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Statement for the Record

Ways and Means Health and Oversight Subcommittees

Hearing on "Medicare Advantage: Past Lessons, Present Insights, Future Opportunities"

July 22, 2025

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Chairs Smith, Buchanan, and Schweikert and Ranking Members Neal, Doggett, and Sewell, on behalf of Families USA, we thank you for holding this important and timely hearing. Central to our organizational mission is a commitment to guaranteeing that all families and individuals throughout the nation have access to high-quality, affordable health care that improves overall health — including our nation's seniors and people with disabilities who rely on Medicare for health insurance.

The high and rising cost of health care is a profound health problem and a significant economic burden on our nation's families, including for people who rely on Medicare—and Medicare Advantage (MA) in particular—for their health coverage. It is more important than ever that Congress addresses how to improve Medicare and Medicare Advantage (MA) as millions of families' access to health care is at risk due to the recently passed H.R.1, which will lead to more than 15 million people losing health insurance, including many who are currently dually enrolled in Medicaid and Medicare for their health and health care.[1]

In recent years, the MA program has become an increasingly critical source of health care coverage within the Medicare program, allowing Medicare beneficiaries to receive Part A and Part B coverage benefits from private plans rather than from Traditional fee-for-service (FFS) Medicare (also referred to herein as TM). Over the last two decades, the MA program has grown rapidly, now providing coverage to more than half (54%) of all eligible Medicare beneficiaries.[2] Notably, this significant growth in MA enrollment is expected to continue, with the Congressional Budget Office projecting that 62% of all Medicare beneficiaries will be enrolled in an MA plan by 2033.[3]

The MA program was originally created to give Americans the option to receive their Medicare benefits and coverage through private insurance plans, while promising to save the Medicare Program and taxpayers money, provide more generous coverage and benefits to enrollees, and improve health care quality.[4] **Yet, the program has not lived up to these goals.** Since its creation, the MA program has not achieved net savings for the Medicare Program or taxpayers. In 2025 alone, Medicare is projected to pay 20 percent more to cover enrollees in MA than it would spend if those same beneficiaries were enrolled in Traditional FFS Medicare—a difference that amounts to $84 billion per year. Since 2007, this inflated spending in Medicare Advantage has cost the federal government nearly $600 billion[5]

At the same time, the MA program does not consistently provide better quality health care or coverage than Traditional FFS Medicare.[6] While the MA program does offer attractive elements to beneficiaries including supplemental benefits, such as dental, vision, and hearing coverage and provide opportunities for reduced cost sharing for certain medical services that are not otherwise offered in TM, the **underlying distortions in the MA payment system have allowed MA insurers to engage in harmful business practices that drive low-value care and coverage for patients and consumers, as well as wasteful spending for the federal government.**[7,8]

Too often, MA insurers manipulate flaws in the MA payment system that directly undermine the health and financial wellbeing of our nation's seniors and older adults, as well as the federal government.[9] **These harmful practices include systematic upcoding of patient diagnoses that**

do not reflect the actual care that beneficiaries are receiving, gaming the star rating program, predatory and deceptive marketing schemes to prospective beneficiaries, and overly aggressive and medically inappropriate care denials, among others.[10] Collectively, these practices deprive beneficiaries of access to medically necessary care when they need it most, drive higher Part B premiums for everyone, and contribute to hundreds of billions of dollars in wasteful federal spending—putting the financial solvency of the Medicare trust fund at risk.[11]

Congress has both the power and the responsibility to advance policy reforms to strengthen the MA payment system and promote meaningful transparency into the MA program to hold insurers accountable to providing the high-value health care and coverage that the 33 million older adults and people with disabilities who rely on MA for health insurance deserve**.**

Reforming the Medicare Advantage Payment System

Fundamentally, flaws in the design of the MA payment and quality reward system are a major driver of the rising costs and mixed quality results of the MA program.[12] **Specifically, the MA payment system has three major components that need reforms: the benchmark and bidding system, the quality bonus program, and risk adjustment.**[13]

