat'l Ass'n of Ins. Comm'rs, Suitability in Annuity Transactions Model Regulation, NAIC 275-1 § 1(b) (West 2007) ("Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.").

bill provides. However, even the Kohl solution is ineffective since stronger state laws are preempted by uniform federal standards that may offer only minimal protections. Additionally, the pending bills continue to deny beneficiaries access to judicial redress. In the interests of preventing future abuse and promoting justice for those already harmed, it is critical to develop a better and more prompt solution.

III. RECONSIDERING THE PRIVATE MEDICARE REGULATION STRUCTURE

Ultimately, beneficiaries do not have the luxury of evaluating complex federal regulations, nor do they have the occasion to reflect on the proper balance of state and federal enforcement authority. Rather, Medicare beneficiaries face declining health and rapidly rising care costs that require immediate access to affordable medical treatment. To continue supporting the medical needs of America's most vulnerable patients, Congress should craft a legislative solution that protects beneficiaries from predatory marketing. First, Congress should draw from consumer protection models to substantively improve marketing regulations without preempting stronger state laws. Second, to remedy enforcement problems, Congress should repeal the preemption clauses in current Medicare law, and expressly delegate enforcement authority to states. Third, Congress should promote individual rights by providing beneficiaries with an explicit private cause of action. Finally, Congress should advance Medicare's policy goals through violation penalties.

A. MEDICARE MARKETING REGULATIONS SHOULD BE STRENGTHENED TO PREVENT ABUSE

Medicare beneficiaries deserve broad statutory protections. Medicare recipients are victimized by deceptive marketing tactics ranging from omitted benefit information¹⁹⁸ to aggressive sales tactics¹⁹⁹ to outright fraud.²⁰⁰ Accordingly, a legislative

198. *E.g.*, Armen Keteyian, *Medicare Disadvantage: Privatized Health Care for Seniors Can Leave Them in the Dark as Insurance Companies Reap a Windfall*, CBSNEWS.COM, July 16, 2007, http://www.cbsnews.com/stories/2007/07/16/cbsnews_investigates/main3062725.shtml#ccmm (describing the story of an individual who did not understand his Medicare Advantage plan coverage until after he broke his leg and experienced claim denials).

199. *E.g.*, Pear, *supra* note 6 (noting how an insurance agent forced his way into a beneficiary's apartment and enrolled her in a private Medicare plan).

200. *E.g.*, Elizabeth Williamson & Christopher Lee, *Abuses in Enrollment*

solution is required that would encompass the assortment of unfair marketing tactics employed by private insurers. As abusive marketing spreads, beneficiaries are less likely to trust, and therefore enroll, in private plans. To preserve the private plan options, the government and insurers administering Medicare plans should support legislation to prevent and remedy marketing abuse.

This Part argues that consumer protection laws represent ideal and workable solutions for abusive marketing problems. Detailing useful consumer protection theories, this Part analyzes how these theories may be employed to protect beneficiaries while preserving Medicare's private programs. This Section concludes by arguing that even if Congress improves federal marketing regulations, stronger state laws should not be preempted.

1. Consumer Protection Laws Are Model Legislative Solutions

Consumer protection laws are a statutory response to the inadequacy of the common law in protecting buyers from unfair and deceptive acts in the marketplace.²⁰¹ Accordingly, many consumer protection statutes developed creative and effective solutions to regulate marketplace conduct.²⁰² State and federal "unfair and deceptive acts and practices" (UDAP) statutes serve as models for a solution to Medicare marketing abuse.²⁰³

UDAP statutes are characterized by broad language²⁰⁴ intended to be construed in favor of consumers.²⁰⁵ Courts interp-

Tactics Found for Private Medicare, WASH. POST, May 16, 2007, at A3 (reporting on insurance agents' use of personal information stolen from federal records to enroll individuals in private plans).

201. Prentiss Cox, *Goliath Has the Slingshot: Public Benefit and Private Enforcement of Minnesota Consumer Protection Laws*, 33 WM. MITCHELL L. REV. 163, 166 (2006).

