January 26, 2026

The Honorable Mehmet Oz, M.D.
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016.

Submitted electronically via regulations.gov

Re CMS-4212-P: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Dear Administrator Dr. Mehmet Oz:

On behalf of the undersigned organizations, we appreciate the opportunity to comment on the *Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program* (i.e., the 2027 Medicare Part C and Part D proposed rule). The undersigned organizations are committed to ensuring that older adults and all those who rely on Medicare for their health care have access to high-quality care and coverage options.

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 in particular Medicare Advantage (MA) and Medicare Part D for their health coverage.

Insurers participating in MA – a program that gives people the option to receive their Medicare Part A and B benefits through private plans – too often engage in harmful business practices that drive low-value care for patients and wasteful spending in the Medicare program.[1] These practices include predatory and deceptive marketing schemes to prospective beneficiaries, overly aggressive and medically inappropriate care denials, gaming of the quality bonus program, and systematic upcoding of patient diagnoses that do not reflect the actual care that beneficiaries are receiving, among other abuses.[2] Collectively, these practices deprive beneficiaries of access to medically necessary care when they need it most, raise Part B premiums for everyone, and contribute to hundreds of billions of dollars in wasteful Medicare spending without delivering better health care quality or coverage to our nation's older adults.[3]

The 2027 Medicare Part C and Part D proposed rule includes significant policy and technical changes related to the coverage and administration of the Medicare Advantage program, which would have significant implications for the health and health care coverage of the over 30 million people who rely on MA for their medical care.[4] Below we offer detailed comments on the following proposals and requests for information that we believe are particularly important

and relevant to ensuring our nation's families have access to affordable and high-quality coverage and care:

1. Section I, Sub-Section D. Supplemental Requests for Information
2. Section V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184)
3. Section VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)

We also offer abbreviated comments related to Section VII. Reducing Regulatory Burden and Costs in Accordance with Executive Order (E.O.) 14192 and IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes), Section E. Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements (§§ 422.2267 and 423.2267), and Section F. Removing Rules on Time and Manner of Beneficiary Outreach (§§ 422.2264, 423.2264, 422.2274, and 423.2274).

Section I, Sub-Section D. Supplemental Requests for Information

In the CY2027 Medicare Part C and Part D proposed rule, the Centers for Medicare and Medicaid Services (CMS) seeks comment on specific areas where MA regulatory requirements can be simplified, consolidated, or eliminated while maintaining program integrity and beneficiary protections. Below, the undersigned organizations offer comments specifically on the critical importance of maintaining and strengthening medical loss ratio (MLR) requirements and MLR-related reporting requirements.

We are disappointed that CMS did not finalize previously proposed policies from the CY2026 Policy and Technical Changes proposed rule to strengthen MLR reporting requirements by ensuring MA insurers 1) only report "incentive and bonus payments" as medical spend for the purposes of MLR reporting if such payments are *directly* linked to well-documented clinical or quality improvement standards and 2) only report expenses related to quality improvement activities as medical spend for the purposes of MLR reporting if such expenses *directly* relate to activities that improve health care quality such as by improving patient safety or preventing hospital readmissions. Federal law requires insurers to spend at least 85 percent of their revenue – which primarily comes from risk-adjusted Medicare payments – on patient care.[5] This requirement is a critical tool that promotes transparency and accountability over MA insurers and helps to drive higher value care for Medicare beneficiaries by ensuring a significant share of premium dollars are used for delivering health care services rather than being used for health insurer administration costs or profits.[6] This regulatory incentive drives insurers to carefully manage their administrative costs to meet the requirements and shifts plans' focus to the efficiency and quality of care delivered to Medicare beneficiaries rather than on maximizing profits through high administrative spending.[7]

Yet, evidence suggests MA insurers subvert federal laws on MLR requirements for profit maximization at the expense of providing high value care to our nation's seniors.[8] MA insurers negotiate faux "value-based contract" agreements with their affiliated or in-network providers – which involve transferring a share of the insurers' premium revenue over time – to artificially inflate their reported medical spending for the purposes of MLR reporting.[9] By negotiating these faux contracts, MA insurers also financially pressure their affiliated providers to diagnose beneficiaries with additional or even erroneous diagnoses to secure higher risk-adjusted payments from CMS.[10] Vertically integrated insurers are particularly adept at circumventing MLR requirements since health care providers, including the insurers' owned provider practices, are not subject to MLR requirements.[11] MA insurers that own a provider group can pay their vertically integrated providers above-market rates (that is, set internal "transfer prices" at above-market rates) for health-related services and report those inappropriately high payments as a medical cost for the purposes of MLR reporting – even though it represents additional profit for the parent company.[12] In other words, vertically integrated plans are using precious health care dollars for patient care to pay themselves instead.

