July 22, 2025

The Honorable Vern Buchanan
Chair, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Lloyd Doggett
Ranking Member, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable David Schweikert
Chair, Oversight Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Terri Sewell
Ranking Member, Oversight Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chair Buchanan, Chair Schweikert, Ranking Member Doggett, and Ranking Member Sewell:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, I write to applaud you for holding this joint subcommittee hearing titled "Medicare Advantage: Past Lessons, Present Insights, Future Opportunities." As you explore lessons learned and opportunities to reform the program moving forward, I would like to provide the below recommendations and feedback on behalf of family physicians and their patients, a growing number of whom are enrolled in Medicare Advantage plans.

The Balanced Budget Act of 1997 established Medicare Part C, known then as the Medicare+Choice program and later renamed Medicare Advantage (MA) in 2003. Medicare Part C authorized the Centers for Medicare and Medicaid Services (CMS) to contract with public or private organizations to offer a variety of health plan options for beneficiaries. These plans – which are frequently administered by commercial insurers – are required to cover the benefits of Medicare Parts A and B and have the option to provide additional (supplemental) benefits. Since its inception, enrollment in MA plans has steadily increased. It now covers the majority of Medicare enrollees. As of March 2025, 51.2 percent of the 68.6 million Medicare beneficiaries were enrolled in MA or other health plans.[i] **Given the explosion in popularity among seniors and other Medicare-eligible populations, the AAFP believes that the MA program is ripe for examination by Congress.**

Family physicians care for patients across the lifespan, including older individuals and those with disabilities or other medical complexities. As a result, most of them contract with and/or otherwise interact with MA organizations (MAOs) on a regular basis. A 2023 AAFP survey among family medicine practices found that 18 percent of their patients were covered by MA plans. At the same time, research is showing that parent companies of MA plans are playing a

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growing in primary care practice acquisition and operation. A study from June found that payer-operated practices account for 4.2 percent of the national primary care market by service volume in 2023, compared to 0.78 percent in 2016. It also found that the prevalence of payer-operated primary care was positively associated with MA penetration; in 2022, payers operated 5.5 percent of the primary care market in counties with above-average MA penetration compared to 1.5 percent in counties with below-average MA penetration.[ii]

As MA enrollment and penetration has grown, however, so have concerns by family physicians about MAOs and their practices. MA plans are consistently cited as one of the biggest sources of burden by family physicians. Some organizations administering MA plans subject physicians and patients to opaque, cumbersome prior authorization requirements and other onerous utilization management processes that lack medical justification and often only serve to delay necessary patient care. They include restrictive clauses in physician contracts and drag out payments for claims, impacting the financial stability of practices. They have gamed existing regulations and payment systems to reward themselves financially for adding unsubstantiated diagnoses to patient charts, without consulting the individual's primary care physician or providing the necessary services to care for said diagnoses.

To put it frankly: MAOs have taken it upon themselves to practice medicine, while at the same time making it increasingly difficult for trained, qualified physicians to do so. Given these concerns, we urge the Subcommittees to thoroughly examine opportunities to hold bad actors within the Medicare Advantage program accountable and reform the program to better serve patients and alleviate the burden placed on physicians. We provide some policy recommendations to this end below.

MA Plans Place Administrative Burden on Physicians

As noted above, interactions with health plans – including MAOs – consistently rank high on the list of sources for family physician burden. However, no standardized system holds health plans accountable for their impact on physician satisfaction, despite these issues being major drivers of burnout. **The Academy believes that federal policymakers should encourage strengthened health plan accountability for physician satisfaction**. Specifically, we believe a stakeholder body such as the National Committee for Quality Assurance should strengthen its health plan measurement framework by incorporating comprehensive physician satisfaction metrics. We also encourage such a body to publicly report on measures that represent health plan support of its physicians and clinicians, such as efficient, timely, comprehensive data exchange and feedback mechanisms, utilization management criteria, prior authorization denial rates and/or timeliness, payment policies, claims denials, prompt pay compliance and customer service.

In some cases, MA plans require authorization (prior authorization, or PA) before they will cover a certain service or item for a beneficiary. Prior authorization is described by payers as a cost-containment mechanism, but many patients and physicians alike report that it largely serves to delay and deny appropriate, medically necessary care. One study from the Department of Health and Human Services Office of the Inspector General (HHS OIG) found that MAOs overturned 75 percent of their own prior authorization and payment denials upon appeal.[iii] Another study found that, of denied prior authorization requests, 13 percent met

Medicare coverage rules and 18 percent of payment denials met Medicare coverage and billing rules.[iv]

We appreciate recent commitments by insurers, including those which administer MA plans, to streamline, simplify, and reduce PA, but these efforts are voluntary and subject to no enforcement by anyone other than the plans themselves.[v] We believe further action is necessary to meaningfully reform PA across MA plans.

