

Beneficiary Experiences with Medicare Advantage Marketing



New Medicare enrollees and those re-evaluating their coverage can find the Medicare Advantage (MA) plan comparison process to be complex and burdensome. For many, the sheer number of plans, along with outdated decision-making tools and insufficient plan data, create barriers to active, informed coverage choices.

Plan, agent, and broker marketing tactics add to this confusion, as beneficiaries are bombarded with ads, calls, and solicitations that are designed to sway their decisions, often in misleading ways.

Confused and overwhelmed, with too little exposure to unbiased sources of information, many people rely on plans and downstream entities like brokers and agents for help choosing coverage.ⁱ But financial incentives mean these players often benefit from pushing products that are in their best interest—not the beneficiary's.^{ii,iii}

Medicare Costs Lead to Affordability Challenges

Medicare's benefit design and lack of financial protections expose beneficiaries to frequent and high costs. Enrollees financially contribute to their coverage through payroll taxes, premiums, deductibles, and other cost-sharing amounts. Many also pay for prescription drug coverage, supplemental insurance, and services that Medicare does not cover,^{iv} such as comprehensive dental, vision, and hearing care.^v Although MA caps enrollee out-of-pocket costs, that ceiling, \$9,350 in 2025, is one 95% of beneficiaries are not expected to meet.^{vi}

Data and our own experiences indicate Medicare costs, and beneficiary struggles with those costs, are growing. In 2012, 21% of callers to the Medicare Rights Center's National Helpline were primarily concerned about affording Medicare.^{vii} In 2023, that number had reached 41%.^{viii}

In 2024, one in four people with Medicare had an income below \$24,600 or less per year, and half had incomes below \$43,200.^{ix} A large and disproportionate share of these dollars goes

toward health care. The average Medicare household spends twice as much on health-related expenses than non-Medicare households (\$7,000 in 2022),^x with over \$2,000 of that spending coming from Part B premiums.^{xi} Those premiums continue to rise; for 2026, Part B premiums are just over \$2,400 annually.^{xii}

These costs are having significant impact on beneficiary access to care. A 2023 survey revealed that one in three people with Medicare delayed or skipped care due to cost in the previous year.^{xiii} Service interruptions and indefinite postponements can lead to poorer outcomes and quality of life. It can also increase Medicare costs, as beneficiaries who forego treatment may need more expensive interventions later, such as emergency department or inpatient care.

The costs also lead to debt, with one in five older adults reporting in 2022 that they had some form of medical debt, with one in ten of those with medical debt owing over \$10,000.^{xiv} Many beneficiaries responded by cutting spending on health care and other necessities, like food and rent. Such sacrifices can erode beneficiary health and well-being. They may also perpetuate the cycle of health care debt by leaving older adults with growing medical needs and fewer resources to meet them.

Unpaid medical bills also cause personal and financial stress, landing people in collections and lowering credit ratings. For the many people with Medicare who live on fixed or limited incomes, this can be particularly hard to undo. They may remain on shaky financial ground—unable to pay incurred spending obligations, meet current needs, or save for the future.

For those who qualify, Medicare financial assistance—the Medicare Savings Programs (MSPs)^{xv}—is a lifeline. MSPs help people with limited resources^{xvi} pay Medicare costs like premiums and cost sharing. Signing up for an MSP also triggers automatic enrollment into the Part D Low Income Subsidy (LIS)/Extra Help, which helps people afford their out-of-pocket prescription drug costs. Combined, these programs make health care costs more manageable, allowing enrollees to maintain Medicare coverage and better meet daily living expenses.

Despite these successes, MSPs and Extra Help have long been under-enrolled.^{xvii} This may be due to lack of information about the programs and how to sign up, as well as difficulty navigating an enrollment process that is notoriously complex.^{xviii}

As a result, MA promises of cost savings, reduced premiums through the “giveback benefit,” or cash-like benefits like over-the-counter debit cards have become more attractive. And marketers have taken note.