Given MA insurers' track record of abusing MLR requirements, CMS should take action to guarantee that MA insurers use the vast majority of health care dollars on delivering patient care for consumers and not to fund inflated profits or administrative costs. CMS's decision to not finalize strengthened MLR and MLR-related reporting requirements is a missed opportunity to hold MA insurers accountable and drive the delivery of high-quality, efficient, and affordable care and coverage.

To ensure taxpayer dollars are spent primarily on patient care rather than insurer profits, we urge CMS to maintain and strengthen MLR and MLR-related reporting requirements, by taking the following actions:

- **Finalize strengthened versions of the MLR reporting requirement proposals from the CY2026 Policy and Technical Changes proposed rule that were not included in the final rule that:[13]**
    - **Restrict MA insurers from reporting "incentive and bonus payments" as medical spend for the purposes of MLR reporting unless such payments are *directly* linked to well-documented clinical or quality improvement standards**
    - **Restrict MA insurers from reporting expenses related to quality improvement activities as medical spend for the purposes of MLR reporting unless such expenses *directly* relate to activities that improve health care quality such as by improving patient safety or preventing hospital readmissions.**
        - **CMS should enumerate the specific activities that are directly related to improving health care quality and that can be reported under the "quality improvement activities" category for the purposes of MLR reporting and require MA insurers to report those specific activities and make them public.**

        - **CMS should exclude spending related to well-documented harmful behaviors that drive wasteful and low-value Medicare spending from the definition of "quality improvement activities" for MLR reporting purposes, including the use of chart reviews and health risk assessments that do not result in additional care or coverage.**
- **Implement stronger MLR and MLR-related transparency and reporting requirements that require vertically integrated insurers to report their transfer prices and their overall MLR for the provider group and the parent company for their Medicare beneficiaries.[14]**
- **Establish pricing benchmarks on transfer prices to ensure vertically integrated insurers are paying the same fair market rates to directly owned and unowned or independent providers.[15]**

Section V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184)

The undersigned organizations offer comments on proposals B and D included in Section V as outlined below, with a focus on CMS's proposed changes to the Quality Bonus Program (QBP) and the star rating system.

B. Adding, Updating and Removing Measures (§§ 422.164 and 423.184)

We support CMS's proposal to reduce the number of star rating measures and rescinding measures that are "topped out," where the vast majority of MA insurers generate high performance scores and do not exhibit meaningful variation in performance across MA insurers and their contracts. Specifically, CMS proposes the removal of seven-star rating measures focused on operational and administrative performance, three additional measures focused on process of care, and two additional measures focused on patient experience of care.[16] CMS also proposes to add one new measure to the set, the Depression Screening and Follow-up Measure.

We agree with CMS's overarching goal to "simplify and refocus the measure set on clinical care, outcomes, and patient experience of care measures" and support CMS's proposal to remove certain measures from the star rating set, though we have concerns about some of the specific measures that are proposed for removal. The quality bonus program uses 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.[17] Since MA plan performance on each quality measure is weighted and then averaged to calculate a final star rating, the more measures in the underlying measure set, the less effective any one measure is to incentivize meaningful changes in MA plan behavior and performance.[18] At the same time, performance targets for each quality measure are set at inconsistent levels that fail to incentivize meaningful improvements in plan performance and often have minimal differences between performance

ranges needed to achieve bonus payments (that is, cut points). Ultimately, the QBP's weaknesses make it too easy for MA insurers to achieve high scores and quality bonuses *without* delivering higher quality care or coverage to our nation's families.[19]

That is why, **we support the removal of certain measures from the star rating measure set, including measures that no longer meaningfully distinguish between different levels of plan performance due to the vast majority of MA contracts scoring at the top end of such measures.** For instance, we support the removal of the C31 – "Plan Makes Timely Decisions about Appeals" measure since the vast majority of MA contracts score extremely high on the measure which means the measure will no longer financially incentivize marginal improvement in MA plan performance.[20] In 2026, the average MA contract scored 98% on this measure (higher represents "better" care), which provides MA contracts 4.1 stars on average, above the threshold to generate quality bonus payments.[21] We encourage CMS to explore adopting replacement measures to help ensure MA plans provide enrollees robust and reliable coverage, including measures that hold MA plans accountable for inappropriate care denials of medically necessary care, especially medically necessary care that should otherwise be covered under Medicare coverage rules

