Medicare Trends and Recommendations

An Analysis of 2023 Call Data from the Medicare Rights Center's National Helpline

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About the Medicare Rights Center

Based in New York, the Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Since 1989, Medicare Rights has helped people with Medicare understand their rights and benefits, navigate the Medicare system, and secure the quality health care they deserve.

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Introduction and Summary

The Medicare Rights Center (Medicare Rights) is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

In 2023, Medicare Rights Center staff and volunteers addressed more than 27,000 questions through its National Consumer Helpline and professional email channels. Additionally, Medicare Rights' free and independent online reference tool, Medicare Interactive (MI), provided more than 3.6 million answers for beneficiaries, their caregivers, and professionals. This report features the top helpline trends and highlights the most commonly sought helpline and Medicare Interactive answers, providing a glimpse into the various questions and needs of Medicare beneficiaries, caregivers, and the professionals assisting them in the community in 2023.

Callers to the national helpline come from diverse backgrounds and search for information, advice, and assistance on various Medicare topics. Helpline callers include beneficiaries, caregivers, family members, health care providers, and community-based professionals. In 2023, 76% of callers were Medicare beneficiaries calling on their own behalf, 19% were caregivers or family members, and 4% were professionals calling on behalf of a client.

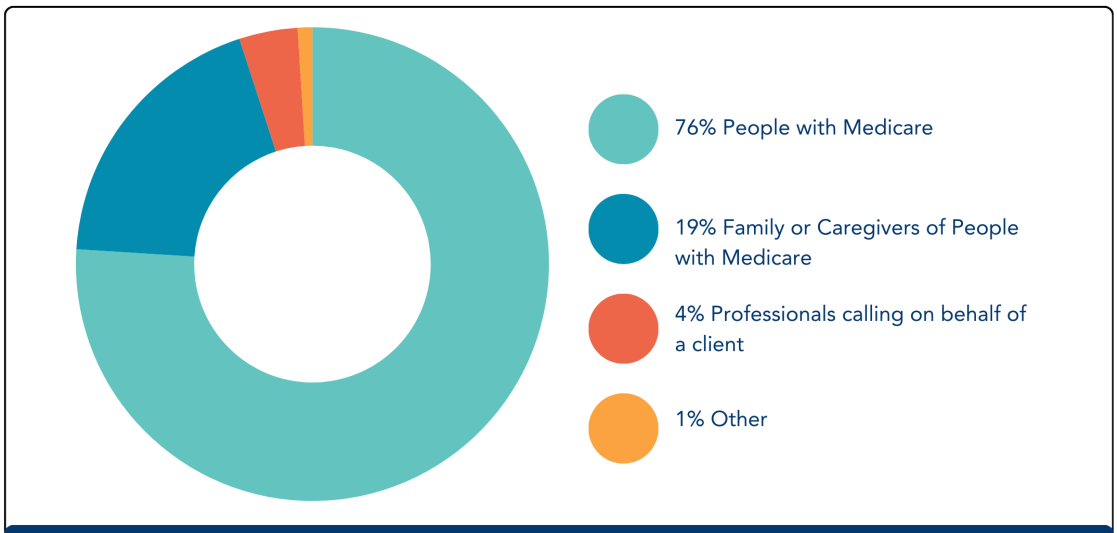

Figure 1: Medicare Rights' national helpline callers in 2023 (n= 9,141)

Throughout 2023, the National Consumer Helpline served callers from all 50 states, Puerto Rico, and abroad. Most callers were from New York (55%), followed by Florida (5%), California (4%), Texas (3%), and New Jersey (3%).

Regarding eligibility, the majority of callers were eligible due to being age 65 or older (80%), followed by individuals eligible due to having a disability (17%), End-Stage Renal Disease (1%), and those who were not yet eligible for the program (2%). Helpline callers were close to evenly split between Original Medicare (40%) and Medicare Advantage (42%), with the remainder of callers having primary coverage from another source such as an employer group health plan, federal employee health benefits, military or Veterans' benefits, and Marketplace coverage.

