

Congress of the United States

Washington, DC 20515

[[DATE]]

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Becerra and Administrator Brooks-LaSure:

We appreciate the Biden Administration’s recent actions to protect patients enrolled in Medicare Advantage plans and the solvency of the Medicare program. In particular, we welcome the updates to the risk adjustment model that the Centers for Medicare and Medicaid Services (CMS) made in the 2024 Medicare Advantage Rate Notice and the actions you have taken to remove the obstacles to care that many MA beneficiaries face. However, we have concerns over recent proposals to increase taxpayer investments in private MA plans without taking similar measures to invest in and strengthen traditional Medicare (TM) for enrollees.

While MA was intended to reduce costs for Medicare, the nonpartisan Medicare Payment Advisory Commission (MedPAC) has found that the MA program has yet to accomplish this goal.¹ Instead, MedPAC estimates that CMS pays MA plans 6 percent more per enrollee than what it would cost to cover the same enrollee in TM.² Yet, the data demonstrates that beneficiaries enrolled in MA may experience poorer outcomes,³ with poor clinical outcomes disproportionately impacting Black, Native American or Alaska Native, and Hispanic individuals^{4,5} who appear to be disproportionately offered and enrolled in plans with lower quality ratings.⁶

Reforms are Needed to Improve Patient Health

¹Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare Payment Policy," March 2023, pp. 13, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf.

²*Id.*

³Centers for Medicare & Medicaid Services Office of Minority Health and The RAND Corporation, "Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex," April 2022, <https://www.cms.gov/files/document/disparities-health-care-medicare-advantage-race-ethnicity-and-sex.pdf>.

⁴KFF, "Disparities in Health Measures By Race and Ethnicity Among Beneficiaries in Medicare Advantage: A Review of the Literature," Nancy Ochieng, Jeannie Fuglesten Biniek, Juliette Cubanski, and Tricia Neuman, December 13, 2023, <https://www.kff.org/medicare/report/disparities-in-health-measures-by-race-and-ethnicity-among-beneficiaries-in-medicare-advantage-a-review-of-the-literature/>.

⁵*Id.*

⁶University of Pennsylvania Leonard Davis Institute of Health Economics, "Why Are There Disparities in Enrollment in Medicare Advantage?" Chris Tachibana, May 5, 2022, <https://ldi.upenn.edu/our-work/research-updates/why-are-there-disparities-in-enrollment-in-medicare-advantage/>.

As CMS works to finalize the 2025 Medicare Advantage Rate Notice, we urge you to consider continued efforts to address remaining issues with the program by making it easier for beneficiaries to seek out and receive care, ensuring funds that are incorrectly going to MA companies are redirected to patients and providers, and modernizing the benefits in TM. Specifically, we urge you to consider the following challenges and proposed reforms to strengthen the Medicare program:

1. Ensure that insurance companies do not prevent older adults and people with disabilities from getting care by putting up obstacles, including onerous prior authorizations, Artificial Intelligence (AI) algorithms, or limited networks;
2. Strengthen provider encounter and patient data collection and transparency to improve public understanding of the effects of insurer-run MA plans on patients and the Medicare program;
3. Rein in overpayments to insurers in MA by adjusting benchmarks to compensate for favorable selection and cracking down on deceptive tactics by private insurance companies, including upcoding;
4. Address misleading and deceptive marketing practices; and
5. Strengthen Medicare for everyone through administrative action, such as by lowering Medicare premiums, and support legislative efforts to expand Medicare benefits, cap out-of-pocket (OOP) costs in TM, and adjust the physician fee schedule to account for increases in provider costs.

1. Ensure that insurance companies do not prevent older adults and people with disabilities from getting care by putting up obstacles, including onerous prior authorizations, Artificial Intelligence (AI) algorithms, or limited networks.

We applaud CMS’s recent actions on insurer tactics that we believe limit care and aim to increase their profits in MA. Specifically, we appreciate CMS prohibiting insurers from imposing additional clinical criteria for prior authorization approvals outside of current Medicare policies and streamlining the prior authorization process.^{7,8} If enforced properly, these actions could decrease the roughly 260,000 medical prior authorizations and 1.5 million payment requests that are improperly denied by MA insurers each year.⁹ These reforms will be even more vital as the number of prior authorizations in MA continues to increase: 97 percent of medical practices recently reported that their patients experienced a delay or

⁷ “Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications.” Federal Register, December 27, 2022.
<https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program>.