A Flood of Marketing

Medicare's high costs and beneficiary financial realities suggest potential susceptibility to MA marketing strategies that promise lower health care costs or benefits beyond what they have been able to afford. Lucrative profits ensure a plentiful field of insurers, brokers, and agents deliver those messages, leading to an explosion of MA marketing in recent years.^{xix}

Unsolicited Outreach

Every year during the Fall Open Enrollment Period, many callers to our helpline report an onslaught of MA marketing calls in addition to a flood of television ads, mailers, sales pitches in retirement communities and facilities, and other in-person solicitation. This echoes national numbers where nearly two-thirds of beneficiaries report being overwhelmed by MA outreach and advertising.^{xx}

Heard on the Helpline:

Unsolicited Outreach

Ms. KM, who is dually eligible, has an MA plan with a monthly over-the-counter (OTC) benefit allowance, which she can use to purchase health-related items. She has been receiving repeated solicitations from another insurer, offering her a plan with a higher monthly allowance. She spoke with one of our helpline counselors and determined the MA plan on offer would have higher cost sharing for the services she often uses and therefore would not be a good fit for her. But the solicitations have not stopped. Ms. KM shared this is not a one-off; she receives frequent solicitations from numerous MA plans.

Not all plan materials and ads are misleading, and not all representatives misstate plan benefits, eligibility, or networks, but beneficiaries do encounter misunderstandings, inaccuracies, half-truths, and deceptive practices as they struggle to find the right coverage for their circumstances.

Some materials and pitches seek to convey a false sense of urgency and compel beneficiaries to act, even if they are satisfied with their current coverage. When prospective enrollees ask questions about the plan they're being sold, the answers are too frequently wrong, either by mistake or intention. And in some of the most egregious cases, callers who decided not to move forward with MA were nevertheless enrolled in a plan unknowingly and without their consent.

Misleading Messages

Aggressive and misleading practices appear to be widespread.^{xxi} They may also be on the rise—complaints to Medicare about such outreach more than doubled between 2020 and 2021,^{xxii} and new reports^{xxiii} and legal proceedings indicate these behaviors drive some plans’ burgeoning enrollment and profits, as well as broker compensation.^{xxiv}

Heard on the Helpline:

Misleading Messages

Ms. CL called the helpline with complaints about misleading MA ads promising extra Social Security benefits, as well as prepaid debit cards for purchasing OTC health products and food. She said when she asked the plan about them, she learned there were limitations on the policy and that she wasn’t eligible for any of the advertised benefits.

Sub-Optimal Enrollments

Between bad actors, honest but wrong representatives, miscommunications, and simple confusion, there are many ways for interactions between beneficiaries and those selling MA plans to result in a sub-optimal enrollment. This can have serious health and financial consequences, like higher costs, problems accessing preferred providers, and delayed care. Despite the risk, there are few avenues for relief. Beneficiaries may be stuck in a plan that does not work for them until the next available enrollment period, or locked into MA indefinitely, due to disenrollment barriers like unaffordable Medigap coverage.

Surprise Coverage Restrictions

Beneficiaries often rely on brokers and plan agents for accurate descriptions of the plans they are selling. When this reliance is misplaced, people can end up with coverage that does not meet their needs.

Heard on the Helpline:

Surprise Coverage Restrictions

Ms. LL, who is dually eligible, chose her MA plan because the plan representative told her it would cover 70 non-emergency medical transportation trips per year. However, after enrolling, she learned she only qualified for 12 round trips.

Ms. MT had an MA plan that paid for a diabetic sensor at no cost to her. An insurance agent told her that a plan from a different company would be a better fit, and that it would also fully pay for her sensor. After switching, she found out her new plan's coverage was actually less generous; it required her to pay \$750 for the sensor.

Provider Network Limitations

Many beneficiaries who enroll in MA and want to keep their providers may not know this isn't guaranteed, due to limited and changing MA provider networks. Others may be aware of the risk but misled about whether their providers are in-network.

Heard on the Helpline:

Provider Network Limitations

Ms. JC, who is dually eligible, enrolled in an MA plan after a broker told her she would not have to switch doctors; she later found out her doctors were not in-network for the plan, forcing her to choose between interrupting her treatment continuity or paying higher rates out of pocket.