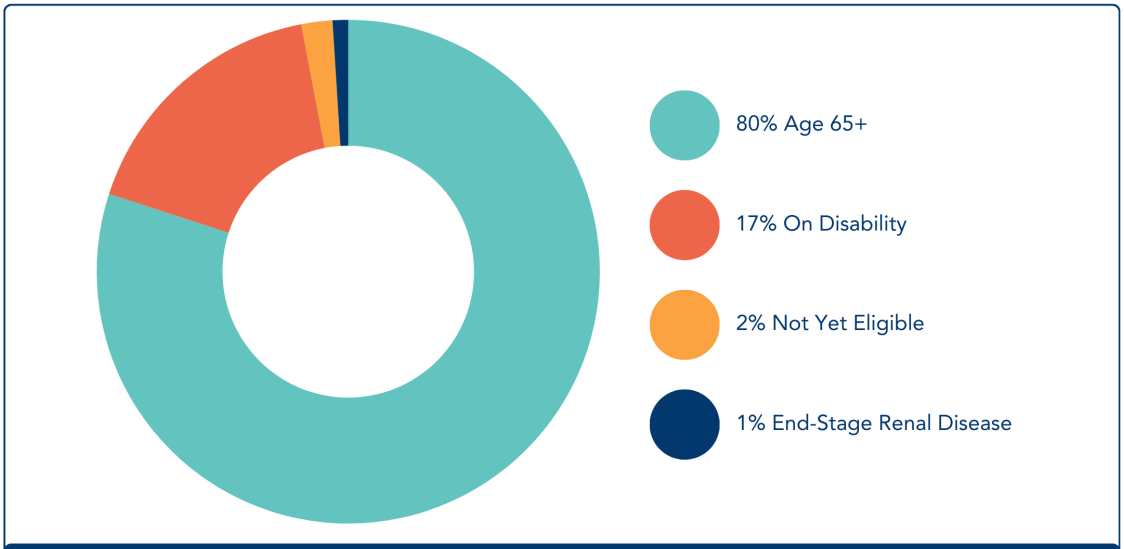

Figure 2: Medicare eligibility of Medicare Rights' national helpline callers in 2023 (n= 9,141)

Of callers who provided their demographic information, 66% identified as White/Caucasian, 14% identified as Black/African American, 11% identified as Hispanic or Latino, 6% identified as Asian, and 3% identified with one or more racial or ethnic identity.

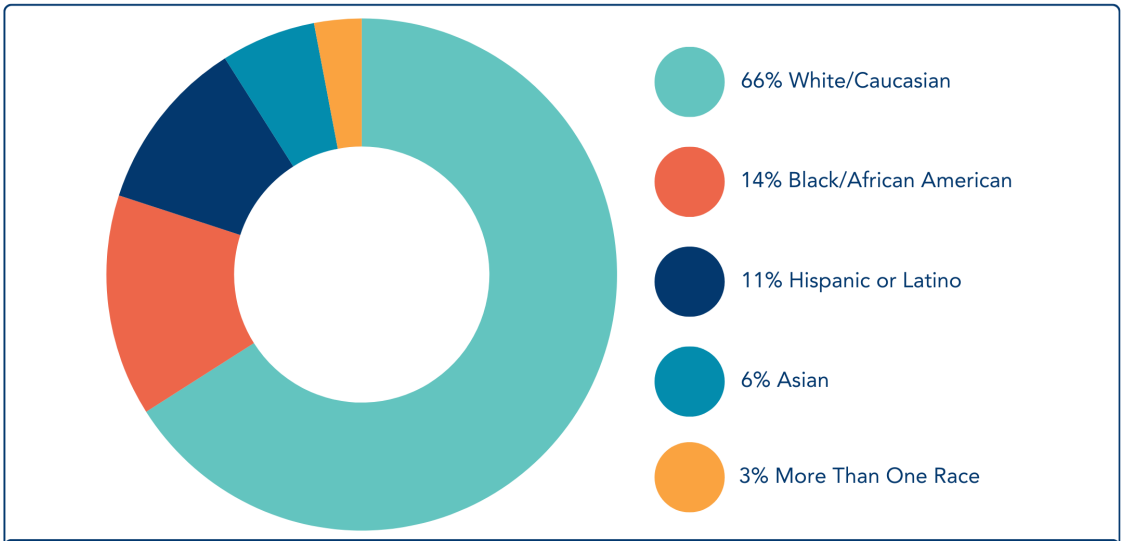

Figure 3: Medicare Rights' national helpline caller demographics in 2023 (n= 1,546)

