Center for Medicare Advocacy

Advancing Access to Medicare and Health Care

Hearing: "Legislative Proposals to Support Patient Access to Medicare Services"

United States House Committee on Energy & Commerce

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TESTIMONY

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SUMMARY

The Center for Medicare Advocacy (CMA) is a national private, non-profit, non-partisan law organization. We offer our comments based on our experience assisting and representing Medicare beneficiaries since 1986. We express support for the following three bills: **H.R. 5243**, To amend title XVIII of the Social Security Act to increase data transparency for supplemental benefits under Medicare Advantage, **H.R. 6210**, Senior Savings Protection Act and **H.R. 6361**, Ban AI Denials in Medicare Act.

TESTIMONY

Chairman Griffith, Ranking Member DeGette, Chairman Guthrie, Ranking Member Pallone, and distinguished members of the Committee, thank you for the invitation to testify today. I am David Lipschutz, Co-Director at the Center for Medicare Advocacy (CMA). CMA is a national private, non-profit, non-partisan law organization based in Connecticut and Washington, D.C. with additional attorneys in Georgia, Wisconsin and California.

CMA works to advance access to comprehensive Medicare coverage, quality health care, and health equity. We provide education and legal assistance to Medicare beneficiaries throughout the United States. We respond to thousands of calls and emails annually, host a website, educational programs, webinars, and a national convening of Medicare beneficiary stakeholders and policymakers, publish a weekly electronic newsletter, and pursue thousands of Medicare appeals. Our policy work is based on the real-life experiences of the beneficiaries and families we hear from every day.

Medicare's promise is that all seniors can age with dignity and know that they will have fair access to affordable health care. Before the enactment of Medicare in 1965, only 50 percent of

seniors had health insurance and 35 percent lived in poverty. The guaranteed coverage Medicare provides, regardless of income, medical history, or health status, has enhanced the health and financial security of older people, people with disabilities, and their families. Because of Medicare, virtually all Americans age 65 or older are insured. We appreciate the Committee's focus on improving access to coverage and care for Medicare beneficiaries. I'd like to express support for three bills at issue at this hearing today.

Legislation Under Discussion Today

H.R. 5243, To amend title XVIII of the Social Security Act to increase data transparency for supplemental benefits under Medicare Advantage.

This bill would require Medicare Advantage (MA) organizations to submit data on each MA plan offered at the enrollee-level on supplemental benefits including eligibility for such benefits, the types of benefit categories offered, data on utilization and payments for such benefits (including the total amount spent by the plan for each enrollee who utilized such benefits and the total out-of-pocket cost per utilization for each enrollee.) CMA supports this data transparency legislation as it would lead to additional, detailed enrollee level information on supplemental benefits.

Virtually all MA plans provide supplemental benefits,[1] however they are not standardized and vary by plan. Research demonstrates that while beneficiaries value supplemental benefits in theory, and these benefits are a major driver in plan selection, many enrollees do not utilize the full range of supplemental benefits available to them.[2]

[1] KFF, "Medicare Advantage 2023 Spotlight: First Look", (Nov. 10, 2022): In 2023, 97% or more individual plans offer some vision, fitness, telehealth, hearing or dental benefits.
[2] Science Magazine, "Medicare Advantage Beneficiaries Show No Increase in Dental, Vision, or Hearing Care Access" (Jan. 14, 2025).

Additional data is necessary to determine what is causing this gap between enrollment and utilization. Current available data on supplemental benefits does not include what types of financial liability exists, if the benefits are serving beneficiaries well, and improving health outcomes,[3] and the levels of utilization of benefits broken down by age, sex, race, disability status, and geographic area.[4] The Medicare Payment Advisory Commission's (MedPAC) *June 2025 Report to Congress* also noted the challenges presented by the lack of data:

> Altogether, our review of numerous data sources pertaining to MA supplemental benefits reveals a fundamental lack of transparency about how often enrollees use the benefits and plans' spending for the benefits. The data that Medicare collects is currently insufficient for examining the use of most of these benefits. The lack of reliable data makes it difficult to answer many important questions about how the rebates Medicare pays to MA plans are used.[5]

MedPAC's Report emphasized that due to the lack of comprehensive data, "it is difficult for policymakers to assess the adequacy of the access provided or to know whether the spending provides good value to enrollees and the taxpayers who fund the program."[6]

As outlined in a recent paper by CMA, Medicare Advantage contracting may also obscure supplemental benefit data:

> A factor in the lack of data on supplemental benefits could be that because MA plans often contract with large, national third-party vendors to administer

[3] KFF, "Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency," (April 10, 2024).
[4] MedPAC, "June 2025 Report to the Congress: Medicare and the Health Care Delivery System," (June 12, 2025).
[5] Id.
[6] Id.