⁸ Centers for Medicare & Medicaid Services, “CMS Finalizes Rule to Expand Access to Health Information and Improve the Prior Authorization Process,” press release, January 17, 2024,
<https://www.cms.gov/newsroom/press-releases/cms-finalizes-rule-expand-access-health-information-and-improve-prior-authorization-process>.

⁹ KFF, “Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021,” Jeannie Fuglesten Biniek and Nolan Sroczynski, February 2, 2023,
<https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/>.

denial of medically necessary care as a result of prior authorization requirements imposed by MA plans.¹⁰ Further, 86 percent of physicians have reported that despite insurer claims that prior authorization is intended to contain costs, such tactics actually lead to higher health care utilization and waste. For example, insurers may require extra diagnostic tests such as x-rays to “confirm” the diagnosis a medical provider has already made.¹¹ Cracking down on prior authorization could reduce physician and hospital overhead and physician burnout while saving taxpayer dollars. We urge you to consider strong enforcement of these regulations and meaningfully penalize plans that do not comply.

We also encourage CMS to evaluate private insurance companies that use AI to make coverage decisions and ensure that they are not creating additional barriers to care. Some medical providers have said that these algorithms misapply Medicare coverage criteria, resulting in inappropriate denials of care.¹² Indeed, there are many harrowing reports of patients with MA coverage who were denied care for stroke recovery, forced into dangerously premature discharges from their hospital stays, and more – all because an arbitrary AI algorithm told the insurance company that the care should be denied.¹³ We urge you to consider developing new regulations to ensure no beneficiary is refused access to care that they are entitled to under the Medicare benefit as a result of a computer algorithm. It is essential that algorithms abide by Medicare coverage requirements, and CMS should enforce existing statutory requirements that require insurers to disclose the methodology behind algorithms used for coverage decisions to CMS and medical providers to ensure beneficiaries are aware of decision-making protocols that could impact their access to care. More broadly, CMS could also consider establishing a centralized claims processing system to ensure consistent application of Medicare benefits and monitor insurers’ compliance with Medicare coverage guidelines.

We further support efforts to ensure restricted networks used by MA insurers do not create additional obstacles to care for beneficiaries. Researchers have found that the effects of restricted networks have been especially burdensome for cancer patients enrolled in MA, as insurance companies are less likely to include top-tier hospitals in their networks. Cancer patients enrolled in MA were five times less likely to receive care at a National Cancer Institute-designated cancer center, three times less likely to receive care at a teaching hospital, and almost half as likely to receive care at a Commission on Cancer accredited hospital.¹⁴ Even when MA enrollees try to find in-network providers, they must rely on plan directories that often contain numerous errors or list providers who are unreachable or unavailable.

¹⁰ Medical Group Management Association (MGMA), “Spotlight: Prior Authorization in Medicare Advantage.” (May 2023). https://www.mgma.com/getkaiasset/fa2103f5-a2f6-47a1-b467-4748b5007c7e/05.03.2023_PA-in-MA_FINAL.pdf

¹¹ American Medical Association, “Toll from prior authorization exceeds alleged benefits, say physicians,” press release, March 13, 2023, <https://www.ama-assn.org/press-center/press-releases/toll-prior-authorization-exceeds-alleged-benefits-say-physicians>.

¹² Stat, “Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need,” Casey Ross and Bob Herman, March 13, 2023, <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/>.

¹³ *Id.*

¹⁴ Journal of Clinical Oncology, “Medicare Advantage: A Disadvantage for Complex Cancer Surgery Patients.” Raouf et al., November 10, 2022, <https://ascopubs.org/doi/abs/10.1200/JCO.21.01359>.

These “ghost” networks make it even more difficult for a beneficiary to find care.¹⁵ CMS should define a sufficient network, as required by statute, as one that includes any provider who accepts Medicare’s approved rate for services covered under Medicare.¹⁶ At the very least, we request that CMS consider requiring insurers to offer the same network for all MA plans in a region and to ensure the top 100 cancer centers in the United States are included in plan networks to fix the dearth of top-rated, in-network cancer care for MA enrollees.

2. Strengthen provider encounter and patient data collection and transparency to improve understanding of the effects of MA on patients and the Medicare program.