The helpline has seen a growing number of callers who are eligible for low-income programs such as a Medicare Savings Program (MSP), Extra Help, or Medicaid. In 2023, 55% of callers reported living below 186% of the federal poverty level (FPL)—$27,118.80 for an individual and $36,679.20 for a married couple in 2023.[i] Individuals

enrolled in Medicare and Medicaid, known as Dual Eligibles, represented 15% of all callers.

Many Medicare beneficiaries, caregivers, and professionals utilize Medicare Rights' online educational tool, Medicare Interactive, which continues to provide people with answers and resources on a variety of Medicare topics. Figure 4 shows the most frequently visited sections of Medicare interactive in 2023.

Medicare Interactive Section Title	Page Views	Percent of Total Page Views
Medicare-Covered Services	1,243,599	27%
Medicare Health Coverage Options	802,265	17%
Medicare Basics	749,287	16%
Cost-Saving Programs for People with Medicare	642,042	14%
Medicare Prescription Drug Coverage (Part D)	544,386	12%
Coordinating Medicare with Other Types of Insurance	344,865	7%
Medicare Denials and Appeals	185,180	4%
Types of Medicare Advantage Coverage	69,428	1%
Planning for Medicare and Securing Quality Care	51,702	1%
Medicare Fraud and Abuse	11,394	<1%
Total	4,644,148	100%

Figure 4: List of Medicare Interactive Sections, Sorted by Number of Page Views, 2023

In 2023, helpline counselors assisted callers with a diverse range of questions. The themes were similar to prior years; however, questions about affordability and cost assistance programs emerged as the top issue. Of all calls, 41% of callers had questions about Medicare affordability; 27% had access to care questions such as coverage, billing, or denials; 24% had questions about Medicare Enrollment; and 8% were a mix of various issues.

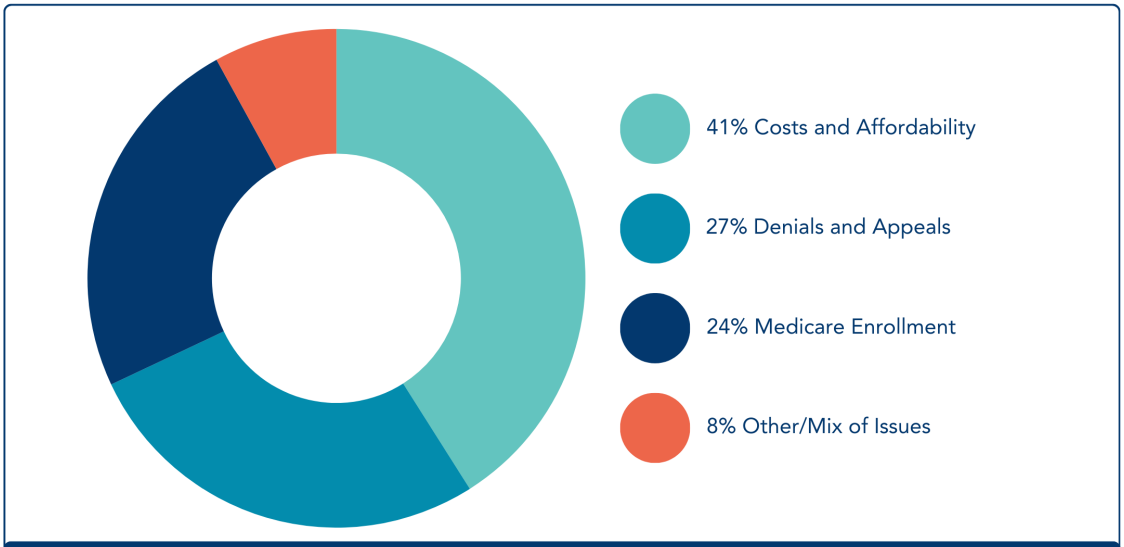

Figure 5: Top issues from Medicare Rights' national helpline in 2023 (n=~ 27,300)

Medicare Rights publishes this report so that stakeholders, including policymakers at the Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA), lawmakers and elected officials, advocates, and others, can better understand the ongoing and evolving needs of Medicare beneficiaries and strive to improve the Medicare program both within Original Medicare and Medicare Advantage.