202. *See id.*

203. The primary federal statute broadly protecting consumers from fraud is the Federal Trade Commission Act (FTCA), which declares unlawful any "unfair or deceptive acts or practices in or affecting commerce." *See* Federal Trade Commission Act, 15 U.S.C. § 45 (2000). Every state has adopted a similar statutory fraud law prohibiting "unfair and deceptive marketplace conduct." Cox, *supra* note 201, at 166.

204. For example, a Minnesota UDAP statute lists thirteen acts that are prohibited when made by a person "in the course of business, vocation, or operation," including any conduct that "creates a likelihood of confusion or misunderstanding." MINN. STAT. § 325D.44, subdiv. 1(13) (2006).

205. *Minnesota ex rel. Hatch v. Fleet Mortgage Corp.*, 158 F. Supp. 2d 962, 967 (D. Minn. 2001) (interpreting the Minnesota UDAP statute and noting that the law is "broader than common law fraud"); *see also* Ly v. Nystrom, 615

ret UDAP language to apply to a range of different practices and actors.²⁰⁶ Commentators note that UDAP provisions allow consumers and government enforcers to establish deception through a much less rigorous showing than is required under the common law.²⁰⁷ Many of these statutes authorize civil penalties²⁰⁸ and provide a private right of action.²⁰⁹ While the liberal UDAP standards have been criticized,²¹⁰ the nationwide implementation of the consumer fraud protections has notably prevented abusive behavior.²¹¹

The UDAP model is an ideal framework to consider when crafting a remedy for Medicare's abusive marketing problems. Private Medicare plans have the potential to offer more inclusive health benefit options for enrollees.²¹² However, preserving the value of consumer health care choices depends on beneficia-

N.W.2d 302, 308 (Minn. Ct. App. 2000) (noting that Minnesota's consumer fraud law "reflects a clear legislative policy encouraging aggressive prosecution of statutory violations" and thus should be "liberally construed in favor of protecting consumers").

206. See, e.g., *F.T.C. v. Sperry & Hutchinson Co.*, 405 U.S. 233, 240–44 (1972) (discussing the broad scope of the FTCA); *Lemelledo v. Beneficial Mgmt. Corp. of Am.*, 696 A.2d 546, 551–52 (N.J. 1997) (holding that although the New Jersey consumer fraud act does not explicitly include insurance, the broad language extends to insurance-sales practices).

207. Victor E. Schwartz & Cary Silverman, *Common-Sense Construction of Consumer Protection Acts*, 54 U. KAN. L. REV. 1, 3 (2005) (noting that consumer fraud laws often do not require the traditional elements of common law fraud and negligent misrepresentation claims, such as reliance, intent, injury, and damages); Jeff Sovern, *Private Actions Under the Deceptive Trade Practices Acts: Reconsidering the FTC Act as Rule Model*, 52 OHIO ST. L.J. 437, 444 (1991).

208. E.g., 15 U.S.C. § 45(a) (2000).

209. See Cox, *supra* note 201, at 167 (stating that although the FTCA has no private right of action, all states, except Iowa, have a private cause of action for violations of state statutory fraud laws).

210. See, e.g., Schwartz & Silverman, *supra* note 207, at 37–42 (noting that consumer protection statutes are increasingly used to assert novel, private causes of action against perceived deep-pocket companies and unpopular industries where liability would not ordinarily exist under common law).

211. See Sovern, *supra* note 207, at 445 (stating that UDAP standards have "vastly aided" the FTC in preventing abusive behavior).

212. Posting of Nelms01 to CBS News, Medicare Disadvantage, http://www.cbsnews.com/stories/2007/07/16/cbsnews_investigates/main3062725.shtml#ccmm (July 17, 2007, 17:13 EST) ("I have found Medicare Advantage plans to be well designed and much more advantageous, for the price, for the plan members. Mine have included membership in the senior exercise program Silver Sneakers, which promotes a healthy lifestyle and which my wife and I have found to be wonderful.").

ries' ability to access accurate coverage information.²¹³ Broad UDAP language allows legal action against a wide scope of marketing abuses, but also promotes truthful advertising that encourages beneficiaries to select plans offering appropriate coverage for their care needs.