Current CMS data collection practices in MA make it difficult for policymakers and regulators to oversee the program and legislate potential reforms adequately. While researchers have access to some data samples and aggregated data, without full data transparency, we see it as impossible to answer many important questions about MA and its impact on older adults and people with disabilities. We support the November 2023 proposal from CMS to require a health equity analysis of prior authorization use and the January 2024 final rule requiring insurers to provide a specific denial reason.¹⁷ We further urge CMS to consider strengthening provider encounter and patient data collection and transparency as part of the agency’s efforts to improve MA data transparency announced in January 2024.¹⁸ CMS could consider creating a centralized data processing system to achieve the goals of increased transparency.

These changes could allow CMS to analyze and publicly share many important data points that researchers can use to answer important questions about the MA program. For example, this data could be used to evaluate the characteristics of patients whose prior authorization requests are approved or denied, ensuring care is not impeded for specific sub-groups. It could also allow researchers to calculate MA enrollees’ average out-of-pocket (OOP) spending. More MA beneficiaries report having trouble paying medical bills or getting care due to cost than TM beneficiaries, and Black beneficiaries

¹⁵Senate Committee on Finance, “Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks,” May 3, 2023, <https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf>

¹⁶ USC 42 CFR § 422.112

¹⁷ Centers for Medicare & Medicaid Services, Federal Register Proposed Rule, “Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications,” November 15, 2023, <https://www.federalregister.gov/documents/2023/11/15/2023-24118/medicare-program-contract-year-2025-policy-and-technical-changes-to-the-medicare-advantage-program>.

¹⁸White House, “FACT SHEET: Biden-Harris Administration Announces New Actions to Lower Health Care and Prescription Drug Costs by Promoting Competition,” fact sheet, December 7, 2023, <https://www.whitehouse.gov/briefing-room/statements-releases/2023/12/07/fact-sheet-biden-harris-administration-announces-new-actions-to-lower-health-care-and-prescription-drug-costs-by-promoting-competition/>.

are more likely to report cost-related problems if they are enrolled in MA versus TM.^{19,20,21} Additionally, examining OOP costs for supplemental benefits, such as vision, dental and hearing benefits could shed light on the value those benefits offer to MA beneficiaries.

CMS could also collect data to better understand why MA beneficiaries in poor health are more likely than healthy beneficiaries to switch from MA to TM, and MA enrollees are more than twice as likely to switch to TM in their last year of life.^{22,23} MA enrollees who are people of color, live in rural areas, are dually eligible for Medicare and Medicaid, and have experienced functional impairment are also all more likely to switch to TM.²⁴ Complete disenrollment data could reveal the magnitude and drivers of demographic shifts from MA to TM, such as out-of-pocket costs and denial rates.

3. Rein in overpayments to insurers in MA by adjusting benchmarks to compensate for favorable selection and cracking down on deceptive tactics by private insurance companies, including upcoding.

Leading government watchdogs, including MedPAC, the Committee for a Responsible Federal Budget, the Congressional Budget Office, and the Government Accountability Office have documented that insurance companies overcharge the government for the MA plans they run by an estimated **\$88-\$140 billion per year**.²⁵ Data indicates that companies obtain these extra taxpayer dollars through 1) upcoding, a process of adding diagnosis codes to a patient’s medical record to make them appear

¹⁹Oseran, Andrew S., Tianyu Sun, Rahul Aggarwal, Ashley Kyalwazi, Robert W. Yeh, and Rishi K. Wadhwa, “Association Between Medicare Program Type and Health Care Access, Acute Care Utilization, and Affordability Among Adults with Cardiovascular Disease,” *Circulation: Cardiovascular Quality and Outcomes*, September 2, 2022, https://www.ahajournals.org/doi/full/10.1161/CIRCOUTCOMES.121.008762?rfr_dat=cr_pub%3Dpubmed&url_ver=Z39.88-2003&rft_id=ori%3Arid%3Aacrossref.org.

²⁰Cubanski, Juliette, Tricia Neuman, and Anthony Damico. “Problems Getting Care Due to Cost or Paying Medical Bills Among Medicare Beneficiaries.” KFF, April 2, 2020. <https://www.kff.org/coronavirus-covid-19/issue-brief/problems-getting-care-due-to-cost-or-paying-medical-bills-among-medicare-beneficiaries/>.