> supplemental benefits, the data collection and sharing can be inconsistent and fragmented. Contracts are often paid annually and per capita, so the plans only receive broad information on utilization from these national partners. An additional complexity is that some large insurers own subsidiary businesses that administer some of the supplemental benefits plans offer. Because of limited data collection requirements, use of these subsidiaries can obscure information on utilization of supplemental benefits.[7]

Due to concerns with underutilization of supplemental benefits, CMS's CY2025 Final Rule required plans to issue annual notices to beneficiaries of "Mid-Year Enrollee Notification of Unused Supplemental Benefits."[8] These personalized notices were going to include a list of the supplemental benefits that have not been used by the beneficiary during the first half of the plan year, and were to begin June 30-July 31, 2026. The notices were to include details about the network requirements, the scope of the benefits, cost sharing, and a customer service number. The planned notices were to be limited to supplemental benefits that had not been accessed by the beneficiary, not a listing of all supplemental benefits available to any enrollee in the plan.

Unfortunately, in September 2025, CMS announced that it was pausing the notification requirement.[9] In the CY2027 Proposed Part C & D Rule, CMS is now proposing to rescind this requirement in line with a movement toward deregulation and limiting MA administrative

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[7] Center for Medicare Advocacy, "Issue Brief: Supplemental Benefits: Main Driver of Enrollment in Medicare Advantage, But Underutilized by Beneficiaries" (Jun. 2025), available at: https://medicareadvocacy.org/issue-brief-medicare-advantage-supplemental-benefits/.
[8] CMS, Final Rule, 89 Fed. Reg. 30448 (Apr. 23, 2024); see also CMS, "Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)" (Fact Sheet), April 4, 2024.
[9] Becker's Payer Issue, "CMS pauses MA supplemental benefit notification rule" (Sept. 9, 2025).

burdens and costs. The proposed rule states that it is rescinding the requirement because it "would impose a significant burden on MA organizations that outweighs the intended benefit."[10] If this proposal is finalized, Medicare Advantage enrollees will miss out on important information about benefits available to them.

The data collection outlined in this legislation, particularly at this granular enrollee level, as well as the public reporting requirements in the legislation, would make accessible essential information on how supplemental benefits vary across plans, utilization and out-of-pocket costs for specific benefits. This would assist in shedding light on the reasons behind underutilization. Gathering detailed information would help guide future policy proposals and CMS guidance aimed at expanding beneficiary access to supplemental benefits. With more than half of Medicare beneficiaries enrolled in MA plans, it is time for legislation that could lead to real improvements for MA enrollees.

H.R. 6210, Senior Savings Protection Act.

This bill would provide a five-year reauthorization of critical funding for State Health Insurance Assistance Programs (SHIPS), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs) and the National Center on Benefits Outreach and Enrollment. First established under the Medicare Improvements for Patients and Providers Act (MIPPA), since 2008 this funding has provided essential outreach and enrollment assistance for millions of low-income older adults and individuals with disabilities, including help with enrolment into programs which provide assistance with Medicare premiums and costs. Reauthorizing funding

[10] Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program, 90 Fed. Reg. 54894 (Nov. 28, 2025).

for five years will help ensure that community-based organizations can continue their important work helping older adults and individuals with disabilities access needed care and lower their health care costs.

This critical work includes helping people enroll in Medicare Savings Programs (MSPs) and the Part D Low-Income Subsidy (LIS/Extra Help). MSPs – the Qualified Medicare Beneficiary (QMB), Specified Low-Income Beneficiary (SLMB) and Qualified Individual (QI) programs, are Medicaid programs that help with Medicare costs for those who qualify.[11] These programs, though, are significantly underutilized, with less than half of individuals eligible actually enrolled.[12] The need for education about and assistance with enrollment in MSPs is even more vital following passage of H.R. 1, the One Big Beautiful Bill Act (OBBB), which delays implementation of a rule streamlining eligibility and enrollment in MSPs, which will result in fewer people accessing this financial help.[13]

SHIPs, AAAs, ADRCs and the National Center on Benefits Outreach and Enrollment all provide critical assistance to the public. In the context of assistance with Medicare issues, we particularly highlight the integral role played by SHIPs, which is a federally-funded program that offers free, objective in-depth counseling and education to Medicare beneficiaries in each state. (These SHIP programs sometimes go by different names in a given state, for example, VICAP in Virginia, SHINE in Florida, CHOICES in Connecticut and HICAP in California.)