In 2024, CMS issued final rules streamlining prior authorization processes across federal payers, including MA plans. However, Congressional action is still needed to enshrine these much-needed reforms into statute. In May, a bipartisan, bicameral group of lawmakers reintroduced the *Improving Seniors' Timely Access to Care Act* (H.R. 3514 / S. 1816), which would codify these changes to standardize prior authorization processes within MA plans. Specifically, it would require a standard electronic prior authorization process for MA prior authorization requirements and expand beneficiary protections to improve enrollee experiences and outcomes. It would also improve transparency across MA plans and address inappropriate coverage denials.

A previous version of this legislation passed the House in the 117th Congress but stalled in the Senate due to a high projected score from the Congressional Budget Office. The bill's sponsors crafted thoughtful changes to the bill in the 118th Congress to ensure the score will be low, if not zero. To meaningfully protect patients and ease burden on the physicians who care for them, **the AAFP urges Congress to support the *Improving Seniors' Timely Access to Care Act* and immediately enact the legislation.**

In addition to supporting legislative efforts that aim to streamline the prior authorization process, the AAFP also supports the *Reducing Medically Unnecessary Delays in Care Act,* (H.R. 2433), which would ensure that prior authorization decisions across health plans are made by licensed, board-certified physicians who use scientific and evidence-based research to make their decisions. It would also require plans to create policies based on medical necessity and written clinical criteria. Through these reforms, clinicians and patients can be assured that prior authorization decisions are made by those with the clinical training and subject matter expertise that is necessary. This will reduce the incidence of illegitimate prior authorization denials and the need for numerous appeals, therefore reducing the administrative burden for physicians and ensuring that patients are receiving the care they need as soon as possible. We encourage the Subcommittees to consider this proposal as they work to reform the MA program.

Further, the Academy has growing concerns about the use of artificial intelligence (AI) to process prior authorization requests. According to a recent survey conducted by the American Medical Association, 61 percent of physician respondents expressed concerns with the expanded use of AI by MA plans for prior authorization.[vi] Although MA plans claim that the use of AI in this context is intended to expedite the processing of claims, there is evidence to suggest that plans are actually utilizing AI to unduly increase denial of prior authorization requests.[vii]

We appreciate that some lawmakers have begun to examine these practices. In October 2024, the Senate Homeland Security Permanent Subcommittee on Investigations released a

report entitled "*Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care."* The Committee cited a number of concerns with MA plans' increased use of AI for prior authorization. In one example, they found that, after implementing the use of AI to process requests, United Healthcare's prior authorization denial rate increased by over 12% in just two years.[viii] The Committee report provided recommendations to CMS to mandate increased transparency by MA plans in their utilization of AI for prior authorization. However, CMS has not formally implemented that recommendation. **The AAFP encourages this Committee to continue to this examination and build upon this work.**

Finally, we remain concerned by the use of "step therapy" among MA plans. Step therapy is a specific type of PA requiring patients to try one or more insurer-preferred medications or treatments prior to implementing a physician recommendation. Plans claim that step therapy PA is used to bring down the cost of care for the treatment of numerous conditions. However, the AAFP believes that step therapy protocols instead delay patients' access to treatments, which can result in severe side effects and disease progression for patients. A recent survey by Avalere Health illustrates these delays. Surveyed clinicians reported that the use of step therapy protocols is increasing, including in MA plans.[ix] Ninety-four percent of respondents stated that step therapy limits their preferred treatments and over 40 percent of respondents says that the majority of their MA patients are now subject to step therapy protocols.[x]

Given the growing prevalence of step therapy reported by physicians and patients, **we strongly encourage the Subcommittees to explore guardrails or other reforms to ensure step therapy use by MA plans does not contradict AAFP policy**. The AAFP maintains that step therapy should not be mandatory for patients already on a course of treatment. Ongoing care should continue while PA approvals or step therapy overrides are obtained. Patients should not be required to repeat or retry step therapy protocols conducted under previous benefit plans.

Step therapy protocols should be flexible and dynamic to allow physicians to make clinical decisions based on the potentially ever-changing aspects of disease management and care. Decisions in response to PA and step therapy requests, exceptions, and appeals must be made in a timely manner. All denials should include the clinical rationale for the adverse determination and allow physicians to provide supporting documentation when needed. Without increased transparency, efficient and evidence-based reviews and flexibility, step therapy protocols only serve to - at best - undermine the patient-physician relationship, and – at worst – delay or deny access to life-saving care.

<u>Coding Intensity and Fragmentation of the Patient-Physician Relationship</u>

Payments from CMS to MA plans are partially determined by a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MAOs are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources.