2. Consumer Protections Encourage Beneficiary Enrollment

Deterring deceptive marketing improves the efficiency of the market.²¹⁴ Ideally, the more accurate information consumers possess when they choose among competing purchases, the more efficiently the market will function.²¹⁵ An underlying theory of UDAP laws is that preventing deceptive sales tactics protects the interests of the economy as a whole when consumers are disappointed, or worse, when products fail to live up to their advertisements.²¹⁶ If beneficiaries believe insurance agents, and rely on accurate marketing materials when making plan selections, insurers' advertising efforts are valuable.²¹⁷ However, if unfair marketing practices continue, beneficiaries may ignore insurers' marketing efforts or avoid private plan options entirely.²¹⁸ Therefore, insurers have an interest in abiding by high ethical standards when marketing their plans.²¹⁹ How-

213. See ELEANOR DEARMAN KINNEY, PROTECTING AMERICAN HEALTH CARE CONSUMERS 105–06 (2002) (noting that coverage information defining the amount, duration, and scope of services underwritten by an insurance plan is “most important” for accessing health care services).

214. See Sovern, *supra* note 207, at 453.

215. See Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 765 (1976) (“Advertising, however tasteless and excessive it sometimes may seem, is nonetheless dissemination of information as to who is producing and selling what product, for what reason, and at what price. It is a matter of public interest that [economic] decisions . . . be intelligent and well informed . . .”).

216. Sovern, *supra* note 207, at 453 (stating that inaccurate advertising distorts the market).

217. Cf. Robert Pitofsky, *Beyond Nader: Consumer Protection and the Regulation of Advertising*, 90 HARV. L. REV. 661, 663 (1977) (“Advertising substitutes for search costs by consumers by providing in a convenient and usable form information necessary for consumers to make choices among available brands, and in the process facilitates the functioning of a market economy.”).

218. Cf. Sovern, *supra* note 207, at 453 (explaining that if consumers do not believe marketing materials, and consequently ignore advertising when deciding which goods and services to purchase, advertising will lose much of its value).

219. At least one plan has supported strengthening marketing regulations. See NAIC Hearing, *supra* note 157, at 2 (follow “BCBS of Michigan” hyperlink) (written Testimony of Catherine Schmitt, Vice President of Federal Programs, Blue Cross-Blue Shield of Michigan) (“We support implementation and en-

ever, even if federal regulations are strengthened to prevent abuse and promote legitimate sales of private plans, they should not displace state laws.

3. Stronger State Laws Should Not Be Preempted

More agile than the federal government, states are better positioned to react quickly to local problems.²²⁰ Medicare marketing abuse is best addressed through dual enforcement. Federal Medicare marketing standards should set a floor of basic protections without preempting more forceful state laws. There are a number of federal consumer protection laws that save stronger state laws from preemption.²²¹ The Medicare law should similarly provide for the use of existing state law.

State consumer protection laws are immediately available to fill the substantive gaps in federal Medicare marketing regulations.²²² All states have enacted such laws.²²³ Some laws specifically prohibit unfair and deceptive practices in the insurance industry.²²⁴ Unfortunately, courts have held that the MMA preempts state consumer protections.²²⁵ Congress should therefore repeal the MMA's preemption clause and allow beneficiaries to access judicial remedies under state laws. In addi-

forcement of CMS marketing guidelines and efforts to strengthen enforcement of these requirements.”)

220. *See* *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

221. *E.g.*, Gramm-Leach-Bliley Act, 15 U.S.C. §§ 6801–6809 (2000); Electronic Communications Privacy Act, 18 U.S.C. § 2510 (2000); Employee Polygraph Protection Act, 29 U.S.C. § 2001 (2000).

222. *E.g.*, ALA. CODE §§ 8-19-1 to -15 (2002 & Supp. 2004); ALASKA STAT. §§ 45.50.471 to 45.50.561 (2006); FLA. STAT. §§ 501.201–.213 (2007); GA. CODE ANN. §§ 10-1-370 to -375 (2000); LA. REV. STAT. ANN. §§ 51:1401 to 51:1420 (2003 & Supp. 2008); ME. REV. STAT. ANN. tit. 10, §§ 1211–1216 (2002 & Supp. 2007–2008). For a state-by-state list of unfair and deceptive trade practices statutes, see Mark E. Swirbalus, *New Rubric of Risk: Unfair Trade Practices*, A.L.I.-A.B.A. CONTINUING LEGAL EDUC., July 19–20, 2007.