Helpline Trend

Medicare Affordability

Medicare Savings Program

> *Case Story*—Violet's family called on her behalf. She was 100 years old and struggling with health care and prescription costs. Even though Violet's monthly income hovered around $1,800 per month, prior to 2023 she was not eligible for any type of cost assistance. With New York State's 2023 expansion of the Medicaid and Medicare Savings Program (MSP) eligibility criteria, Violet was newly eligible for the Medicare Savings Program. Medicare Rights helped her apply. She received the Medicare Savings Program to pay for her Part B premium and was deemed into Extra Help to assist with her Part D prescription costs.

In 2023, 41% of callers contacted the helpline with questions about how to afford Medicare premiums, cost-sharing, or prescription drugs. This represents approximately a 14% increase in calls related to affordability compared to 2022, due in part to an increase in calls about New York state expanding the income limits for Medicare Savings Programs and Medicaid.

Medicare Savings Programs pay for Medicare Part B premiums ($164.90 in 2023), deem individuals into the Extra Help program for assistance with prescription drug costs, and in some cases pay for the Part A premium. In 2023, the estimated savings for an eligible individual were $7,300 annually in Medicare costs. MSPs also aid with Part B and Part D enrollment and eliminate late enrollment penalties for individuals who missed initial deadlines.

In 2023, New York State increased the income limits for the Medicare Savings program from 135% of the FPL to 186% of the FPL. Due to the expansion, it is estimated that approximately 300,000 New Yorkers became newly eligible for the Medicare Savings Program. Of individuals referred to our helpline for assistance with low-income benefits, approximately 33% were newly eligible for the Medicare Savings program due to the expansion.

Policy Recommendations

Expand and Ease Access to Medicare Low-Income Assistance

Medicare's low-income assistance programs bolster affordability and outcomes, but many who need this help are not getting it. Often, people struggling with Medicare costs do not fit the overly strict MSP and Extra Help eligibility thresholds, and burdensome administrative requirements can further limit participation. Federal and state policymakers should raise income limits, eliminate asset tests, streamline application processes, and work toward fully automatic enrollment into the programs.

Increase Outreach on MSP and Extra Help Availability

Lack of awareness about the programs is also a barrier to participation. We welcome steps Medicare has taken to improve beneficiary outreach and urge redoubled efforts, as well as adding information about the value of and ways to enroll in MSPs and Extra Help to more Medicare materials.

Increase Funding for SHIPs

Medicare Rights also supports adequate funding for State Health Insurance Assistance Programs (SHIPs) to provide one-on-one enrollment and coverage counseling to people with Medicare. With locations in every state, SHIPs are a primary and trusted source of unbiased information. Current funding levels are unable to meet or keep pace with a growing Medicare population and an increasingly complex program.

Include Out-of-Pocket Maximum for Original Medicare

Unlike most modern health insurance coverage, Original Medicare has no out-of-pocket maximum, exposing beneficiaries to limitless financial risk. Medicare Rights supports establishing a standardized, affordable, out-of-pocket maximum for Medicare Parts A and B in both Original Medicare and Medicare Advantage (MA). Although MA Plans currently include an out-of-pocket maximum in their benefit packages, the threshold is too high: $8,850 for in-network services is far beyond the reach of many Medicare beneficiaries. These containment measures must be coupled with efforts to meaningfully address the drivers of high and rising health care costs.

Fill Gaps in Medicare Coverage

MA Plans may offer some vision, dental, and hearing coverage, but it is typically limited and not available to beneficiaries with Original Medicare. Medicare Rights supports adding comprehensive coverage for these essential services to Medicare Part B. Doing so would best ensure such care is consistent and available program-wide.