At the same time, we oppose CMS's proposal to remove other specific measures from the star rating measure set, including those that directly survey enrollees on their experience with their MA plan or that seek to hold MA plans accountable for high rates of plan disenrollment. Specifically, we urge CMS not to remove the "Rating of Health Care Quality", "Customer Services," and "Members Choosing to Leave the Plan" measures. These measures assess critical aspects of MA plan quality and administration as well as MA plans' ability to keep enrollees from leaving their plan, respectively.[22] MA plans consistently underperform on these measures, including below 4 stars on average – the level needed to generate bonus payments – and have not shown meaningful improvement and have even worsened in some cases, since 2021.[23] CMS should preserve these measures, and the financial incentive they create for MA plans to focus on quality improvement and plan administration, in order to drive higher value into the MA program.[24]

For example, the "Members Choosing to Leave the Plan" measure, which assesses the rate of enrollees choosing to leave their MA plan, is a particularly important measure to keep in the star rating measure set.[25] Levels of disenrollment is a critical indicator of patient experience and quality as high disenrollment may reflect MA plans not meeting their enrollees' health and health care needs.[26] Almost half of all MA enrollees leave their MA plan within just a few years after they initially enroll, and enrollees with more substantial health and health care needs are more likely to disenroll compared to healthier enrollees.[27] This raises serious concerns about MA plan's ability to serve enrollees with complex care needs and warrants further study and attention.[28] **We urge CMS to maintain the "Members Choosing to Leave the Plan" measure in the QBP and build upon it by requiring additional information about the underlying reason(s)**

for disenrollment so that CMS, lawmakers, and the public can definitively assess what is driving such high rates of plan disenrollment over time. MA plans must be held accountable for high rates of disenrollment, particularly if they are driven by MA plan abuses, mismanagement or the delivery of low-quality care or coverage.[29]

D. Health Equity Index Reward

The undersigned organizations oppose CMS's proposal to stop implementation of the health equity index (HEI) reward for the purposes of calculating MA contract star ratings starting in 2027. The HEI is an important tool to incentivize plans to drive meaningful quality improvement among their enrollees with social risk factors and social-related health needs.[30] The HEI, otherwise known as Excellent Health Outcomes for All, increases an MA insurer's star rating by up to 0.4 points if the MA insurer achieves relatively high performance scores (compared to other plans) on certain star rating measures among their enrollees with social risk factors, such as enrollees with lower incomes and dual eligibility for Medicare and Medicaid or with a disability.[31] Without the HEI, the star rating system does not adequately account for enrollees' social risk, leading to low-income beneficiaries, such as those in rural areas, relying on MA plans with lower quality performance compared to higher-income beneficiaries, according to the Medicare Payment Advisory Commission (MedPAC).[32] Ultimately, by financially rewarding plans to improve their quality performance among their patients with social risk factors, the HEI would strengthen the QBP's ability to encourage MA plans to address patients' social related health needs, including the socioeconomic factors that drive 80 to 90% of people's health outcomes.[33] **We urge CMS to reverse its proposal and continue implementation of the HEI; the HEI would directly advance the Trump Administration's stated goal of improving the health of Americans by incentivizing MA insurers to address the non-clinical factors that contribute to poor health, chronic disease, and inflated health care spending.**

Section VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)

In the CY2027 Medicare Part C and Part D proposed rule, CMS seeks public comment on opportunities to modernize and strengthen the Medicare Advantage program, including by enhancing the risk adjustment system and the quality bonus program to support competition and maximize the value of the program for beneficiaries and taxpayers. CMS is particularly interested in changes that can "enhance competition in the MA program; level the playing field for smaller regional, and less well-resourced MA plans; and address factors that may place these types of plans at a competitive disadvantage." Below, we offer comments in response to this request for information, focused on reforms to the risk adjustment system and the quality bonus program.