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[11] See, e.g., Medicare website at: https://www.medicare.gov/basics/costs/help/medicare-savings-programs.
[12] MACPAC, "Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled" (Aug. 2017), available at: https://www macpac.gov/publication/medicare-savings-programs-new-estimates-continue-to-show-many-eligible-individuals-not-enrolled/.
[13] §71101 of OBBB prohibits the Secretary of Health & Human Services from implementing (for 9 years) certain provisions of the final rule published by CMS on September 21, 2023 (88 Fed. Reg. 65230), which was aimed at making it easier for Medicare beneficiaries to enroll in and qualify for MSPs. The Congressional Budget Office (CBO) estimates that this will lead to over $66 billion in Medicare savings over 10 years due to fewer people enrolling in MSPs.

Beneficiaries face an overwhelming number of plan options as well as complex decisions when deciding whether to enroll in an MA plan, or whether to select traditional Medicare with a Part D drug plan and a Medigap plan. In 2026, a typical Medicare beneficiary may face a choice of an average of 39 MA plans.[14] The annual open enrollment period every fall also brings a barrage of marketing materials overwhelming beneficiaries even more. To cut through all of this information overload, over 4 million beneficiaries annually,[15] from across the country, have turned to their local State Health Insurance Assistance Programs (SHIPS) for unbiased guidance. SHIP counselors help them review their options and weigh the complex tradeoffs involved in making these important health care decisions that will have a major impact on their access to care, providers and out-of-pocket costs.

SHIPS fill the unique role of providing accurate, unbiased information through trained counselors whose only objective is helping provide information so individuals can make informed decisions about their health coverage, as well as helping people determine if they qualify for programs that can provide assistance with costs. SHIPS also provide tailored advice based on the area in which they are located, guiding beneficiaries to select coverage that best meets their needs.[16] SHIPs often provide much more in-depth counseling than 1-800-Medicare is

[14] KFF, "Medicare Beneficiaries Have 32 Medicare Advantage Prescription Drug Plans Available, on Average, for 2026," (Oct. 14 2025).
[15] Roughly 4.3 million Medicare beneficiaries, family members, and caregivers received SHIP services in 2022. KFF, "The Role of SHIPs in Helping People with Medicare Navigate Their Coverage," (Sept. 24, 2025).
[16] KFF, "The Role of SHIPs in Helping People with Medicare Navigate Their Coverage," (Sept. 24, 2025): There are a total of 54 SHIPs nationwide, operating in every state and the District of Columbia, as well as Guam, Puerto Rico, and the U.S. Virgin Islands. State SHIPs in turn contract with a network of approximately 2,000 local affiliates, including health systems, senior centers, and Area Agencies on Aging, to oversee the daily operations of the program. This structure enables SHIPs to offer locally focused counseling that reflects the Medicare coverage options, hospitals, and physician groups available in a given area, as well as any regional- or county-level aging and disability resources.

equipped to offer. In fact, as KFF points out, SHIPs often receive referrals from 1-800-Medicare for the more complex cases.[17]

In contrast, agents and brokers, upon whom an increasing number of beneficiaries rely for this guidance,[18] often have a financial incentive to enroll beneficiaries in specific plans. Commission-based incentive models in contracts between insurance companies and agents creates a situation where an agent's own financial interest might be at odds with the health care needs of the beneficiary he or she is advising. This is particularly the case when agent compensation varies based on the particular plan or type of coverage being offered to a beneficiary.[19]

This problem of skewed financial incentives in the marketing and sale of Medicare plans is so pervasive that when the Senate Finance Committee studied and reported on MA marketing across 14 states in 2022, it found rampant "false," "misleading" and "predatory" actions.[20]

This underscores how essential the unbiased guidance of SHIPs is for Medicare beneficiaries. While CMS could do much more to promote SHIPs and support SHIPs, it has unfortunately moved in the opposite direction. For example, the Medicare Advantage and Part D proposed rule for contract year 2027 released in November 2025 proposes to remove mention of SHIPs in the third-party marketing organizations (TPMO) disclaimer requirements. Part of the reasoning the rule provides is that SHIPs may not be able to handle complex cases, and that during a secret shopper survey SHIPs did not always mention the option of D-SNPs as a viable option for dually