The intent of the MA payment system is to incentivize MA insurers to compete on the cost, quality and efficiency of the coverage they offer to enrollees relative to other MA insurers and to TM.[14] If MA insurers offer Medicare coverage at a lower cost than average TM spending, particularly while achieving high quality scores (that is, high star ratings), they are financially rewarded.[15] However, flaws in each of the three components of the MA payment system have allowed MA insurers to inflate their payments from the federal government without meaningfully and consistently providing better quality care to our nation's seniors.[16] For example:

The Benchmark and Bidding System. CMS sets monthly payments to MA plans based on a comparison between MA plan bids (that is, the plan's best guess of how much it will cost to cover Medicare Part A and B benefits for an average enrollee) and TM based benchmarks (that is, the cost of providing Part A and B services for the average enrollee in TM).[17] The core payment structure for MA insurers relies on a quartile-based benchmark system which allows plans to be paid differently based on geographic factors.[18] While the quartile-based system was originally designed to increase efficiencies and incentivize access to MA plans across the country —including in historically underinsured communities —this structure is no longer necessary to maintain access to affordable supplemental coverage, and fails to generate savings for the Medicare program.[19] Now, the average beneficiary has access to 42 different MA plans, and nearly 100 percent of eligible beneficiaries have access to at least one zero-dollar premium plan with drug coverage.[20] As a result, the MA program has outgrown the need for a quartile-based benchmark payment system.

As it exists now, the quartile-based benchmark system drives higher MA payments into geographic regions of the country that are utilizing less health care and thus require fewer resources while driving lower MA payments into regions of the country that require more care and greater resources.[21] For example, the quartile-based benchmark system allows higher payments to MA

plans in areas where FFS spending is low, despite the fact that most plans bid below FFS spending in these areas. As a result, payments to MA plans are 9% higher than the FFS spending in those areas.[22]

At the same time, this payment structure fails to drive plan efficiency in areas with higher FFS spending.[23] Plans in higher FFS spending areas of the country can game the system by submitting lower bids compared to the benchmark which results in the federal government paying a disproportionately higher rebate to these plans.[24] While MA plans are required by law to use their rebate dollars to provide additional benefits and/or lower cost-sharing to beneficiaries, increasingly plans are applying smaller and smaller shares of those rebates to the benefit of enrollees.[25] Evidence suggests that plans actually retain a large share of these dollars in the form of higher profits, with consumers receiving less than half of the rebate in new benefits or cost-sharing, and in many cases as little as 12.5% of the increased MA plan payments.[26]

The Quality Bonus Program. After the benchmark and bidding process, CMS further adjusts MA plan payments based on the quality of the care and coverage provided to their enrollees using a five-star rating system under the Quality Bonus Program (QBP). This system measures plan performance on a large number of clinical quality, patient experience, and administrative performance measures.[27] However, despite the fact that 80% of MA plans achieve quality bonus payments (meaning they receive a star rating of 4 or higher), numerous external studies have found that quality bonus payments do not drive meaningful or consistent improvements in plan quality.[28] There are a number of problems with the QBP including:[29]

- Quality is scored at the overarching contract level, even for contracts covering large and disparate areas. As a result, star ratings do not necessarily accurately reflect the quality of the care that any one beneficiary would receive under a specific plan. Companies are allowed to consolidate contracts to maximize star ratings and QBP payments. This resulted in an estimated $1.1 billion in extra payments to MA plans just between 2012 and 2016.
- Differences in enrollee social risk are not adequately accounted for, which skews plan performance on driving meaningful quality improvements.
- There are both too many measures and not enough of the right measures to fully account for plan performance and to hold plans accountable for driving quality improvement.
- Performance targets are set at inconsistent levels, making it challenging for plans to know how quality ratings impact QBP payments and failing to incentivize meaningful improvements in plan performance.
- The program is not budget-neutral: it only provides bonus payments and does not include financial penalties for poor performance, failing to balance the substantial rewards it provides to plans and to more effectively hold plans accountable for improving health care quality.