Medicaid

> *Case Story*—James contacted the helpline because he was having several issues navigating his Medicare and Medicaid coverage. James had enrolled in a Dual-eligible Special Needs Plan (D-SNP) hoping for better coordination of benefits; however, it turned out that two of his necessary specialists were not in network, and he was struggling to find in-network providers. Simultaneously, he was in the process of re-certifying his Medicaid benefits and struggling to understand all of the recertification paperwork and deadlines. Adding to James' stress, he had also received coverage denials because his doctors were out of network, and he needed support with the appeals process.

Medicare Rights' helpline continues to receive calls from individuals seeking guidance on eligibility for or enrollment assistance with the Medicaid program. In 2023, 15% of callers were dually eligible—enrolled in Medicare and Medicaid—and 8% of overall calls pertained to the Medicaid program. Dually eligible individuals commonly need

assistance with plan selection, counseling about D-SNP Medicare Advantage Plans, or help coordinating their services and benefits across the different pieces of Medicare and other related programs.

Medicare Rights frequently sees dually eligible individuals struggle to navigate multiple benefits at the same time. Those who opt into D-SNPs have to manage maintaining their Medicaid eligibility, understanding and accessing plan networks, and making sure their providers are in network and their medications are on the plan's formulary.

Policy Recommendations

Improve Medicare Plan Finder (MPF)

People searching for an MA Plan need better information about the integration level of D-SNPs and clearer explanations for benefits, including which are Medicaid benefits and which are Medicare supplemental benefits. MPF results should highlight D-SNPs when MPF users indicate that they are dually enrolled, including by putting D-SNP results at the top of the page and by giving more information about the integration level—and what such integration means—of each plan.[ii] In addition, there must be information about the plan network and participating providers to ensure dually eligible individuals, and all beneficiaries, have access to accurate information before making plan choices.

Improve Integration of D-SNPs

Currently, even integrated MA Plans like Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) do not truly make accessing care seamless for enrollees. One big gap is a lack of network congruency, meaning that some providers are only enrolled in Medicare or Medicaid but not both. In addition, most plans are not integrated at the appeals level, and many places beneficiaries turn for answers, such as plan helplines or state Medicaid offices, may not have a full understanding of both programs. As D-SNPs gain in popularity, they must be more accountable for integrating care and ensuring enrollees do not fall through the cracks.

Improve Medicaid Enrollment and Redeterminations

Medicaid-eligible individuals may struggle to enroll in and maintain coverage due to state administrative and policy barriers. To reduce these burdens and coverage losses, states must modernize the Medicaid determination process, including by adopting and leveraging effective ex parte renewal strategies.[iii]

Helpline Trend

Medicare Enrollment

Part B Enrollment

> *Case Story*—Theo called the helpline because he had been living abroad when he first turned 65 a year ago. He moved back to the U.S. in January of 2023 to be closer to family, and at that point, he realized he should not have declined Medicare during his Initial Enrollment Period (IEP). Theo had urgent health care needs and wanted to enroll in Medicare as soon as possible. A helpline counselor counseled him on how to enroll in Medicare during the General Enrollment Period (GEP). He enrolled in January, and his Medicare became effective one month later in February.

In 2023, 24% of helpline callers had questions about enrolling in Medicare. This was a comparable number to prior years. Frequent questions included how to enroll in Medicare when eligible at age 65, how to utilize the Part B Special Enrollment Period (SEP), and how to use the General Enrollment Period. Callers utilizing the GEP had often made mistakes related to their Initial Enrollment Period, resulting in coverage gaps and late enrollment penalties.

Before 2023, callers like Theo faced a gap in coverage between the GEP and when their coverage went into effect in July of that calendar year. As a result of changes in enrollment rules due to the passage of key provisions of the BENES Act, the gap in coverage from January to July has been eliminated. Individuals can enroll in the GEP, and their coverage will take effect the first of the following month, eliminating problematic gaps in coverage.