[17] Id.
[18] Steven Findlay, et al, "The Role of Marketing in Medicare Beneficiaries' Coverage Choices" (explainer), Commonwealth Fund, Jan. 5, 2023: In 2022 about one in three beneficiaries used insurance agents or brokers to help them choose a plan.
[19] Commonwealth Fund, "The Challenges of Choosing Medicare Coverage: Views from Insurance Brokers and Agents,"(Feb. 28, 2023).
[20] U.S. Senate Committee on Finance, Majority Staff, "Deceptive Marketing Practices Flourish in Medicare Advantage," Nov. 2022, at 19.

eligible beneficiaries. Even while explaining this, CMS conceded that SHIPs provided accurate information regarding the difference between MA and traditional Medicare 94% of the time. The rule proposes to include only 1-800- Medicare or Medicare.gov as an alternate source of information. As discussed above, the SHIPs generally provide much more detailed counseling than 1-800-Medicare provides.

CMA strongly supports this legislation that would extend funding for the essential, unbiased guidance SHIPs provide millions of beneficiaries across the country, along with assistance provided by AAAs, ADRCs and the National Center on Benefits Outreach and Enrollment.

H.R. 6361, Ban AI Denials in Medicare Act.

This legislation would prohibit HHS from testing the Wasteful and Inappropriate Services Reduction (WISeR) Model and would prohibit the implementation of payment models testing prior authorization in traditional Medicare. CMA supports this legislation.

Currently prior authorization requirements are applied to a very limited set of services in traditional Medicare. In 2023, this translated to around 400,000 prior authorization requests.[21] By contrast, Medicare Advantage plans make extensive use of prior authorization. Virtually all MA enrollees are required to obtain prior authorization for some services, usually higher cost services such as skilled nursing facility stays and chemotherapy administration.[22] In 2023, there were nearly 50 million prior authorization requests in MA.[23] This is particularly striking given that the number of

[21] KFF, "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023" (Jan. 28, 2025), available at: https://www kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

[22] KFF, "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023" (Jan. 28, 2025), available at: https://www kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.

[23] Id.

enrollees in MA and traditional Medicare is essentially the same, with 54% of eligible beneficiaries enrolled in MA in 2025.[24]

Extensive research and studies have found that prior authorization requirements can result in inappropriate denials, and delays in obtaining medically necessary care. The Department of Health & Human Services' Office of Inspector General (OIG) reported in 2022 that Medicare's annual audit of MA plans "have highlighted widespread and persistent problems related to inappropriate denials of services and payment."[25] Despite efforts to curb inappropriate use of prior authorization by MA plans, including a CMS rule finalized in 2023,[26] significant barriers to care remain for many MA enrollees. As noted in an October 2024 report issued by the Senate Permanent Subcommittee on Investigations examining MA plans' use of prior authorization and ongoing denials regarding post-acute care, MA plans:

> are intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities. Insurer denials at these facilities, which help people recover from injuries and illnesses, can force seniors to make difficult choices about their health and finances in the vulnerable days after exiting a hospital.[27]

MA plans often claim that prior authorization is a method to curb unnecessary care, however the rate of denials successfully appealed exposes the more troubling reality behind this claim.

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[24] KFF, "Medicare Advantage in 2025: Enrollment Update and Key Trends" (Jul. 28, 2025).
[25] Department of Health & Human Services, Office of Inspector General, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022, OEI-09-18-00260), available at: https://oig hhs.gov/oei/reports/OEI-09-18-00260.pdf.
[26] CMS, Final Rule, 88 Fed. Reg. 22120 (April 12, 2023).
[27] Majority Staff Report, U.S. Senate Permanent Subcommittee on Investigations, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care" (Oct. 17, 2024), at: https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

According to KFF, from 2019 through 2023, more than eight in ten (81.7%) denied prior authorization requests that were appealed were overturned;[28] this means that the coverage that was denied was often actually for appropriate, medically necessary care, that should have been approved. According to KFF:

> [t]hough a small share of prior authorization denials were appealed to Medicare Advantage insurers, most appeals (81.7%) were partially or fully overturned in 2023. That compares to less than one-third (29%) of appeals overturned in traditional Medicare in 2022. These requests represent medical care that was ordered by a health care provider and ultimately deemed necessary but was potentially delayed because of the additional step of appealing the initial prior authorization decision. Such delays may have negative effects on a person's health.[29]

This exposes what prior authorization actually is: a utilization management tool employed by plans to lower costs, putting company profits over patient access to care. As reported in the KFF study, just under 12 percent of denials are appealed.[30] Given this, even though the appeals are overwhelmingly successful, millions of beneficiaries are forgoing the appeals process and experiencing delays and denials of likely necessary and appropriate care.