Risk Adjustment

MA insurers identified a major loophole in CMS's risk adjustment system, which they developed into a multibillion-dollar business tactic at the expense of our nation's seniors and Medicare's solvency.[34] Since Medicare pays MA insurers a monthly capitated payment to cover the expected health care costs of their beneficiaries, and those payments are risk-adjusted based on the health status and medical diagnoses of each enrolled patient, MA plans can generate billions in additional government payments by identifying and recording as many diagnoses as possible among their enrolled beneficiaries.[35] By taking advantage of this loophole, MA insurers generate over $40 billion in additional government payments every year because of higher risk scores, even though many of the patient diagnoses they record are not supported by a patient's medical record nor result in any additional care or coverage to Medicare beneficiaries.[36] Ultimately, these MA insurer coding abuses are a major driver of wasteful and low-value Medicare spending, puts the financial solvency of the Medicare Trust Fund at serious risk and takes money directly out of the pockets of all Medicare beneficiaries in the form of higher Part B premiums.

MA insurers should not be able to upcode their way to financial success without delivering high-quality care or coverage to our nation's families. We applaud CMS's previous efforts to rein in MA insurer coding abuses by strengthening the accuracy and integrity of the MA risk adjustment model, including phasing in the updated 2024 CMS-HCC Risk Adjustment Model and announcing enhanced risk adjustment data validation audits. Now CMS needs to build upon these efforts and further strengthen the risk adjustment system against industry gaming. **Specifically, we urge CMS to use its existing statutory authority to enact national regulatory improvements to the risk adjustment system to finally end MA insurers' ability to systematically upcode (i.e., increase coding intensity) patient diagnoses without improving patient care. CMS should take the following actions:**

- **Publicly confirm it conducted an annual analysis of coding pattern differences as required by federal law and promptly release any such analysis along with all underlying data necessary to evaluate its conclusions.**[37]
- **Apply a higher coding adjustment factor above and beyond what is minimally required in statute to fully account for MA plans' intensive coding, using a tiered approach that targets MA plans who engage in upcoding to the greatest extent in order to remove their unfair competitive advantage as compared to other less-resourced MA plans.**
- **Exclude information exclusively collected via in-home health risk assessments (HRAs) or chart reviews as a source of diagnoses for Medicare Advantage risk adjustment scores and payments, which MedPAC and the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) note are easily abused and represent a significant driver of coding intensity and upcoding.**[38]

- **Use two years of Traditional Medicare and MA diagnostic data for calculating MA risk-adjusted payments and explore alternative sources of data for MA risk adjustment that industry cannot as easily game.[39]**
- **Initiate longer term reforms of the CMS-HCC (Hierarchical Condition Category) Risk Adjustment Model that drive toward a health care system that promotes population health and social and economic wellbeing of every MA beneficiary by taking the following actions:**
    - **Explore alternative sources of data for MA risk adjustment that industry cannot easily game.**
    - **Incorporate additional measures of health-related social needs to more accurately account for expected health care costs among populations with certain social risk factors or more complex care needs and drive towards improvements in population health and improved protections against adverse selection.[40]**

Quality Bonus Program

The evidence is clear that the quality bonus program, which is designed to hold MA insurers accountable to delivering high-quality care and coverage to Medicare beneficiaries, does not generate meaningful or consistent improvements in MA plan quality. Wasteful spending under the QBP is significant. In 2025 alone, Medicare paid MA plans an additional $15 billion through the quality bonus program, where 80% of MA plans now achieve quality bonus payments, despite little evidence to demonstrate commensurate improvements in health care quality.[41] The QBP has a number of specific problems, many of which we outlined in our comments on Section V above, including:

- Quality is scored at the overarching contract level, even for contracts that cover large and disparate areas through multiple MA plans and plan designs. This means star ratings assigned to an individual MA plan do not necessarily reflect the quality a beneficiary would receive, since the ratings are based on quality scores averaged across *multiple* MA plans included under one contract. MA insurers game this flaw by combining their lower-performing MA plans and contracts into contracts with higher star ratings in order to inflate their QBP payments without actually improving health care quality or coverage.[42] Between 2012 and 2016 alone, this gaming drove an estimated $1.1 billion in extra Medicare payments to MA plans.[43]
- Star rating calculations do not adequately account for differences in enrollee social risk, which skews plan performance on driving meaningful improvements. Ultimately, plans may still be disincentivized to enroll beneficiaries with social risk factors and relatedly higher health care needs and spending, and some plans even engage in discriminatory

behavior such as adverse selection in order to maintain their high star ratings and QBP payments.[44]