The AAFP recognizes that risk adjustments are important for ensuring payments to MAOs accurately reflect patient complexity and support access to coverage and care for patients. However, a growing body of evidence suggests that some MAOs may be overly focused on recording health conditions that increase risk scores and therefore increase their monthly payments without a corresponding level of care documented for enrollees. For example, plans have reported diagnosis codes that are not fully supported by patients' medical records, an indication that patients aren't receiving related or indicated care.[xi] **An October 2024 HHS OIG report found that diagnoses reported only in enrollees' health risk assessments (HRA) and HRA-linked chart reviews led to an estimated $7.5 billion in MA risk-adjusted payments in 2023**. Of that amount, in-home HRAs and HRA-linked chart reviews accounted for nearly two-thirds of the payments. To be clear, in-home HRAs are separate and distinct from home-based primary care (HBPC) delivered by a patient's usual source of care. Many family physicians provide comprehensive, continuous HBPC for often medically complex patients. These visits are both medically necessary and patient-centered, and Congress must ensure that reforms taken to address misaligned incentives in the MA program do not unintentionally impede the delivery of high-value HBPC.

These OIG findings raise significant concerns about the validity of diagnoses obtained via in-home HRAs and HRA-linked chart reviews, as well as the ways in which MA plans are fragmenting existing patient-physician relationships. Family physicians frequently report that they had no knowledge of the in-home HRA being conducted or of the diagnoses identified during the HRA. They often only learn of it when their patient mentions a nurse or other clinician coming to their residence at a later service visit. These experiences are verified by the OIG report finding that most in-home HRAs are conducted by third-party vendors that MAOs partnered with rather than the enrollees' own primary care providers, which may create gaps in care coordination. The Medicare Payment Advisory Commission (MedPAC) has also questioned the accuracy of diagnoses only obtained through in-home HRAs, noting that diagnoses are often based on enrollee self-reporting or may require verification by diagnostic equipment not present during the visit.[xii]

The OIG report further found that MAOs relied mainly on in-home HRAs to collect certain diagnoses associated with some of the top thirteen health conditions. For example, MAOs used in-home HRAs to diagnose secondary hyperaldosteronism for 74 percent of all enrollees with this diagnosis obtained via an HRA or HRA-linked chart review. Meanwhile, only 3 percent of enrollees received this diagnosis during a facility-based HRA. **For thousands of MA enrollees, the in-home HRA was their only encounter recorded in 2022.** Specifically, the report found that 77 MA organizations generated $60.6 million in payments for 14,103 enrollees who did not have any recorded encounter of receiving tests, supplies, or services other than an in-home HRA. This is particularly concerning as it suggests that MA plans may be adding diagnoses to a patient's chart and maximizing risk-adjusted payments without actually connecting the patient to services and improving their care – *or*, that the diagnoses are inaccurate and thus follow-up services are not required for the patient.

The AAFP believes the accuracy of data used for risk adjustment purposes is paramount and that the physicians and other clinicians who serve as the patient's usual source of continuous primary care are best positioned to provide these data. **Third-party assessments or**

encounters designed solely to identify patient risk factors do not serve the best interest of the patient as they focus on identifying illness over treating it and are potentially disruptive to established patient-physician relationships. We have encouraged CMS to consider additional guardrails to prevent the use of such third-party assessments and, in the absence of regulatory action, we urge the Subcommittees to consider legislation that would implement them.

Last year, MedPAC projected the federal government would overpay MA plans by $88 billion in 2024. The AAFP is strongly supportive of comprehensive and accurate documentation of all patient's diagnoses and advises members that all coding should comply with the ICD-10-CM coding guidelines. If reports of overpayment are accurate, the AAFP is concerned that significant funding that could support broader, more widely available access to high-quality primary care is being diverted with no benefit to MA enrollees. Some proponents of the MA program argue that the quality of care and patient outcomes is better, but evidence has not consistently supported that. A comprehensive literature review by the Kaiser Family Foundation compared MA and traditional Medicare based on measures of beneficiary experience, affordability, service utilization, and quality. It found "few differences [...] that are supported by strong evidence or have been replicated across multiple studies."[xiii]

Therefore, the Subcommittees should consider advancing policies to address incentives that create unintended consequences and ensure that payments to MA organizations are being used to connect MA enrollees to high-value services, including comprehensive, continuous primary care that can help to reduce health care expenditures in the long run. At a minimum, MA plans must be required to coordinate with and disclose any in-home HRAs to a patient's PCP.

In implementing any of the above recommendations or related reforms, Congress should also take actions to prevent MA organizations from failing to invest in and support the provision of high-quality primary care. Specifically, we recommend additional guardrails that will ensure MA organizations do not pass potential revenue reductions onto the physician practices they contract with. Primary care practices continue to struggle with inadequate physician payment rates, staffing shortages, and overwhelming administrative burden. Additional payment cuts, costly system updates, and other downstream effects of these changes could further destabilize the primary care practices Medicare beneficiaries depend on.