In recent years, many MA plans have used AI or algorithmic software to assist them with making coverage decisions, which has exacerbated access to care challenges for MA enrollees. As

[28] KFF, "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023" (Jan. 28, 2025), available at: https://www kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.
[29] Id.
[30] Id.

discussed in a 2023 *STAT News* series called "Denied by AI", various MA insurers have been using algorithms to predict how long patients would need to stay in certain health care settings and then cut off care beyond that calculated length of stay.[31] The 2024 Senate Permanent Subcommittee on Investigations report referenced above found that MA prior authorization denials tend to increase when AI or algorithmic review processes are integrated into coverage determinations; for example, UnitedHealthcare more than doubled its prior authorization denial rate for post-acute care (from 10.9% in 2020 to 22.7% in 2022) after automating its processes.[32]

In addition to causing delays and denials of care for beneficiaries, providers find prior authorization processing to be extremely burdensome. According to a 2024 American Medical Association (AMA) physician survey, "prior authorization is overused, costly, inefficient, opaque and causes patient care delays." [33] The AMA physician survey found that 89% of physicians reported that prior authorization increases physician burnout, while 29% of respondents also warned that prior authorizations have led to "a serious adverse event for a patient in their care."[34] The public agrees – according to a KFF poll, a large majority (73%) "think that delays and denials of services and treatments by health insurance companies are a major problem."[35] Half of insured adults report that in the last two years, their health insurance company has required them or their provider "to get prior authorization before they could receive a health care service,

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[31] *STAT News* series "Denied by AI" by Casey Ross and Bob Herman (2023) https://www.statnews.com/denied-by-ai-unitedhealth-investigative-series/

[32]Majority Staff Report, U.S. Senate Permanent Subcommittee on Investigations, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care" (Oct. 17, 2024), at: https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

[33] AMA, The Issue | Fix Prior Auth

[34] American Medical Association, "About the Current Prior Authorization System" https://fixpriorauth.org/issue.

[35] "KFF Health Tracking Poll: Public Finds Prior Authorization Process Difficult to Manage" (July 2025), available at: https://www kff.org/patient-consumer-protections/kff-health-tracking-poll-public-finds-prior-authorization-process-difficult-to-manage/.

treatment, or medication that they needed" and among those who reported needing to obtain prior authorization in the past two years, "about half say their health insurance company has delayed their ability to get (48%, 24% of all insured adults) or denied coverage (43%, 22% of all insured adults) for a service, treatment, or medication that their doctor requested."[36]

For the first time, CMS's new WISeR demonstration introduces a broad scale of services that will now require prior authorization requests prior to service for Medicare beneficiaries in traditional Medicare. This six-year pilot program has begun in six states: Washington, New Jersey, Ohio, Oklahoma, Texas and Arizona, with the potential to eventually expand prior authorization requirements for more services into the entire traditional Medicare population. Borrowing from Medicare Advantage prior authorization practices, the model employs private vendors using AI or algorithmic tools to review and approve or deny coverage. Such vendors are compensated, in part, based on a share of "averted expenditures" creating financial incentives to deny care.

In "Consensus Statement on Expanding Prior Authorization in Traditional Medicare," released by former government officials, providers, policy experts and other stakeholders, including CMA, we raised concerns with the model's participant payment model, participant selection, prior authorization protocols and use of enhanced technology, and how all combined could result in delays and denials of needed care for older adults and people with disabilities enrolled in traditional Medicare.[37]

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[36] Id.