- 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. For instance, the QBP is missing many externally validated measures used to assess clinical quality, such as measures assessing mortality rates and hospital readmissions, while the QBP's "administrative measures" do not hold MA insurers accountable for inappropriate care denials that run contrary to Medicare coverage requirements or for overly restrictive and narrow provider networks.[45]
- 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. Targets for each quality measure are set based on the relative performance of other plans, which are adjusted annually and often have minimal differences between performance targets that give an MA insurer a three-star rating versus a four-star rating and so on.[46]
- The QBP 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 failing to more effectively hold plans accountable for improving health care quality.[47]

Medicare Advantage is an expensive taxpayer investment that delivers inconsistent performance on health care quality and access compared to Traditional Medicare.[48] CMS must take action to ensure the MA program is delivering on its core promise to deliver high quality and more coordinated care at a lower cost. Strengthening the QBP is a critical tool to ensuring MA insurers do just that. **We urge CMS to use its extensive statutory authority (and where necessary seek new legislative authority) to reenvision the quality bonus program to ensure MA insurers drive meaningful improvements in health care quality and coverage to the benefit of our nation's seniors who rely on MA. To do so, CMS should take the following actions:**

- **Streamline the star rating measure set that holds MA plans accountable for the areas of plan quality and administration that are most important to the health and health care of Medicare beneficiaries.**
    - **Predominately include measures that assess self-reported patient experience and employ clinically validated measures that assess health care quality and outcomes, especially for beneficiaries with chronic disease and complex medical conditions, as well as measures that hold plans accountable for well-documented abuses such as in the areas of network adequacy, utilization management, and long-term care coverage and access.[49]**
    - **Stratify all measures and measure scores by patient characteristics and demographics.**

- **Institute more robust performance targets that are prospectively set, incentivize continuous quality improvement (that is, avoids cliff effects), and are not based on average plan performance.[50]**
    - **Ultimately, CMS should ensure that star ratings and bonus payments are afforded to MA plans along a normal distribution as is done in other CMS rating systems such as Nursing Home Compare.**
- **Assess plan performance and calculate a star rating score at the plan or market level rather than the contract level.[51]**
- **Seek legislative authority to incorporate financial penalties for subpar plan performance and ultimately make the QBP budget neutral.**

In addition to the recommendations above, the undersigned organizations offer abbreviated comments on several other key areas of CMS's proposal:

VII. Reducing Regulatory Burden and Costs in Accordance with Executive Order (E.O.) 14192

- *C. Rescind Mid-Year Supplemental Benefits Notice (§§ 422.111(l) and 422.2267(e)(42)):* **We oppose CMS's proposal to rescind the requirement that plans notify enrollees of unused supplemental benefits at the mid-year mark.** CMS themselves stated when finalizing the requirement in the CY 2025 MA and Part D rule that "the underutilization [of supplemental benefits] may be due to a lack of effort by the plan to help the beneficiary access the benefits or a lack of easy ability to know what benefits have not been accessed and are still available."[52] And in 2025, a poll of MA beneficiaries reported that 80% would like to receive notifications about unused benefits.[53] With so many eligible beneficiaries choosing plans based on supplemental benefits, and MA plans receiving approximately $86 billion in rebates in 2025 (that predominately fund such supplemental benefits), ensuring that enrollees utilize those benefits is important for their care and to ensure responsible spending for the federal government.[54]
- *E. Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137(c)(5), (d)(6) and (d)(7)):* **We oppose CMS's proposal to remove the requirement that at least one member of the Utilization Management (UM) Committee have an expertise in health equity, that the UM Committee conduct an annual analysis of health equity and prior authorization, and that the resulting analysis be publicly posted on plan's websites.** The UM Committee is responsible for reviewing the utilization management policies of MA plans and ensuring that they are consistent with Traditional Medicare coverage requirements. It is important to maintain and strengthen these requirements given MA plans' pattern of engaging in aggressive care denials, which particularly harms beneficiaries with complex care needs and other social risk factors.[55] In order to ensure that MA plans are meeting coverage requirements, this analysis needs to be done and there must be transparency for policymakers, researchers, and the public.

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes), Section E. Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements (§§ 422.2267 and 423.2267)

- **We oppose CMS's proposal to remove references to State Health Insurance Assistance Programs (SHIPs) from the standard language that TPMOs are required to use when speaking with potential enrollees.** SHIPs provide objective, free, one-on-one assistance to Medicare beneficiaries, their families, and caregivers and the SHIP network is a trusted resources with proven success.[56] Aggressive TPMO marketing adds to beneficiary confusion about their choices within the MA plan landscape but SHIP counselors, unlike agents and brokers, are not compensated by insurers and their independence allows them to offer full beneficiary-centered assistance.[57] Removing reference to SHIPs from the TPMO standard language would create unnecessary hardships for beneficiaries and the undersigned organizations encourage CMS to retain and strengthen the current language.

IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes), Section F. Removing Rules on Time and Manner of Beneficiary Outreach (§§ 422.2264, 423.2264, 422.2274, and 423.2274)

- **We oppose CMS's proposal to remove several requirements related to oversight of marketing to eligible MA beneficiaries and beneficiary protections from abusive marketing behaviors, including: removal of the 12-hour delay requirements limiting how soon after educational events a marketing event can take place; eliminating the 48-hour waiting period between a Scope-of-Appointment (SOA) completion and a personal marketing appointment, in addition to clarifying some SOA policies and practices; and rescinding limitations on when plans can collect beneficiary information.** There is longstanding evidence that MA insurers use deceptive and misleading tactics to persuade seniors to enroll in an MA plan instead of Traditional Medicare.[58] In some cases, MA insurers or their agents make completely false or misleading statements when they market MA plans, including about which doctors are in or out of network.[59] When enrollees go to use their coverage down the line, they often find the benefits a plan promised to cover differ from what is actually available. The undersigned organizations encourage CMS to prioritize protecting beneficiaries from abusive marketing practices over the interests of marketing and brokerage firms or MA plans.

Conclusion

We appreciate the opportunity to respond to proposed changes to the Medicare Advantage and Medicare Part D programs for CY 2027. For questions or comments, please reach out to Hazel Law, Policy Analyst at Families USA (hlaw@familiesusa.org).

Sincerely,
Families USA
Medicare Rights Center
Center for Medicare Advocacy
Legal Action Center
Colorado Consumer Health Initiative
National Association of Social Workers (NASW)

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[1] Robert Gilfillan and Don Berwick, "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game," Health Affairs, September 2021. https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game; See also, OIG, "Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments" OEI-03-17-00474, HHS, September 2021. https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.asp; MedPAC, "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, "Chapter 12, MedPAC, Report to Congress: Medicare Advantage program: Status Report," March 2024. https://www.medpac.gov/wpcontent/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf; OIG, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. OEI-09-18-00260," HHS, April 2024. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf; Jeannie Fuglesten Biniek, Nolan Sroczynski, Meredith Freed, and Tricia Neuman, "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023," KFF, January 2025, https://www.kff.org/medicare/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.

[2] Ibid; See also, 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 2023. https://www.medpac.gov/document/medpac-comment-on-cmss-advance-notice-of-methodological-changes-for-cy-2024-for-medicare-advantage-capitation-rates-and-part-c-and-d-payment-policies/; See also, Tricia Neuman, Juliette Cubanski, and Meredith Freed, "Monthly Part B Premiums and Annual Percentage Increases," KFF, January 2022. https://www.kff.org/medicare/monthly-part-b-premiums-and-annual-percentage-increases/; CMS, "Medicare Savings Programs," https://www.medicare.gov/basics/costs/help/medicare-savings-programs; MedPAC, "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, "January 2024 Public Meeting Transcript, Page 265," January 2024. https://www.medpac.gov/document/january-2024-meeting-transcript/

[3] Ibid.

[4] Juliette Cubanski, Anthony Damico, "Key Facts About Medicare Part D Enrollment, Premiums, and Cost Sharing in 2024," KFF, July 2024. https://www.kff.org/medicare/issuebrief/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2024/

[5] 42 CFR 422, Subpart X, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-X

[6] Richard G. Frank and Conrad Milhaupt, "Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation," Brookings, March 24, 2023, https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/; Rooke-Ley, Medicare Advantage and Vertical Consolidation;

[7] Ibid.

[8] Ibid; See also, Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Health Care," American Economic Liberties Project, April 2024. https://www.economicliberties.us/our-work/medicare-advantage-and-vertical-consolidation-in-health-care/; Richard G. Frank and Conrad Milhaupt, "Related Businesses and

Preservation of Medicare's Medical Loss Ratio Rules," Brookings, June 2023. https://www.brookings.edu/articles/related-businesses-and-preservation-of-medicares-medical-loss-ratio-rules/.