Medicare Advantage vs. Medigap Enrollment

> *Case Story*—Genevieve had been enrolled in Original Medicare and a Medigap for several years and made the switch to a Medicare Advantage Plan during Fall Open Enrollment. Upon enrolling in the MAPD, Genevieve faced a variety of unanticipated issues, such as a specialist being out of network, denials of lab work, and confusing billing. She wanted to switch back to Original Medicare and her Medigap. A helpline counselor advised her on the potential enrollment periods to return to her Medigap but warned that re-enrolling may be

challenging or more expensive now that she is outside of her Medigap Open Enrollment Period.

In 2023, for the first time, the majority of helpline callers were enrolled in Medicare Advantage Plans (42%) compared to Original Medicare (40%). Compared to prior years, the helpline has seen a gradual shift of helpline callers enrolled in Original Medicare versus Medicare Advantage. Previously, the breakdown was 44% Original Medicare compared to 37% Medicare Advantage (2022), 46% versus 33% (2021), and 48% versus 32% (2020). This is in line with the trend of the entire population shifting towards Medicare Advantage, with over 50% of the overall Medicare population enrolled in MA Plans in 2024.[iv] in 2024.[v]

Many helpline callers explore Medicare Advantage due to lower cost-sharing and access to supplemental benefits. However, the helpline often hears from individuals who have enrolled in Medicare Advantage and later seek to change back to Original Medicare due to complex health conditions. The helpline has assisted many callers who enrolled in an MA Plan when they were healthy or had low health care needs but later hoped to switch to Original Medicare with a Medigap because they developed a new or complex health issue.

Switching to Original Medicare can be done during the Fall Open Enrollment Period, a Special Enrollment Periods (SEP), or the Medicare Advantage Open Enrollment Period; however, purchasing a Medigap policy can prove challenging. Once a person is outside of their Medigap open enrollment period, or does not have a guaranteed issue right, they may be locked out of Medigap enrollment indefinitely or priced out due to age or health status.

Policy Recommendations

Pass the BENES 2.0 Act

While most older adults are automatically enrolled in Medicare Part B because they are receiving Social Security benefits at age 65, a growing number are not. In 2016, only 60% of Medicare-eligible 65-year-olds were taking Social Security, compared to the 92% who were in 2002.[vi] This growing cohort must actively enroll, which means navigating a thicket of complicated Medicare rules and stringent deadlines. Mistakes are common and carry serious consequences, like harsh financial penalties, higher out-of-pocket costs, and gaps in coverage. In 2021, nearly 800,000 people were paying a Part B late enrollment penalty (LEP). The average amount increased their monthly

premium by nearly 30%,[vii] and research suggests few know about these penalties in advance.[viii] The bipartisan Beneficiary Enrollment Notification and Eligibility Simplification (BENES) 2.0 Act (S. 1687) would help by requiring Medicare to alert people approaching eligibility about the actions they must take and the deadlines they must meet. Although this information would support informed beneficiary decision-making and help reduce enrollment missteps, today, no such notice is required.

Modernize Enrollment Penalties and Remedies

Medicare should make it easier for people to correct their enrollment errors, including through increased use of equitable relief and flexibility in the Special Enrollment Periods created by the original BENES Act. Similarly, we urge Congress to review the efficacy of the Part B LEP structure. Though intended to encourage individuals to enroll in Medicare when first eligible, complex enrollment rules mean many are likely paying the LEP because of an honest error, not a deliberate deception. Additional study would help determine "whether the late-enrollment penalties are having the desired effects" as well as guide reforms.[ix]

More Accurately Depict Coverage Trade-offs

To ensure people understand their options, Medicare must better explain the near- and long-term consequences of an enrollment choice. For example, Medicare's decision-making tools and materials, such as Medicare Plan Finder, should accurately and fully depict the pros and cons of beneficiary coverage choices, including between Original Medicare with a Medigap and Medicare Advantage. Further, CMS must explain the differences between Original Medicare and MA in a way that reflects beneficiaries' primary considerations. For example, one of the most significant decision points for many is access to the provider of their choosing. Most MA Plans have ever-shifting networks that may exclude an individual's chosen provider, but this may not be well or widely understood. Even when it is, discovering which providers are in network can be difficult, and networks can change at any time, leaving MA enrollees at risk of losing—or never even having—access to their preferred provider. Few resources make this plain.