[37] Consensus Statement on Expanding Prior Authorization in Traditional Medicare, sent to HHS (Aug. 5, 2025), available at: https://pnhp.org/news/consensus-statement-on-expanding-prior-authorization-in-traditional-medicare/

The financial structure utilized by this model – one in which companies performing the prior authorization determinations receive a share of the savings for denying claims –would create clear financial incentives for denials. As we noted:

> The WISeR model will focus on testing the implementation of prior authorization and pre-payment review for specific selected services that will be performed by third party entities leveraging enhanced technologies, that would be paid under a novel payment approach where the model participants are compensated based on a share of averted expenditures.[38]

The incentives created by this system will encourage denials of prior authorization requests to boost their financial stake. This is a concern echoed by the AMA in their 2025 letter to CMS expressing concerns about the WISeR model. AMA CEO and Executive Vice President John Whyte wrote to CMS Deputy Administrator for Center for Medicare & Medicaid Innovation (CMMI) that:

> [w]e are also concerned that the vendor incentive structure within the WISeR Model could result in excessive denials motivated more by the potential for vendor profit than by fair and balanced clinical judgment. When third-party entities are paid based on the volume of denied services, there is a clear risk that care that is medically necessary for certain patients will be inappropriately denied in pursuit of savings.[39]

[38] Federal Register: Medicare Program; Implementation of Prior Authorization for Select Services for the Wasteful and Inappropriate Services Reduction (WISeR) Model

[39] American Medical Association letter to CMS, (Jul 16, 2025).

Similarly, noting that the WISeR model was finalized without an opportunity for public comment or stakeholder engagement, a recent article in the *New England Journal of Medicine* states:

> WISeR will expand prior authorization using opaque algorithms and perverse financial incentives that are new to utilization management in traditional Medicare and may negatively affect both patients and clinicians. Misaligned incentives in WISeR could weaken the integrity of the prior-authorization process. Because the participating companies receive shared savings proportional to the volume of services denied, they will have strong incentives to restrict access to care. This phenomenon has been observed among Medicare Advantage insurers, which face similar incentives to deny care to control costs and maximize profits.[40]

The use of private vendors with a financial stake in their decision-making is in stark contrast to how the limited set of prior authorization determinations in traditional Medicare are currently handled. The Medicare Administrative Contractors (MACs) that administer prior authorizations in traditional Medicare have an accuracy rate of over 98%.[41] This fact, coupled with the low rate of traditional Medicare denials overturned (referenced previously in the KFF report at about 29% for 2022), indicates that the MAC decisions have a much higher likelihood of accurately assessing prior authorization requests than the companies that handle MA claims.

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[40] *New England Journal of Medicine (NEJM)*, "Proliferation of Prior Authorization in Traditional Medicare — None the WISeR?" by Michael Liu, M.D., Kushal T. Kadakia, M.D., and Rishi K. Wadhera, M.D., M.P.P (October 16, 2025) 393;15, available at: https://www.nejm.org/doi/full/10.1056/NEJMp2510451?query=health-policy

[41] U.S. Centers for Medicare & Medicaid Services, Prior Authorization and Pre-Claim Review Program Statistics for Fiscal Year 2023, January 17, 2025, https://www.cms.gov/files/document/pre-claim-review-program-statistics-document-fy-23.pdf.

Similar to the lack of transparency in MA regarding supplemental benefits data (as discussed above), there is a dearth of information regarding prior authorization decisions based on type of service, contract, or reason for denial. The systems and requirements employed to make determinations are not available to patients, providers, or policy makers. As we stated in our Consensus Statement, "[g]iven that prior authorization in MA is a black box with documented adverse effects on patients and moral injury to providers, expanding the process without a full public audit of how it is currently conducted with recommendations for improvement is risky."[42]

The model description also explains that it will use MA prior authorization practices that have utilized AI or algorithms to make decisions as a model. Touting the speed (not necessarily the accuracy) with which these decisions can be made it states, "[s]ome MA plans reported decision time to prior authorization approval being almost instantaneous for services with very clear clinical coverage criteria. As a result, CMS is exploring findings from MA plans regarding enhanced technologies. . . ."[43] Especially concerning is the finding in a Senate Permanent Subcommittee on Investigations report that denials increase when AI-driven review processes are integrated into determination: documents from MA insurers demonstrate that denials for post-acute care services rose sharply following the implementation of AI-driven review processes administered by naviHealth, a subsidiary of UnitedHealth Group. [44]

The AMA letter to CMS also outlined the need for meaningful review of AI-generated denials:

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[42] Consensus Statement on Expanding Prior Authorization in Traditional Medicare, sent to HHS (Aug. 5, 2025).
[43] Federal Register :: Medicare Program; Implementation of Prior Authorization for Select Services for the Wasteful and Inappropriate Services Reduction (WISeR) Model.
[44] U.S. Senate Permanent Subcommittee on Investigations, Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care, Majority Staff Report (October 17, 2024), https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

> [. . .] it is essential that AI-based determinations do not override sound clinical judgment. Any flagged services should be reviewed with meaningful human clinical oversight so that unique patient needs and medical complexities are fully considered.[45]

While CMS states in the description that safeguards would exist in the model to ensure that denials are accurate, it is unclear what these guardrails would be. Again, as evidenced by the high appeal overturn rate, if MA is used as a model, existing guardrails are insufficient to protect beneficiaries from harm.