[9] Richard Gilfillan and Donald M. Berwick, "Medicare Advantage, Direct Contracting, and the Medicare 'Money Machine,'Part 1: The Risk-Score Game," Health Affairs Forefront (blog), September 2021. https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game; See also, Tara Bannow et al., "Health Care's Colossus: Inside UnitedHealth's Strategy to Pressure Physicians: $10,000 Bonuses and a Doctor Leaderboard," STAT, October 2024. https://www.statnews.com/2024/10/16/united-health-optum-care-medicare-advantage-strategy-dashboard-emails-documents/.

[10] Ibid.

[11] January Angeles and Michael Bailit, "How Insurers That Own Providers Can Game The Medical Loss Ratio Rules," Health Affairs, September 2025, https://www.healthaffairs.org/content/forefront/insurers-own-providers-can-game-medical-loss-ratio-rules

[12] Ibid.

[13] 9 FR 99340, https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare

[14] Center for Advancing Health Policy Through Research "Comments on the Request for Information (RFI) seeking input on Medicare Advantage Data (CMS-4207-NC)," Brown University School of Public Health, March 24, 2024, https://cahpr.sph.brown.edu/sites/default/files/documents/Brown_CAHPR_CMS_MA_Data_RFI.pdf; See also, Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Health Care," American Economic Liberties Project, April 2024, https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-AdvantageAELP.pdf; Richard G. Frank and Conrad Milhaupt, "Related businesses and preservation of Medicare's Medical Loss Ration rules," The Brookings Institution, June 29, 2023, https://www.brookings.edu/articles/related-businessesand-preservation-of-medicares-medical-loss-ratio-rules/

[15] Center for Advancing Health Policy Through Research "Comments on the Request for Information (RFI) seeking input on Medicare Advantage Data (CMS-4207-NC)," Brown University School of Public Health, March 24, 2024, https://cahpr.sph.brown.edu/sites/default/files/documents/Brown_CAHPR_CMS_MA_Data_RFI.pdf; See also, Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Health Care," American Economic Liberties Project, April 2024, https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-AdvantageAELP.pdf; Richard G. Frank and Conrad Milhaupt, "Related businesses and preservation of Medicare's Medical Loss Ration rules," The Brookings Institution, June 29, 2023, https://www.brookings.edu/articles/related-businessesand-preservation-of-medicares-medical-loss-ratio-rules/

[16] These measures include the following: Plan Makes Timely Decisions about Appeals; Reviewing Appeals Decisions; Special Needs Plan (SNP) Care Management; Call Center – Foreign Language Interpreter and TTY Availability; Call Center – Foreign Language Interpreter and TTY Availability; Complaints about the Health/Drug Plan; Medicare Plan Finder Price Accuracy; Diabetes Care – Eye Exam; Statin Therapy for Patients with Cardiovascular Disease; Members Choosing to Leave the Plan; Customer Service; Rating of Health Care Quality.

[17] Laura Skopec and Robert Berenson, "The Medicare Advantage Quality Bonus Program," Urban Institute, June 2023. https://www.urban.org/sites/default/files/2023-06/The%20Medicare%20Advantage%20Quality%20Bonus%20Program.pdf; See also, MedPAC, "Chapter 3: Replacing the Medicare Advantage quality bonus program," June 2020. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf ; David Meyers, Amal Trivedi, and Andrew Ryan, "Flaws in the Medicare Advantage Star Ratings," JAMA Health Forum, January 2025. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2829436

[18] Ibid.

[19] Ibid.

[20] CMS, "Medicare 2026 Part C & D Star Ratings Technical Notes," Updated November 2025. https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf.

[21] CMS, "Medicare 2026 Part C & D Star Ratings Technical Notes," Updated November 2025. https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf.

[22] The "Rating of Health Care Quality" measure relies on a survey question asking MA enrollees to rate the quality of the health care quality received under their MA plan; the "Costumer Service" measure relies on multiple survey questions asking MA enrollees how easy it is to get information and administrative help from their MA plan; and

the “Members Choosing to Leave the Plan” measure uses administrative enrollment data to calculate the percent of members who chose to leave their MA plan.

[23] ”2023 Medicare Advantage and Part D Star Ratings,” CMS Newsroom, October 2022. https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings; See also, CMS, ”Fact Sheet: 2026 Medicare Advantage and Part D Star Ratings,” HHS, November 2025. https://www.cms.gov/files/document/2026-star-ratings-fact-sheet.pdf

[24] Ibid.

[25] CMS, ”Medicare 2026 Part C & D Star Ratings Technical Notes,” Updated November 2025. https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf

[26] David Meyers, Andrew Ryan, and Amal Trivedi, ”Trends in Cumulative Disenrollment in the Medicare Advantage Program, 2011-2020,” JAMA Health Forum, August 2023, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808747.