223. *Sovern*, *supra* note 207, at 446 (noting that in the 1950s, states began to enact statutes designed to prohibit deceptive and unfair practices and that by 1981, every state in the country had enacted such a statute).

224. *See, e.g.*, CONN. GEN. STAT. § 38a-815 (2006); 18 DEL. CODE ANN. tit. 18, § 2303 (1999); HAW. REV. STAT. § 431:13-102 (2005).

225. *See* *Dial v. HealthSpring of Ala., Inc.*, 501 F. Supp. 2d 1348, 1350, (S.D. Ala. 2007) (preempting state consumer protection claims); *Uhm v. Humana, Inc.*, No. C06-0185-RSM, 2006 WL 1587443, at *2 (W.D. Wash. June 2, 2006) (same).

tion to offering greater substantive protection for beneficiaries, states have also developed effective enforcement mechanisms that could quickly remedy marketing abuses.

B. STATES ARE APPROPRIATE ENFORCEMENT AUTHORITIES TO RESPOND TO THE NEEDS OF MEDICARE BENEFICIARIES

CMS's failure to enforce marketing regulations may be remedied by delegating enforcement authority to states. This Section argues that in addition to enforcing their own laws, states should enforce federal marketing regulations because local authorities are more accountable to their citizens.

1. States Should Enforce Federal Marketing Regulations

A number of federal consumer protection statutes delegate authority to states to sue for violations of federal consumer protection laws.²²⁶ Often these laws provide specific remedies that may differ from those authorized for the federal agency.²²⁷ Most federal statutes authorizing enforcement by states also contain provisions noting that the federal grant of authority does not limit state investigatory powers.²²⁸

States have shown that they possess the necessary independence and infrastructure to effectively regulate private Medicare plans.²²⁹ States already regulate Medicare-related insurance products, such as Medigap.²³⁰ The Medigap regulatory framework balances state and federal regulation.²³¹ Federal legislation requires state approval of Medigap insurers under a

226. See, e.g., Fair Credit Reporting Act § 622, 15 U.S.C. § 1681s(c) (2000); Telemarketing and Consumer Fraud and Abuse Prevention Act § 4, 15 U.S.C. § 6103 (2000).

227. For example, state remedies may include statutory injunctive relief, damages on behalf of citizens, restitution, civil penalties, and attorneys' fees and costs. See Prentiss Cox & Tom James, *Government Enforcement Actions and Regulatory Oversight*, in 2 10TH ANN. CONSUMER FIN. SERVICES LITIGATION INSTITUTE 491, 499 (2005).

228. See *id.*

229. See, e.g., *Humana Pays \$500,000 Fine in Oklahoma for Unlicensed Sales*, INS. J., Aug. 24, 2007, available at <http://www.insurancejournal.com/news/southcentral/2007/08/24/82982.htm>.

230. *Aging Hearing*, *supra* note 20, at 23 (statement of Sean Dilweg, Insurance Comm'r, Wisconsin) ("From the Medicare beneficiary standpoint, Medigap is a proven successful example of shared state-federal regulation of a Medicare-related product that works well, and is popular with Medicare beneficiaries.").

231. 42 U.S.C. § 1395ss (2000 & Supp. V 2007) (providing for state and federal certification of Medigap policies).

regulatory program that meets or exceeds the federal minimum standards.²³² This framework mirrors Senator Kohl's proposal,²³³ since the NAIC developed Medigap's uniform standards.²³⁴ However, unlike Senator Kohl's bill,²³⁵ the uniform federal standards for Medigap are a floor—allowing states to set the ceiling.²³⁶ States have enacted rigorous requirements for insurers, including marketing regulations.²³⁷ This existing regulatory structure allows states to enforce marketing requirements against both agents and companies.²³⁸ The existing infrastructure and state regulatory system should be used to control private Medicare plans. Doing so would facilitate speedy remedies for beneficiaries and prevent the escalation of abusive marketing since states are not distracted by conflicted interests in promoting private Medicare programs.

2. States Provide Greater Accountability to Citizens

State regulation will offer greater accountability to victimized citizens. Unlike the presidential appointees charged with administering CMS,²³⁹ state law enforcement officials are more

232. *Id.*; see also 42 C.F.R. §§ 403.200–.258 (2006).