Strengthen Medigap Access and Education

Another often overlooked or under-explained trade-off is access to Medigaps. Each year, Medicare's annual enrollment periods allow beneficiaries to change from one MA plan to another or to switch coverage pathways. But changing from Original Medicare to MA, or vice versa, has profound consequences for affordable Medigap access. Most states lack Medigap enrollment flexibilities and protections that mirror those available

through MA, so residents can only sign up during very limited times. Beneficiaries may not know this or the implications of forgoing their Medigap open enrollment period or later canceling their policy. Congress and states should address the root of this problem by expanding Medigap access. This includes extending current Medigap buying protections for those 65 and older to younger Medicare enrollees and providing for open enrollment, guaranteed issue, and community rating of Medigaps for all beneficiaries. In the meantime, CMS, as well as plans, brokers, and other agents, must fully communicate the Medigap-related and other implications of leaving or declining Original Medicare.

Standardize and Limit Medicare Advantage Plans

The cluttered plan landscape makes comparing plans a challenging, intimidating, and time-consuming task that few people with Medicare perform.[x] This analysis may be particularly burdensome for consumers with limited English proficiency, those who have cognitive impairments or other serious health needs, and people with inadequate internet access. Standardizing plans with only high-quality options that are meaningfully different from one another removes some of this complexity and risk. In addition to easing plan evaluations, ensuring plans are limited in number and easier to compare would advance equity by allowing CMS, consumers, advocates, and researchers to more readily identify and prevent discriminatory benefit designs.

Helpline Trend

Access to Care

> *Case Story*—Alan contacted the helpline after having multiple issues with accessing care. He had enrolled in a Medicare Advantage Plan with the promise of supplemental benefits like transportation and dental care. After being hospitalized, Alan needed rehabilitation services at a skilled nursing facility (SNF), but his MA Plan denied the prior authorization request. Alan and his family considered switching him back to Original Medicare, but they were concerned about losing the supplemental transportation benefits. Our helpline counselor advised Alan and his family about coverage options and how to appeal the plan's coverage denial for the SNF rehabilitation stay.

In 2023, the helpline received 5,327 questions about coverage and denials. Of those, the majority of questions were related to Medicare Advantage health services (31%), followed by Part B (26%), Part D through stand-alone plans or Medicare Advantage (16%), and Part A (12%). Medicare beneficiaries often struggle to navigate the appeal

process during periods of illness and face challenges with the cumbersome process of filing multiple appeals to gain access to necessary medical services.

Adding to the complexity, many people seek out MA Plans due to the supplemental benefits offered, such as dental, vision, hearing, or transportation—services that are not covered by Original Medicare. Supplementary benefits can have their own complexities, such as varying eligibility, provider networks, and out-of-pocket costs, which prove challenging to untangle.

Policy Recommendations

Reduce Improper Denials

Coverage denials force beneficiaries to choose between seeking other care, paying out of pocket, or going without—or getting embroiled in a daunting appeals system. Importantly, even successful appeals come at a cost. The most significant risks are care delays and the resulting negative health outcomes. To reduce harmful and inaccurate denials—and the likelihood that an enrollee needs to file an appeal in the first place—we urge clearer rules, stronger enforcement, more transparency, tightened audit standards, firmer guidance about MA coverage criteria, and beneficiary relief, including a change of plans, where violations are rampant.

Improve Plan Communications

We continue to urge CMS to simplify Medicare's appeals processes, including by improving plan communications with enrollees. Under current rules, when plans issue a denial, they are required to notify the affected enrollee in a timely manner. Without this notice, beneficiaries may not understand their rights, how to appeal, or even that they have been denied coverage. Despite the importance of this obligation, many plans fail to comply. CMS must do more to make sure that plan notices are correct, promptly delivered, available in languages other than English, and accessible to people with varying levels of health literacy. We also support invalidating and immediately escalating coverage denials that were not accompanied by proper notice.