²¹KFF, “Black Medicare Beneficiaries Are More Likely Than White Beneficiaries to Have Cost-Related Problems with Their Health Care, Across both Traditional Medicare and in Medicare Advantage Plans,” press release, June 25, 2021, <https://www.kff.org/medicare/press-release/black-medicare-beneficiaries-are-more-likely-than-white-beneficiaries-to-have-cost-related-problems-with-their-health-care-across-both-traditional-medicare-and-in-medicare-advantage-plans/>.

²²Cosgrove, James, Rosamond Katz, Richard Lipinski, Will Crafton, Betsy Conklin, Krister Friday, and George Bogart. “Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight.” GAO. U.S. Government Accountability Office, April 28, 2017. <https://www.gao.gov/products/gao-17-393>.

²³Gordon, Leslie V., William Black, Michael Erhardt, Manuel Buentello, Sonia Chakrabarty, Amy Leone, Drew Long, Brandon Nakawaki, Vikki Porter, and Lillian Riehl Schultze. “Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight.” GAO. U.S. Government Accountability Office, June 28, 2022. <https://www.gao.gov/products/gao-22-106026>.

²⁴KFF, “Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature,” Nancy Ochieng and Jeannie Fuglesten Biniek, September 16, 2022, <https://www.kff.org/report-section/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature-report/>.

²⁵Physicians for a National Health Program, “Our Payments Their Profits: Quantifying Overpayments in the Medicare Advantage Program,” October 4, 2023, https://pnhp.org/system/assets/uploads/2024/01/MAOverpaymentReport_Oct2023.pdf.

sicker, 2) favorable selection, in which insurers recruit healthier enrollees who require less care, 3) quality bonus payments, which are based on flawed metrics that have failed to improve plan quality, and 4) inflated benchmarks due to “induced utilization” from supplemental coverage.²⁶

We applaud the changes CMS finalized in the 2024 Medicare Advantage Rate Notice to cut down on insurers’ misuse of medical codes to increase payments. However, we urge you to consider fully implementing the remaining changes to the MA risk adjustment model in 2025 rather than phasing them in through 2026. We also urge CMS to consider increasing the coding intensity adjustment to further correct for upcoding by insurance companies. Researchers estimate that the proper coding intensity adjustment is over 15 percent; however, CMS has never increased the coding intensity factor above the statutory minimum adjustment of 5.9 percent.²⁷ We further propose adopting the Demographic Estimate of Coding Intensity (DECI) model over the existing risk adjustment model. The DECI model estimates that, after correcting for demographics, MA beneficiaries are no sicker than FFS beneficiaries despite their inflated risk scores; rather, MA enrollees are healthier than TM beneficiaries.²⁸ This model could be most effective if applied in a targeted manner to crack down on the bad actor plans that participate in intense risk score gaming without hurting plans that do not participate in risk score gaming.

In addition, we support restricting the use of chart reviews and health risk assessments, allocating more agency resources to risk adjustment data validation audits, and raising the standard for quality bonus payments. CMS could institute a “favorable selection factor” into the benchmark calculation, which would eliminate overpayments that occur due to MA’s much healthier and lower-cost population. Together, these steps could save taxpayers over \$100 billion per year.²⁹

We dispute claims that such efforts could result in higher premiums or reduced benefits. Following congressional action to curb overpayments to MA plans in the Affordable Care Act, enrollees in MA plans did not face decreased access to care or higher costs despite threats to the contrary.³⁰

4. Address misleading and deceptive marketing practices.

Unfortunately, fraudulent and deceptive marketing practices that harm older adults and people with disabilities have been found to be prevalent in the MA program. Marketing middlemen sell beneficiaries information and inundate them with marketing materials to encourage them to enroll in a different plan. We applaud the steps CMS has taken to provide guidance to plans around marketing and enforce rules that prohibit these deceptive practices.³¹ Congress has also worked to identify and address

²⁶ *Id.*

²⁷ Committee for a Responsible Federal Budget, “Reducing Medicare Advantage Overpayments,” February 23, 2021, https://www.crfb.org/sites/default/files/managed/media-documents2022-02/HSI_MAOverpayments.pdf.