Another concern to consider with the WISeR model is whether physicians will exit traditional Medicare as a result of the increased use of prior authorization in traditional Medicare. In a July 2025 letter to CMS, the AMA expressed serious concerns about the model:

> Beyond the risk for patient harm, expansion of PA requirements under the WISeR model will exacerbate the major administrative burdens already associated with PA. . . .The introduction of such PA protocols in Traditional Medicare only risks creating unnecessary delays in patient care, increasing practice expenses, and diverting time and resources away from direct patient care.[46]

The WISER model's purported purpose is to root out waste, fraud and abuse, and limit costly and even dangerous care that is unnecessary. Clearly, CMA supports safeguards to protect Medicare beneficiaries from harm and the program from unnecessary expenditures. The Medicare Advantage (MA) program is a rich target for addressing wasteful payment; as the Medicare Payment Advisory Commission (MedPAC) notes, Medicare was projected to spend about 20%

[45] American Medical Association letter to CMS, (Jul 16, 2025).
[46] American Medical Association letter to CMS, (Jul 16, 2025).

more for MA enrollees than it would spend if those enrollees were in traditional Medicare, a difference of $84 billion in 2025 alone.[47]

While combating fraud, waste and abuse are certainly laudable goals, there are existing mechanisms that are more appropriately tailored to address these concerns than a broad application of prior authorization requirements that would create barriers to care for traditional Medicare beneficiaries subject to this model. CMS has oversight authority that allows it to identify and, in cooperation with other agencies, penalize bad actor providers who may be engaged in fraudulent or even harmful behavior. As explained by KFF, CMS and the Department of Justice are equipped and experienced in handling program integrity concerns and combating waste, fraud and abuse:

> CMS, primarily through the Center for Program Integrity (CPI), plays a key role in efforts to promote program integrity in Medicare. In addition, the HHS Office of Inspector General (HHS OIG), often in collaboration with the Department of Justice (DOJ) and other agencies, monitors and combats fraud, waste, and abuse to improve the efficiency of Medicare by conducting audits, evaluations, and investigations, and carrying out enforcement actions, which in some instances have resulted in criminal or civil penalties.[48]

Similarly, as noted in the *NEJM* article cited above, there are other ways to address waste, fraud and abuse in Medicare:

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[47] MedPAC, March 2025 Report to Congress: Medicare Payment Policy (March 13, 2025), available at: https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/.
[48] KFF, "Medicare Program Integrity and Efforts to Root Out Improper Payments, Fraud, Waste and Abuse" (Mar. 31, 2025).

> A less disruptive strategy [than employing prior authorization] could involve addressing waste, fraud, and abuse where they are occurring, rather than applying blanket requirements affecting all clinicians. CMS could use validated definitions and measures in Medicare claims databases to identify health care organizations and clinicians with a history of delivering low-value or inappropriate services and implement targeted audits of those entities and practitioners.[49]

As outlined above, the WISeR model incorporates third-party vendors who have a financial incentive to deny claims for care even if it is actually medically necessary, representing perhaps the worst form of prior authorization used in the Medicare Advantage industry. Even without this financial incentive, for the reasons outlined above, prior authorization should not be further enhanced and incorporated into the traditional Medicare program. We support this bill that would halt the WISeR model and prohibit future models that would incorporate harmful prior authorization requirements in traditional Medicare.

Conclusion

Thank you again for the invitation to testify and I look forward to answering any questions.

Respectfully submitted,

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[49] *New England Journal of Medicine (NEJM)*, "Proliferation of Prior Authorization in Traditional Medicare — None the WISeR?" by Michael Liu, M.D., Kushal T. Kadakia, M.D., and Rishi K. Wadhera, M.D., M.P.P (October 16, 2025) 393;15, available at: https://www.nejm.org/doi/full/10.1056/NEJMp2510451?query=health-policy