In 2025 alone, Medicare paid MA plans an *additional* $15 billion through the Quality Bonus Program, despite little evidence to demonstrate commensurate improvements in health care quality being delivered by these plans.[30]

The Risk Adjustment System. In the final component of MA payment, CMS uses a risk adjustment model to increase or decrease payments to MA insurers based on the characteristics and diagnoses of each enrolled patient to account for differences in health care costs between healthier and sicker enrollees.[31] One of the major goals of risk adjustment is to prevent insurers from engaging in discriminatory behavior such as adverse selection.[32] However, the current risk adjustment model is prone to significant MA plan gaming, where plans use certain billing and coding practices to make their enrollees appear sicker and more expensive relative to Traditional Medicare beneficiaries in order to generate a higher reimbursement from the federal government.[33] This systematic "upcoding" occurs despite the fact that MA enrollees actually tend to be healthier and less costly to cover overall than those in TM.[34] Since MA plan payments are risk-adjusted primarily by the numbers and types of diagnoses reported by MA plans on behalf of their enrollees (e.g., plans are paid more to cover enrollees with relatively more diagnoses or diagnoses linked to higher care and treatment costs), MA plans have a strong financial incentive to identify and record as many diagnoses as possible among their enrolled beneficiaries.[35] Most concerningly, some MA plans go as far as assigning patient diagnoses that are not even supported by the patient's medical record, relying on sham health risk assessments and chart reviews.[36] These coding practices allow MA insurers to receive higher risk-adjusted payments, often without delivering additional care or coverage to beneficiaries, even in the cases of patients with chronic diseases and comorbidities who truly need that additional care.[37] These coding abuses of the risk adjustment system further inflate Medicare payments to MA plans, costing Medicare an *additional* $40 billion every year.[38]

Improving Transparency to Ensure Quality Coverage

As a result of this deeply flawed payment system, many MA plans are further failing our nation's seniors through harmful business practices such as aggressive care denials or marketing misleading supplemental benefits that ultimately fail to provide tangible or comprehensive benefits.[39]

It is well established that MA insurers use overly aggressive prior authorization restrictions to deny medically necessary care for older adults and people with disabilities.[40] For example, MA plans deny millions of health care claims every year, yet 83% of those denials are appealed and overturned, raising serious concerns that MA insurers are denying care inappropriately.[41] In fact, MA insurers were found to have denied 85,000 prior authorization requests that actually met Medicare coverage rules, preventing and delaying medically necessary care for these MA enrollees.[42]

Prior authorization can serve as an important tool to reduce access to low-value care. However, despite growing evidence about the number of inappropriate denials of care carried out by MA plans, there is a significant lack of data transparency to fully inform the use, misuse and potential remedies around the use of prior authorization in the MA program.[43]

Similarly, nearly every MA plan now *offers* at least one supplemental benefit, often attempting to lure in new enrollees with promises of comprehensive benefits not otherwise offered in TM—like dental, vision, and hearing. In fact, one in four Medicare beneficiaries decide to enroll in MA plans based on these additional benefit offerings.[44] Yet there is limited data that enables us to understand the full scope of supplemental benefits being offered and what is actually available to Medicare beneficiaries through MA.[45] MA insurers often fail to explain exactly which services a particular MA plan may cover, their value to seniors, and the barriers to accessing these benefits.[46] Even CMS suspects that "…MA plans may be using these supplemental benefits primarily as a marketing tool to steer enrollment" instead of ensuring patients can actually use and benefit from them to improve their health and health care.[47]

Congress Can and Should Act Today

Fortunately, bipartisan, well-vetted policy solutions are ready to be enacted by lawmakers right away to begin to strengthen and improve the MA program by reining in MA plan abuses and reforming the MA payment system, including by:

- **Strengthening the risk adjustment system against industry gaming** to prevent MA insurers from billing diagnoses to inflate their Medicare payments without providing additional care or coverage. Coding reforms such as those drafted in the bipartisan No UPCODE Act, would rein in key tools used by MA insurers to inflate their payments, including sham health risk assessments and chart reviews and save up to $1.5 billion over 10 years according to the Congressional Budget Office.[48]
- **Improving the MA benchmark and bid system** to ensure MA insurers are only financially rewarded for bidding below their true costs and to promote healthy competition between MA plans and TM. Potential benchmark reforms could include moving towards calculating benchmarks using a blend of national and county level TM spend as well as initiating long term reforms that test setting MA benchmarks using an administrative benchmark approach or through competitive bidding.[49]
- **Holding MA insurers accountable to delivering high quality care and coverage** by strengthening the quality bonus payment program. QBP reforms should include making quality bonus payments budget neutral and incorporate financial penalties, setting higher absolute performance targets that are not based on average plan performance, and rewarding incremental progress towards such targets.[50]
- **Promoting meaningful transparency into the MA program** by requiring MA insurers to submit high quality and complete encounter data to CMS, so lawmakers and the public understand the extent the MA program is fulfilling their obligations to deliver affordable and high-quality care. Additionally, greater transparency and oversight is needed to better understand the data around the use of prior authorization as well as the marketing of supplemental benefits and the impact of Medicare patients' access to high-value health care.

- **Invest in improving Traditional Medicare such as adding a standard dental, vision, and hearing benefit** as key steps to improve meaningful competition between Medicare Advantage and Traditional Medicare.

Families USA appreciates these subcommittee's focus on this critical issue and looks forward to working with all of its members to improve affordable and accessible health care for our nation's seniors.

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[1] KFF, *About 17 Million More People Could be Uninsured due to the Big Beautiful Bill and other Policy Changes,* July 1, 2025. https://www.kff.org/quick-take/about-17-million-more-people-could-be-uninsured-due-to-the-big-beautiful-bill-and-other-policy-changes/

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

[3] KFF, Medicare Advantage in 2023: Enrollment Update and Key Trends, August 9, 2023. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

[4] Erin Fuse Brown, et al., *Legislative and Regulatory Options for Improving Medicare Advantage*, December 2023. https://pubmed.ncbi.nlm.nih.gov/37497876/

[5] MedPAC, *Report to the Congress: Medicare Payment Policy,* March 2025. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf; See also, Robert Berenson, Bowen Garrett, and Adele Shartzer, *Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending*, September 27, 2022. https://www.urban.org/research/publication/understanding-medicare-advantage-payment

[6] Ibid.

[7] KFF, *Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization,* August 8, 2024. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/

[8] Richard Gilfillan and Donald M. Berwick, Medicare Advantage, Direct Contracting, And the Medicare 'Money Machine,' Part 1: The Risk-Score Game, Health Affairs, 2021, https://data.cms.gov/tools/medicare-enrollment-dashboard; See also, HHS OIG, Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments, September 20, 2021. OEI-03-17-00474. https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp; Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf; MedPAC Report to the Congress: Chapter 12- The Medicare Advantage Program: Status Report, March 2024, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf; Christi A. Grimm, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OIG, 2022, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (OEI-09-18-00260) (hhs.gov); Jeannie Fuglesten Biniek, Nolan Sroczynski, Meredith Freed, and Tricia Neuman, Medicare

Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023, KFF, 2025, Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022 | KFF