²⁸ *Id.*

²⁹ Physicians for a National Health Program, “Our Payments Their Profits: Quantifying Overpayments in the Medicare Advantage Program,” October 4, 2023, https://pnhp.org/system/assets/uploads/2024/01/MAOverpaymentReport_Oct2023.pdf.

³⁰ American Journal of Managed Care, “Did Medicare Advantage Payment Cuts Affect Beneficiary Access and Affordability?” Laura Skopec, Joshua Aarons, and Stephen Zuckerman, August 30, 2019, https://ajmc.s3.amazonaws.com/media/pdf/AJMC_09_2019_Skopec%20final.pdf.

³¹ Centers for Medicare & Medicaid Services, “Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Plan Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of

some of these practices – the Senate Finance Committee led an investigation in November 2022,³² as well as held a hearing on this issue in October 2023³³ - and we must continue to work together to ensure that beneficiaries are protected from these harmful tactics through greater enforcement and transparency.

5. Improve the overall Medicare program through administrative action, such as lowering Medicare premiums, and support legislative efforts to expand Medicare benefits, cap OOP costs in TM, and adjust the physician fee schedule to account for increases in provider costs.

We share your goal of improving the Medicare program to ensure it provides comprehensive and affordable care for beneficiaries today and in the future, and we support CMS making necessary changes to the program to realize this shared vision. Nearly all of the following actions could be paid for solely by stopping overpayments to insurance companies in MA. Doing so would also directly decrease Medicare Part B premiums by as much as \$260 billion over the next nine years by reducing the actuarial rate that CMS uses to set premiums.^{34,35}

However, there is more that this Administration can do to strengthen the Medicare program for its 65.7 million enrollees. Specifically, we support using the savings from MA payment reforms to expand Medicare benefits to cover comprehensive dental, vision, and hearing care. These savings could also be used to apply the Medicare Economic Index to the Physician Fee Schedule, which could ensure that payments to physicians account for rising costs and in turn allow more physicians to treat older adults and people with disabilities on Medicare. Finally, we strongly support legislative efforts to establish an OOP cap in TM, which would help level the playing field between TM and MA. Beneficiaries that seek to switch from MA into TM frequently do not qualify for supplemental plans like Medigap, and without Medigap, beneficiaries may be expected to pay up to 20% of their cost of care out of pocket,

All-Inclusive Care for the Elderly, and Health Information Technology Standards,” fact sheet, November 6, 2023, <https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-policy-and-technical-changes-medicare-advantage-plan-program-medicare>.

³²Senate Committee on Finance, “Deceptive Marketing Practices Flourish in Medicare Advantage: A Report by the Majority Staff of the U.S. Senate Committee on Finance,” November 2, 2022, <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>.

³³Senate Committee on Finance, “Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences,” October 18, 2023, <https://www.finance.senate.gov/hearings/medicare-advantage-annual-enrollment-cracking-down-on-deceptive-practices-and-improving-senior-experiences>.

³⁴Center on Budget and Policy Priorities, “Informing the Debate About Cirbing Medicare Advantage Overpayments,” Edwin Park, May 13, 2008, https://www.cbpp.org/research/informing-the-debate-about-curbing-medicare-advantage-overpayments-0#_ftn11.

³⁵Committee for a Responsible Federal Budget, “New Evidence Suggests Even Larger Medicare Advantage Overpayments,” July 17, 2023, <https://www.crfb.org/blogs/new-evidence-suggests-even-larger-medicare-advantage-overpayments#:~:text=Combining%20these%20estimates%20with%20the,billion%20in%20higher%20Medicare%20premiums>.

without a cap.³⁶ This creates significant financial barriers for individuals that prevents them from being able to choose the coverage that is best for them.

Thank you for your attention to issues in MA and the steps you have taken to protect beneficiaries. We support building on this progress by ending delays and denials of care by insurance companies running MA plans, strengthening transparency efforts, reining in overpayments to insurance companies, and supporting efforts to lower costs and expand benefits in TM. We look forward to continuing to work together towards our shared vision for a comprehensive, sustainable Medicare program that serves patients' needs, not insurers' profits.

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³⁶Washington Post, "Medicare Advantage is popular, but some beneficiaries feel buyer's remorse," Sarah Jane Tribble and McKenzie Beard, January 23, 2024, <https://www.washingtonpost.com/politics/2024/01/23/medicare-advantage-is-popular-some-beneficiaries-feel-buyers-remorse/>.