233. Accountability and Transparency in Medicare Marketing Act of 2007, S. 1883, 110th Cong. (2007).

234. Mary Elizabeth Derwin & Diane C. Lehman, *Medicare and Private Supplemental Insurance*, in 1 ELDERLAW: ADVOCACY FOR THE AGING § 10:133 (Joan M. Krauskopf et al. eds., 2d ed. 2006) (summarizing the regulatory structure for Medigap insurance).

235. The bill permits states to impose sanctions against insurance companies and agents selling private Medicare plans *only* for violations of federal standardized marketing requirements. See S. 1883 § 2(c)(2)(B); 153 CONG. REC. S10,153 (daily ed. July 26, 2007) (statement of Sen. Kohl) (noting that uniform marketing standards will be adopted and enforced by individual states).

236. The NAIC Model Regulations for Medigap insurance clarify that stronger state laws are not preempted. See, e.g., NAT'L ASS'N OF INS. COMM'RS, NAIC MEDICARE SUPPLEMENT INSURANCE MODEL REGULATIONS COMPLIANCE MANUAL 4 (1999) (noting that states must "provide for the application and enforcement of Medicare supplement standards that are at least as stringent as the NAIC Model standards").

237. E.g., CAL. HEALTH & SAFETY CODE § 1358.20 (West 2006); MINN. STAT. § 62A.39 (2006).

238. *Aging Hearing*, *supra* note 20, at 24 (statement of Sean Dilweg, Insurance Comm'r, Wisconsin) ("One of the significant benefits of using Medigap as a model regulatory approach for the MMA products is that states will be again able to regulate both the agents and the companies in the marketing and sales of these products.").

239. 42 U.S.C. § 1317(a) (Supp. V 2007) ("The Administrator of the Centers for Medicare & Medicaid Services shall be appointed by the President by and with the advice and consent of the Senate.").

responsive to local citizens. Often state attorneys general or insurance commissioners are elected positions.²⁴⁰ Therefore, if beneficiaries are frustrated with inadequate law enforcement, they can respond democratically. Even if not elected, state government agencies may be more receptive to citizens because their duties are limited in scope and not polluted by a conflicted interest in supporting Medicare's private plans; unlike the federal government, states do not pay insurers to remain in the Medicare program. Additionally, states will not levy disciplinary actions under the shroud of federal bureaucracy.²⁴¹

Although state enforcement may be more responsive than federal agencies, there is still a risk that state governments will be unable or unwilling to forcefully pursue claims of marketing abuse. Therefore, it is important to ensure that beneficiaries have access to a judicial forum.

C. EMPOWERING MEDICARE BENEFICIARIES THROUGH A PRIVATE RIGHT OF ACTION

As public benefits are increasingly privatized, the government must ensure that beneficiaries' individual rights are protected.²⁴² Beneficiaries are currently hindered by the MMA's preemption clause,²⁴³ and depend on ineffective government enforcers for redress. Congress should therefore remove the statu-

240. See, e.g., CAL. CONST. art. 5, § 11 (providing for the election of the attorney general); CONN. CONST. art. 4, § 1 (same); DEL. CONST. art. 3, § 21 (providing for the election of the insurance commissioner); OKLA. CONST. art. 6, § 23 (same).

241. When advocates file complaints with Medicare about plan conduct, the results of these complaints, if any, are rarely made available. NAIC Hearing, *supra* note 157, at 4 (follow "California Health Advocates" hyperlink) (written testimonies of Bonnie Burns, Training & Policy Specialist, and David Lipschutz, Staff Attorney, California Health Advocates). But, states may be eager to showcase their law enforcement achievements. See Press Release, Okla. Ins. Dep't, Commissioner Holland Fines Humana \$500,000 for Unlicensed Insurance Sales to Oklahoma Seniors (Aug. 22, 2007), available at <http://www.oid.state.ok.us/www2.oid.state.ok.us/News/News%20Releases/2007/Humana%20Consent%20Order%20082207.pdf>.

242. Beneficiaries are frequently not given proper notice of their appeal rights under Part D. See VICKI GOTTLICH, BENEFICIARY CHALLENGES IN USING THE MEDICARE PART D APPEALS PROCESS TO OBTAIN MEDICALLY NECESSARY DRUGS 2-3 (2006), available at <http://www.kff.org/medicare/upload/7557.pdf>.