Ms. DK switched MA plans based on assurances from the sales representative that her doctors were in-network, and that she would receive additional services including a dedicated counselor. While Ms. DK's primary care physician was in-network, her long-term psychiatrist was not, and she experienced care delays while waiting to hear from the MA plan on whether it would cover those appointments. Additionally, her new MA plan did not provide a dedicated counselor, as was promised.

Prescription Drug Coverage

Similarly, many people may not know they need to ensure their prescriptions are on a plan's formulary. Or, if they ask, they may receive incorrect information.

Heard on the Helpline:

Prescription Drug Coverage

Mr. GL, who is dually eligible, recently switched MA insurers. The agent assured him that all his prescriptions were on the new plan's formulary, but did not explain they were subject to "step therapy," which is a requirement by the plan that enrollees try a different or lower-cost drug first. Mr. GL had already tried the other drugs, and they were not effective. He was left to navigate next steps on his own; the agent did not return his calls.

Unauthorized Enrollments

In some instances, beneficiaries can inadvertently enroll in plans or be enrolled under unclear circumstances.

Heard on the Helpline:

Unauthorized Enrollments

Ms. SC, who is dually eligible and has limited English proficiency, was enrolled in an MA plan and satisfied with her coverage. A representative from a different insurance company called her and switched her plan. She did not want to make that change and was unsure what to do next; she was receiving letters from the plan in English that she did not understand.

In some cases, by switching plans or plan types, beneficiaries may lose access to exclusive benefits.

Heard on the Helpline:

Unauthorized Enrollments

Ms. MP was receiving coverage for a long-term care benefit. She met a plan representative who gave a presentation at her senior center. He enrolled her in a plan, but this triggered a loss of the long-term care benefit.

Ms. IS's daughter explained that Ms. IS mistakenly enrolled in an MA Plan at a grocery store, which cut her off from union benefits such as 50% premium reimbursement.

Challenges Leaving MA for Original Medicare

Another common problem is the difficulty people can face when they want to disenroll from MA entirely, in favor of OM. Many were unaware that Medigap has limited protected buying windows and were caught off guard by their cost exposure. While the underlying problem is Medicare's lack of cost protections, MA marketing communications do not always make the OM vs MA trade-offs clear.

Heard on the Helpline:

Challenges Leaving MA for Original Medicare

Mr. RS was enrolled in a Medigap plan for several years. An MA agent said that Mr. RS could try out MA and had a two-year period within which he could change back to Medigap. Mr. RS decided to return to his Medigap plan, but the agent would not return his calls. When he called his MA plan directly, representatives told Mr. RS that he could have re-enrolled in his Medigap plan within one year of enrolling in MA, but the one-year period had expired. Mr. RS had no right to re-enroll but must apply to see if the plans would accept him. The Medigap plans he applied for denied him.

Discussion

With any product, consumers may misunderstand or be misled about the costs and benefits of what they buy. But with health insurance, the stakes are unusually high. The health and financial implications are extremely serious. Tolerance for deceptive marketing should reflect this dynamic.

Standardization of MA offerings and addressing the proliferation of plans could help reduce the need for broker services. This would, in turn, reduce the opportunity for brokers to steer profitable beneficiaries into lucrative plans.

Equalizing commissions between MA and other insurance products, such as Medigap and stand-alone Part D plans, would also limit the potential for misaligned incentives.

Reforms could also make sub-optimal enrollments less risky. Better enrollment processes for MSPs would reduce pressure on people with few resources. Enhanced relief pathways and expanded Medigap purchasing rights would make it easier for people to correct mistakes and obtain coverage that works well for them, whether that's leaving one MA plan for another or for OM.

Ultimately, larger-scale change is also needed. Medicare benefits and cost protections should be strengthened and equalized across coverage pathways, leveling the playing field between MA and OM.