[9] Richard Gilfillan and Donald M. Berwick, Medicare Advantage, Direct Contracting, And the Medicare 'Money Machine,' Part 1: The Risk-Score Game, Health Affairs, 2021, https://data.cms.gov/tools/medicare-enrollment-dashboard; See also, HHS OIG, Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments, September 20, 2021. OEI-03-17-00474. https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp; Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf; MedPAC Report to the Congress: Chapter 12- The Medicare Advantage Program: Status Report, March 2024, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf; Christi A. Grimm, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OIG, 2022, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (OEI-09-18-00260) (hhs.gov); Jeannie Fuglesten Biniek, Nolan Sroczynski, Meredith Freed, and Tricia Neuman, Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023, KFF, 2025, Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022 | KFF

[10] MedPAC Regulatory Comment on Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, March 1, 2023. https://www.medpac.gov/wpcontent/uploads/2023/03/Mar2023_MA_C_AND_D_CY2024_MedPAC_COMMENT_v2_SEC.pdf; Tricia Neuman, Juliette Cubanski, & Meredith Freed, Monthly Part B Premiums and Annual Percentage Increases, January 12, 2022. https://www.kff.org/medicare/slide/monthly-partb-premiums-and-annual-percentageincreases/; CMS, Medicare Savings Programs, https://www.medicare.gov/basics/costs/help/medicaresavings-programs; See Chapter 11, MedPAC, Report to the Congress: Medicare Payment Policy, March 2023, https://www.medpac.gov/wpcontent/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf ; See also, page 265 of MedPAC, January 2024 Public Meeting Transcript, MedPAC, January 2024, https://www.medpac.gov/wpcontent/uploads/2023/10/January-2024-meeting-transcript.pdf.

[11] Ibid.

[12] MedPAC, *Rebalancing Medicare Advantage benchmark policy,* June 2021. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_ch1_medpac_report_to_congress_sec.pdf; MedPAC, *Report to the Congress: Medicare Payment Policy,* March 2025. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf; See also, Robert Berenson, Bowen Garrett, and Adele Shartzer, *Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending*, September 27, 2022. https://www.urban.org/research/publication/understanding-medicare-advantage-payment

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Ibid.

[17] Ibid.

[18] Ibid.

[19] Ibid.

[20] Ibid.

[21] Ibid.

[22] Ibid.

[23] Ibid.

[24] Ibid.

[25] Ibid.

[26] Steven Lieberman, et al., *The case for reforming competitive bidding in Medicare Advantage,* Brookings. https://www.brookings.edu/articles/the-case-for-reforming-competitive-bidding-in-medicare-advantage/;

Cabral M, Geruso M, Mahoney N. Do Larger Health Insurance Subsidies Benefit Patients or Producers? Evidence from Medicare Advantage. Am Econ Rev. 2018 Aug;108(8):2048-87. PMID: 30091862; PMCID: PMC10782851.

[27] Robert Berenson, Bowen Garrett, and Adele Shartzer, *Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending*, September 27, 2022. https://www.urban.org/research/publication/understanding-medicare-advantage-payment; Laura Skopec, Robert Berenson, *The Medicare Advantage Quality Bonus Program: High Cost for Uncertain Gain*, June 26, 2023.

[28] Ibid. Erin Fuse Brown, et al., *Legislative and Regulatory Options for Improving Medicare Advantage*, December 2023. https://pubmed.ncbi.nlm.nih.gov/37497876/

[29] Ibid. Robert Berenson and Lauren Skopec, *The Medicare Advantage Quality Bonus Program: New Ideas and New Conversations,* March 2024. https://www.urban.org/sites/default/files/2024-03/The%20Medicare%20Advantage%20Quality%20Bonus%20Program%20New%20Ideas%20and%20New%20Conversations.pdf

[30] Ibid.

[31] MedPAC, *Report to the Congress: Medicare Payment Policy,* March 2025. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf; See also, Robert Berenson, Bowen Garrett, and Adele Shartzer, *Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending*, September 27, 2022. https://www.urban.org/research/publication/understanding-medicare-advantage-payment

[32] Ibid.