243. See, e.g., *Dial v. HealthSpring of Ala., Inc.*, 501 F. Supp. 2d 1348, 1359 (D. Ala. 2007) (holding that private causes of action based on insurer misconduct in soliciting private Medicare plan enrollment fall within areas that Congress intended to regulate through the MMA, and thus are preempted by federal law).

tory impediments and expressly include a private right of action. Other federal consumer protection statutes include private enforcement provisions,²⁴⁴ and most state consumer protection laws provide for a private right of action.²⁴⁵ However, none of the pending legislative solutions to the Medicare marketing crisis allow beneficiaries to independently sue.²⁴⁶ This Section argues that private enforcement options are more flexible and effective for remedying power disparities between beneficiaries and insurers.

1. Private Enforcement Is More Flexible

Unlike government agencies, private plaintiffs are not limited by the public policy implications of their lawsuits and are not forced to make judgments about how to expend limited resources.²⁴⁷ Government agencies often lack sufficient resources to pursue every consumer fraud claim vigorously and face strong incentives to confine their enforcement activities to cases that have a broad impact.²⁴⁸ While public agencies may exercise their discretion improperly, in the consumer arena they usually err on the side of doing too little, rather than too much.²⁴⁹ Even though public enforcement may reduce wasteful litigation,²⁵⁰ it may also neglect valid claims.²⁵¹ The same principles apply to private Medicare plans.

Even if state and federal government agencies combine enforcement efforts, they will likely overlook some individuals'

244. *E.g.*, Truth in Lending Act, 15 U.S.C. § 1640 (2000); Fair Debt Collection Practices Act, 15 U.S.C. § 1692(k) (2000); Fair Credit Reporting Act, 15 U.S.C. § 1681(n)–(p) (2000).

245. *E.g.*, MINN. STAT. § 8.31 (2007); N.C. GEN. STAT. § 75-16 (2007).

246. *See* Preventing Medicare Seniors from Being Confused Due to Abusive Marketing (Prevent Medicare SCAMs) Act of 2007, H.R. 2307, 110th Cong. § 1 (2007); Accountability and Transparency in Medicare Marketing Act of 2007, S. 1883, 110th Cong. (2007).

247. *See* Philip G. Schrag, *In Her Majesty's Secret Service: Protecting the Consumer in New York City*, 80 YALE L.J. 1529, 1529–30 (1971) (explaining that inadequate funding, understaffing, and the absence of a common mission “conspired to render government agencies ineffective or, in some cases, servants of industry, while consumer fraud flourished”).

248. *Id.*

249. *Sovern*, *supra* note 207, at 452.

250. *Id.*

251. *See, e.g.*, *Beslity v. Manhattan Honda*, 467 N.Y.S.2d 471, 474 (App. Div. 1983) (noting that New York’s private claim statute was enacted because of the “inability of the New York State Attorney-General to adequately police false advertising and deceptive trade practices”).

claims due to the sheer volume of complaints.²⁵² Victims of abusive marketing frequently receive “drastically reduced” coverage for medical treatment.²⁵³ It is therefore necessary to ensure prompt resolution in order to prevent physical injury and detrimental economic damages.²⁵⁴ Individual enforcement action is the most effective means of redressing personal harm: beneficiaries would not have to depend on the benevolence of government enforcers, but could seek immediate relief through the courts. Unlike public enforcement measures, private suits provide tailored remedies in proportion to the amount of harm suffered. For example, a beneficiary may not have suffered a large amount of damages to justify government intervention, but even a small amount of economic damage is likely to disproportionately impact the individual beneficiary. The beneficiary therefore deserves to bring suit in a forum that will conscientiously review the individual circumstances of the case.

2. Congress Should Address Power Disparities Between Plans and Patients

Beneficiaries should have adequate status and power in any dispute resolution process with insurers to assure that their concerns are fairly adjudicated.²⁵⁵ Health care consumers often have difficulty conceptualizing their concerns in a way that will command a remedy, and this disadvantage is enhanced when patients are poor and sick.²⁵⁶ Commentators have noted that the imbalance of power between patients and their health plans is exacerbated by the inadequacy of current legal doctrines that limit due process protections and restrict access to the judicial system under broad preemption provisions.²⁵⁷ Private enforcement would be an important step towards remedying the problem of beneficiaries’ lesser bargaining power.²⁵⁸

252. Enrollment in Medicare Advantage plans has increased sharply, from 4.7 million in 2003 to more than 8 million in 2007. Pear, *supra* note 10.