Streamline Appeals

In addition to notice requirements, appeals should be streamlined by reducing the number of steps enrollees must take. In Medicare Part D, for example, a beneficiary who gets a denial of coverage at the pharmacy counter must independently submit a formal and separate coverage determination request rather than being able to appeal the point-of-sale denial directly. This extra step creates an unnecessary barrier to care.

In all appeals, the first level of review should be handled by an independent entity rather than the plan. This would simplify the system, help ensure that beneficiaries have more timely access to care, and encourage plans to make accurate initial coverage determinations.

Better Data and Oversight

Policymakers should require better data collection and reporting on MA Plan and Medicare contractor decisions regarding coverage and care. We specifically recommend monitoring for patterns of high denial and overturn rates, low appeal rates, and inappropriate denials for specific services or categories of care. Identified trends should trigger more comprehensive reviews, and plans that regularly engage in such practices should lose the ability to contract with CMS.

Strengthen Supplemental Benefit Guardrails

Medicare Rights also asks CMS to advance rulemaking about plan marketing of supplemental benefits. Clear guidelines and increased transparency would allow CMS to better oversee marketing materials and for beneficiaries and advocates to raise concerns when promised services are not being delivered. It is essential to continually verify that plans are not merely using supplemental benefits as a selling point but are providing them adequately, equitably, and promptly. We also support CMS establishing network adequacy requirements and clear appeals processes for this coverage, as well as including better information about supplemental benefits on Medicare Plan Finder and other resources on which beneficiaries rely to make informed coverage decisions.

Conclusion

Data from Medicare Rights' 2023 National Consumer Helpline highlight the many hurdles encountered by Medicare beneficiaries and their caregivers when trying to access and afford needed medical care. The main trends—affordability, enrollment, and access to care—remain persistent from prior Helpline Trends Reports, demonstrating the need to simplify, strengthen, and improve the Medicare program for all beneficiaries.

The Medicare Rights Center looks forward to continuing to work with CMS, SSA, fellow advocates, and beneficiaries to strengthen and protect the Medicare program for this and future generations.

Citations

[i] U.S. Department of Health and Human Services. *Detailed Guidelines: 2023*. Accessed January 6, 2025. https://aspe.hhs.gov/sites/default/files/documents/1c92a9207f3ed5915ca020d58fe77696/detailed-guidelines-2023.pdf.

[ii] Association for Community Affiliated Plans, et al. "Letter to CMS Regarding Medicare Plan Finder." October 13, 2023. Accessed January 6, 2025. https://www.scribd.com/document/681343491/Medicare-Plan-Finder-Identified-Changes#from_embed.

[iii] Centers for Medicare & Medicaid Services. *Ex Parte Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding*. October 20, 2022. Accessed January 6, 2025. https://www.medicaid.gov/resources-for-states/downloads/ex-parte-renewal-102022.pdf.

[iv] KFF. *Medicare Advantage in 2024: Enrollment Update and Key Trends*. August 8, 2024. Accessed January 6, 2025. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/.

[vi] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*. June 2019. Accessed January 6, 2025. http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.

[vii] Congressional Research Service. *Medicare Part B: Enrollment and Premiums*. May 19, 2022. Accessed January 6, 2025. https://www.everycrsreport.com/files/2022-05-19_R40082_143a23f28239eec6ef87bac952856d5a14d0a22e.pdf.

[viii] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*. June 2019. Accessed January 6, 2025. http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.

[ix] Medicare Payment Advisory Commission. *Beneficiary Enrollment in Medicare: Eligibility Notification, Enrollment Process, and Part B Late-Enrollment Penalties*. June 2019. Accessed January 6, 2025. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch1_medpac_reporttocongress_sec.pdf.

[x] Freed, Meredith, et al. *More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually*. October 29, 2020. Accessed January 6, 2025. https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/.; Koma, Wyatt, et al. *Seven in Ten Medicare Beneficiaries Did Not Compare Plans During the Past Open Enrollment Period*. October 13, 2021. Accessed January 6, 2025. https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/.