MA overpayments, which increase as enrollment does, boost plan profits at Medicare and taxpayer expense. This profit-driven cycle means nominal tweaks are unlikely to yield sufficient results. Systemic, beneficiary-centered reforms uniquely can fix the structures that today drive higher and higher enrollments, overpayments, and Medicare costs.^{xxv} In the long term, the issue must be solved at the root, through meaningful changes to MA's payment structure.^{xxvi}

ⁱ Steven Findlay, *et al.*, "The Role of Marketing in Medicare Beneficiaries' Coverage Choices" (January 5, 2023) <https://www.commonwealthfund.org/publications/explainer/2023/jan/role-marketing-medicare-beneficiaries-coverage-choices>.

ⁱⁱ For example, commissions and other payments that are higher for MA plans than for supplemental coverage like Medigap may incentivize agents and brokers to steer consumers into MA. Riaz Ali & Lesley Hellow, "Agent Commissions in Medicare and the Impact on Beneficiary Choice" (October 12, 2021), <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>.

ⁱⁱⁱ For more on broker commissions and incentives, see our companion piece on MA marketing, brokers, and agents.

^{iv} Medicare Rights Center, "Medicare Coverage Gaps: The Need to Curb Beneficiary Out-of-Pocket Spending" (March 1, 2023) <https://www.medicarerights.org/policy-documents/medicare-coverage-gaps-the-need-to-curb-beneficiary-out-of-pocket-spending>.

^v Medicare Rights Center, "Filling Gaps in Medicare Coverage: Dental, Vision, and Hearing" (March 1, 2023) <https://www.medicarerights.org/policy-documents/filling-gaps-in-medicare-coverage-dental-vision-and-hearing>.

^{vi} 42 CFR § 422.100(f)(4)(iv)(A).

^{vii} Charlotte Sutton, *et al.*, "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Helpline (last accessed February 26, 2025), <https://www.medicarerights.org/pdf/2012-helpline-trends-report.pdf>.

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- ^{ix} Alex Cottrill, *et al.*, “Income and Assets of Medicare Beneficiaries in 2024” (August 25, 2025), <https://www.kff.org/medicare/income-and-assets-of-medicare-beneficiaries/>.
- ^x Nancy Ochieng, *et al.*, “Medicare Households Spend More on Health Care Than Other Households” (March 14, 2024), <https://www.kff.org/medicare/issue-brief/medicare-households-spend-more-on-health-care-than-other-households/>.
- ^{xi} Medicare Interactive, “Medicare in 2022” (2022), <https://medicareinteractive.org/pdf/medicare-in-2022-guide.pdf>.
- ^{xii} Centers for Medicare & Medicaid Services, “2026 Medicare Parts A & B Premiums and Deductibles” (November 14, 2025), <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-a-b-premiums-deductibles>.
- ^{xiii} Karen Politz, *et al.*, “KFF Survey of Consumer Experiences with Health Insurance” (July 15, 2023), <https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/>.
- ^{xiv} Alex Cottrill, *et al.*, “What are the Consequences of Health Care Debt Among Older Adults?” (July 26, 2024), <https://www.kff.org/medicare/issue-brief/what-are-the-consequences-of-health-care-debt-among-older-adults/>.
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- ^{xvii} Medicaid and CHIP Payment and Access Commission, “Medicare Savings Programs” (September 08, 2023), <https://www.macpac.gov/subtopic/medicare-savings-programs/>.
- ^{xviii} Centers for Medicare & Medicaid Services, “Navigating the Medicare Savings Program (MSP) Eligibility Experience” (last accessed June 5, 2025), <https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf>.
- ^{xix} Jared Ortaliza, *et al.*, “Health Insurer Financial Performance in 2023” (July 2, 2024), <https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/>.
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- ^{xxii} 87 Fed. Reg. 1842.
- ^{xxiii} U.S. Senate Finance Committee Ranking Member Ron Wyden, “Pushing Medicare Advantage on Seniors : Unraveling the Complex Network of Marketing Middlemen” (March 2025), https://www.finance.senate.gov/imo/media/doc/pushing_medicare_advantage_on_seniors_unraveling_the_complex_network_of_marketing_middlemen_-_32425docx.pdf.
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