253. See, e.g., *Harris v. Pacificare Life & Health Ins. Co.*, 514 F. Supp. 2d 1280, 1285 (M.D. Ala. 2007) (noting that the plaintiffs contended that their medical coverage was “drastically reduced” under the defendant’s private Medicare Advantage plan and resulted in denied treatment, which caused “physical injury and mental distress” as well as “large medical bills”).

254. See *id.*

255. KINNEY, *supra* note 213, at 162.

256. *Id.*

257. *Id.* at 163.

258. Cf. Cox, *supra* note 201, at 172 (explaining that a “progressive” con-

Congress should equalize the power differential by providing incentives for beneficiaries to sue. In an effort to make it worth the individual's while to pursue merchants who engage in deceptive practices, many state consumer laws award treble damages,²⁵⁹ punitive damages,²⁶⁰ or statutory damages.²⁶¹ Nearly all state private consumer enforcement statutes authorize the award of attorney's fees to successful consumer plaintiffs.²⁶² In the Medicare context, insurers will no doubt have concerns about large economic awards and are likely to lobby against damage provisions. The purpose of private enforcement should be to prevent marketing abuse and remedy harm, without jeopardizing the sustainability of the benefits. Accordingly, Congress should authorize courts to award attorney's fees to encourage enforcement, but perhaps cap damage awards to appease insurers and avoid frivolous suits. The possibility of damage recovery or attorney's fees would likely deter companies from engaging in deceptive practices.²⁶³ Even so, Congress should also consider elevating administrative penalties.

D. MOTIVATING COMPLIANCE THROUGH RIGOROUS PENALTIES

Congress has great latitude to delineate critical policies pertaining to Medicare's commercial health plans through the contracting process.²⁶⁴ Congress should leverage this power to enhance the effectiveness of violation penalties. This Section proposes dual state and federal issuance of intermediate sanctions while reserving plan exclusion sanctions as a sole federal power. This Section concludes by arguing that all sanctions for

sumer protection enforcement means "lawsuits that have the effect of rectifying an imbalance of power between consumers and the sellers who typically control the terms of marketplace transactions").

259. See, e.g., N.C. GEN. STAT. § 75-16 (2007) (awarding treble damages); see also *Marshall v. Miller*, 276 S.E.2d 397, 404 (N.C. 1981) (stating that treble damages make it "more economically feasible" for private individuals to bring an action).

260. See, e.g., MO. REV. STAT. § 407.025(1) (2007); R.I. GEN. LAWS § 6-13.1-5.2 (2007).

261. See, e.g., ALA. CODE § 8-19-10 (1975) (limiting damages to \$100); MICH. COMP. LAWS § 445.911 (2007) (capping damages at \$250).

262. Steven J. Cole, *State Enforcement Efforts Directed Against Unfair or Deceptive Practices*, 56 ANTITRUST L.J. 125, 130 (1987) (noting that all states that have private rights of action also have provisions for attorneys' fees, which are intended to encourage private enforcement of the consumer protection laws on the theory that a free market is in the public interest).

263. See *Sovern*, *supra* note 207, at 449.

264. *KINNEY*, *supra* note 213, at 57.

marketing abuse should advance the core social policies of the Medicare program.

Under current regulations, CMS may impose intermediate sanctions and civil money penalties on insurers.²⁶⁵ The agency may also order plans to suspend the enrollment of Medicare beneficiaries, halt payments to the insurer, and require suspension of all marketing activities.²⁶⁶ The sanctions may continue until CMS is satisfied that the deficiency is corrected and will not recur.²⁶⁷ These are important tools to incorporate into a shared federal-state enforcement scheme. Since CMS is reluctant to regulate plans, states should be empowered to leverage these sanctions. But the most powerful penalty, plan exclusion, should be reserved for CMS.