MA Plans Payments to Physicians

There are no statutory or regulatory requirements dictating the type of payment arrangements MA organizations must have with contracted physicians. While this has the potential to encourage payment model flexibility and innovation, such as capitated payments for primary care, we hear more often from family physicians that they are struggling to get on-time payments from MA plans. As discussed previously, MA organizations use aggressive prior authorization and other utilization management processes that lead both to delayed care for patients and delayed payments for physicians.

One way that Congress can help to address this issue is by implementing prompt payment requirements for MA plans to in-network physicians and other providers. We

applaud Ranking Member Doggett and Representative Murphy on the Subcommittee for their leadership in introducing legislation that would do just this. Specifically, the bill stipulates that MAOs must pay clean claims received within 14 days (if submitted electronically) or 30 days (all other claims). If the MAO does not pay the claim within the defined timeframe, they are also required to pay interest on the claim. Additionally, it provides HHS with enforcement authority and establishes a payment floor of traditional Medicare for MA plan payments to physicians. We support this legislation and encourage the Subcommittees to advance it.

A related issue that we frequently hear of from family physicians is that MAOs require them to waive their right to interest on delayed claim payments as part of their contracts. We encourage Congress to prohibit this unfair practice as it considers opportunities to reform the MA program.

Beneficiary Benefits and Coverage

Access to longitudinal, coordinated, comprehensive primary care has been shown to increase utilization of preventive care, improve outcomes for patients with chronic conditions, and reduce costly emergency visits, hospitalizations, and unnecessary specialty outpatient visits. Yet the United States has continuously underinvested in primary care. In 2022, primary care spending dropped to less than five cents of every dollar, with Medicare spending the lowest at 3.4%.[xiv]

The impact of this long-term underinvestment is evidenced in our nation's health. When we look at health outcomes across the world, we're not doing well by almost any measure. Compared to other high-income, peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[xv] A common theme across countries with better health outcomes and lower health care costs is that they invest more in their primary care system with estimates placing primary care spending between 12 and 17% of total health care spending for these high-performing nations.[xvi]

Our nation cannot afford to keep spending less than five cents of every dollar on primary care. Improving health outcomes and preventing a further explosion of chronic illness requires us to reallocate our existing resources away from expensive sick care and toward prevention. As a starting point toward increasing primary care spending, **the Academy has long advocated for all payers to be required to track and publicly disclose the amount they spend on primary care services.** Specifically, we're urging the introduction of legislation that would require federal health programs and MA organizations to track and report data on their primary care spending so we have a clearer picture of the current landscape.

In the vein of increased transparency and reporting, the AAFP believes that MA plans must be required to disclose what supplemental benefits they offer to beneficiaries and what the utilization of those benefits among beneficiaries is. MAOs can provide supplemental benefits outside of what traditional Medicare covers, such as enhanced Part D benefits (i.e.: coverage of additional drugs), lower cost sharing across Parts A, B, and D, and coverage of non-Medicare services such as dental or vision benefits. These additional benefits are often heavily marketed in "direct-to-member" materials as an incentive to enroll. However, as MedPAC and others have noted, reliable data collection on the utilization of these benefits by beneficiaries

is limited. MeDPAC projected that CMS would pay MA plans $83 billion in rebates support the furnishment of supplemental benefits in 2024.[xvii] To better assess the value to beneficiaries and taxpayers, we believe that MAOs should be required to collect and publicly report data related to what benefits are offered, how much they spend on them, and how much beneficiaries utilize them. We are encouraged that CMS recently took steps to implement encounter data submission and reporting requirements by MA plans, and we continue to urge additional action to increase transparency and accountability.

Finally, the AAFP strongly supports patient choice in making personal and professional choices regarding their health care access. We have consistently advocated for voluntary patient selection to be the default method, both in patient attribution to their usual source of care and their source of coverage. Patients enrolled in traditional Medicare have the flexibility to see any Medicare-participating physician or other provider of their choice, whereas patients enrolled in MA plans are required to choose from narrow provider networks or face higher cost sharing responsibilities. Therefore, **the Academy opposes proposals to automatically enroll Medicare-eligible individuals into MA plans and believes that all patients should have reasonable flexibility to choose both their clinician and their coverage**.

Thank you for holding this timely and welcome examination of the Medicare Advantage program. We share the Subcommittees' commitment to ensuring that our federal health care programs, including MA, are working in the best interest of the patients they're intended to serve. The AAFP looks forward to working with you to advance thoughtful reforms that will meaningfully improve coverage for patients and make it easier for family physicians to best care for them. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

Steve Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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