[33] Richard Gilfillan and Donald M. Berwick, Medicare Advantage, Direct Contracting, And the Medicare 'Money Machine,' Part 1: The Risk-Score Game, Health Affairs, 2021, https://data.cms.gov/tools/medicare-enrollment-dashboard; See also, HHS OIG, Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments, September 20, 2021. OEI-03-17-00474. https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp;

[34] Erin Brown, Travis Williams, Roslyn Murray, et al., *Legislative and Regulatory Options for Improving Medicare Advantage*, Journal of Health Politics, Policy and Law. December 2023.; Li Q, Trivedi AN, Galarraga O, Chernew ME, Weiner DE, Mor V. Medicare Advantage Ratings And Voluntary Disenrollment Among Patients With End-Stage Renal Disease. Health Aff (Millwood). 2018 Jan;37(1):70-77. doi: 10.1377/hlthaff.2017.0974. PMID: 29309223; PMCID: PMC6021124.; MedPAC, *Report to the Congress: Medicare Payment Policy,* March 2025. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf

[35] Ibid.

[36] Ibid.

[37] Ibid.

[38] Ibid.

[39] Christi A. Grimm, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OIG, 2022, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (OEI-09-18-00260) (hhs.gov); Jeannie Fuglesten Biniek, Nolan Sroczynski, Meredith Freed, and Tricia Neuman, Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023, KFF, 2025, Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022 | KFF CMS, Dental Coverage Status and Utilization of Preventative Dental Services by Medicare Beneficiaries. Medicare Current Beneficiary Survey. https://www.cms.gov/files/document/dental-coverage-status-and-utilizationpreventive-dental-services-medicare-beneficiaries-poster.pdf; Currently, there is no specific requirement for MA organizations, beyond more general care coordination requirements, to conduct outreach to enrollees to encourage utilization of supplemental benefits. For more information, see Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and 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 (PACE). Fed. Reg 30448, 30448-30848 (April 23, 2024).

[40] Ibid.

[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] The Commonwealth Fund, *Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why.* October 17, 2022. https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose ; US Senate Committee on Finance (Majority Staff), Deceptive Marketing Practices Flourish in Medicare Advantage. https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Med icare%20Advantage.pdf
[45] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf GAO, *Medicare Advantage: Plans Generally Offer Some Supplemental Benefits, but CMS Has Limited Data on Utilization,* January 31, 2023. https://www.gao.gov/products/gao-23-105527; Eric Roberts, Robert Burke, and Kathleen Haddad, *Medicare Advantage Supplemental Benefits: Origins, Evolution, and Issues for Policy Making.* September 19, 2024. https://www.healthaffairs.org/content/forefront/medicare-advantage-supplemental-benefits-origins-evolution-and-issues-policy-making
[46] Ibid. Government Accountability Office, Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization, January 2023. https://www.gao.gov/assets/gao-23-105527.pdf
[47] CMS-4201-F3 & CMS-4205-F. https://www.federalregister.gov/d/2024-07105
[48] https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf
[49] Erin Fuse Brown, et al., *Legislative and Regulatory Options for Improving Medicare Advantage*, December 2023. https://pubmed.ncbi.nlm.nih.gov/37497876/; Michael Chernew, *The Case for Administrative Benchmarks (and Some Challenges),* September 2023. https://catalyst.nejm.org/doi/full/10.1056/CAT.23.0194?logout=true
[50] Robert Berenson and Lauren Skopec, *The Medicare Advantage Quality Bonus Program: New Ideas and New Conversations,* March 2024. https://www.urban.org/sites/default/files/2024-03/The%20Medicare%20Advantage%20Quality%20Bonus%20Program%20New%20Ideas%20and%20New%20Conversations.pdf Robert Berenson, Bowen Garrett, and Adele Shartzer, *Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending*, September 27, 2022. https://www.urban.org/research/publication/understanding-medicare-advantage-payment; Laura Skopec, Robert Berenson, *The Medicare Advantage Quality Bonus Program: High Cost for Uncertain Gain*, June 26, 2023.