CMS may presently terminate contracts with insurers that violate marketing standards.²⁶⁸ Unlike the Medicare+Choice program that struggled to retain private insurers, the MMA programs experienced higher than expected plan participation.²⁶⁹ Economic incentives are likely a reason for this high participation.²⁷⁰ The lucrative compensation insurers earn through their participation also makes the threat of exclusion particularly powerful. Although states should coordinate their enforcement efforts with CMS and recommend exclusion of particularly egregious plans, CMS should be the only enforcer that expels abusive plans. Keeping the exclusion sanction centralized is important since it has a nationwide impact. The overriding goal of all penalties should be the promotion of Medicare's social policies.

Marketing abuse remedies should promote and protect accessible health care.²⁷¹ Medicare was created to provide medical

265. 42 C.F.R. § 422.750 (2006).

266. *Id.*

267. *Id.*

268. *Id.* § 422.510 (permitting CMS to terminate a contract with a Medicare Advantage sponsor for substantially failing to comply with the marketing requirements).

269. Oberlander, *supra* note 65, at 189.

270. *E.g.*, Gold, *supra* note 72, at 1303–04 (stating that higher payments created an influx of participating plans).

271. *Cf.* ELLEN DANNIN, TAKING BACK THE WORKERS' LAW 43–44 (2006) (emphasizing the role legislative policy should play in litigating cases under the National Labor Relations Act, in that “the evidence must do more than demonstrate that certain acts have taken place; it must show how those actions violate the Act’s language and purposes and why a particular remedy is appropriate in promoting those purposes”).

coverage for aged and disabled Americans.²⁷² The program has a strong history of making medical care accessible and valuing patient choice.²⁷³ Insurer conduct that restrains patients' treatment options and degrades beneficiaries' ability to make informed choices violates the essential goals of the Medicare program,²⁷⁴ and should be publicly sanctioned. Advancing Medicare's policy goals requires not only remedying individual injuries as described above, but also preventing marketing abuse through rigorous sanctions by state and federal authorities.

CONCLUSION

The effectiveness of this solution is best evaluated from the perspective of victimized beneficiaries. Therefore, it is worth considering how such a solution could have assisted T.W. Aldridge. Mr. Aldridge spent his last days plodding through a federal bureaucratic maze and died worrying that his medical debt would burden his family.²⁷⁵ If Congress amended the Medicare law with the solution presented in this Note, Mr. Aldridge's struggle may have ended differently. Once Mr. Aldridge realized that he was fraudulently enrolled in a Medicare Advantage plan, he could have filed complaints with federal *and* state law enforcers. Upon learning of the incident, the insurance company would have likely immediately canceled Mr. Aldridge's enrollment, as he requested, or else risk government and judicial sanctions. If Mr. Aldridge did not obtain the relief that he requested from government enforcers, he could have independently brought suit alleging unfair and deceptive trade practices. Any one of these actions could have reinstated Mr. Aldridge's medical coverage and reimbursed his economic loss. This proposed solution provides multiple remedial avenues for patients like Mr. Aldridge, rather than the single and seriously inadequate remedy available under the current law. Providing full access to state judicial and law enforcement options would not have forced Mr. Aldridge to take on the private insurance company alone.

272. The title of the Medicare Act is "Health Insurance for Aged and Disabled." 42 U.S.C. § 1394 (2000 & Supp. IV 2005).

273. *See id.* § 1395a (guaranteeing patients' free choices).

274. *See id.* § 1395b-2 (requiring a "clear, simple explanation" of benefits).

275. Keteyian, *supra* note 1 (quoting Mr. Aldridge's last words to his son, "take care of your mom, make sure you take care of those bills. Don't leave all those on her").

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Abusive marketing degrades the quality of health care available to Medicare patients. While congressional attention to predatory marketing is commendable, legislators should incorporate more stringent protections for Medicare patients. Community health is an asset, and nothing is more valuable to individuals than health.²⁷⁶ Medicare incorporates the American values of consumer choice and social concern for our nation's sickest patients. As the program struggles and adapts to accommodate an aging baby-boomer population, the original vision and purpose of Medicare must be advanced through fair and honest interactions with beneficiaries that protect accessible medical care.

276. *Skillings v. Allen*, 173 N.W. 663, 664 (Minn. 1919).