[27] David Meyers, Andrew Ryan, and Amal Trivedi, “Trends in Cumulative Disenrollment in the Medicare Advantage Program, 2011-2020,” Jama, August 2023, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808747**.**

[28] Ibid.

[29] Ibid.

[30] Marc Ryan, ”The Health Equity Index- What is it, what should you do about it and will it last?,” Lilac Software, March 2025. https://lilacsoftware.com/the-health-equity-index-what-is-it-what-should-you-do-about-it-and-will-it-last/

[31] The HEI applies to enrollees with certain social risk factors (SRFs) -- including those eligible for certain low income subsidies, dually eligible for Medicare and Medicaid, and/or have a disability. Moreover, the HEI bonus factor only applies to MA insurers who enroll a relatively high proportion of enrollees with SRFs.

[32] MedPAC, ”Chapter 3: Replacing the Medicare Advantage quality bonus program,” June 2020. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf

[33] Sanne Magnan, « Social Determinants of Health 101 for Health Care: Five Plus Five,” National Academy of Medicine, October 2017, https://nam.edu/perspectives/social-determinants-of-health-101-for-health-care-five-plus-five/

[34] Ibid; See also, Richard Gilfillan and Donald Berwick, ”Medicare Advantage, Direct Contracting, And The Medicare ’Money Machine,’ Part 1: The Risk-Score Game,” Health Affairs, September 2021. https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game

[35] MedPAC, ”Chapter 11: The Medicare Advantage program: Status Report,” March 2025, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

[36] MedPAC, ”Chapter 11: The Medicare Advantage program: Status Report,” March 2025, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf ; See also, OIG, ”Medicare Advantage: Questionable Use of Health Risk Assessments continues To Drive Up Payments to Plans by Billions,” HHS, October 2024, https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf

[37] Sec. 1853. [42 U.S.C 1395w-23] (a). https://www.ssa.gov/OP_Home/ssact/title18/1853.htm

[38] MedPAC, ”Chapter 11: The Medicare Advantage program: Status Report,” March 2025, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf ; See also, OIG, ”Medicare Advantgae: Questionable Use of Health Risk Assessments continues To Drive Up Payments to Plans by Billions,” HHS, October 2024, https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf

[39] MedPAC, “Chapter 12: Report to the Congress: Medicare Payment Policy,” March 2016

[40] Mark McClellan, Sara Debab, Frank McStay, et al, “Modernizing Medicare Risk Adjustment and Performance Measurement: Moving Beyond Fee-For-Service for Payment Accuracy, Care Improvement, and Burden Reduction,” Duke Margolis Institute for Health Policy, February 2024, https://healthpolicy.duke.edu/sites/default/files/2024-03/Modernizing_Medicare_Risk_Adjustment_and_Performance_Measurement.pdf

[41] Erin Fuse Brown, Travis C. Williams, Roslyn Murray, et al, "Legislative and Regulatory Strategies for Revitalizing Medicare Advantage," Center for Advancing Health Policy Through Research Brown University School of Public Health, https://cahpr.sph.brown.edu/sites/default/files/documents/Policy_Options_MA.pdf
[42] Adele Shartzer, Avani Pugazhendhi, and Bowen Garrett, "Quality Bonus Payments in Medicare Advantage," Urban Institute, July 2024, https://www.urban.org/sites/default/files/2024-07/Quality%20Bonus%20Payments%20in%20Medicare%20Advantage.pdf
[43] Ibid.
[44] Berenson, Garrett, and Shartzer, Understanding Medicare Advantage Payment; See also, Skopec and Berenson, The Medicare Advantage Quality Bonus Program; Fuse Brown et al., "Legislative and Regulatory Options"
[45] Adele Shartzer, Avani Pugazhendhi, and Bowen Garrett, "Quality Bonus Payments in Medicare Advantage," Urban Institute, July 2024, https://www.urban.org/sites/default/files/2024-07/Quality%20Bonus%20Payments%20in%20Medicare%20Advantage.pd
[46] CMS, "Medicare 2026 Part C & D Star Ratings Technical Notes," CMS, updated November 2025, https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf; See also, Adele Shartzer, Avani Pugazhendhi, and Bowen Garrett, "Quality Bonus Payments in Medicare Advantage," Urban Institute, July 2024, https://www.urban.org/sites/default/files/2024-07/Quality%20Bonus%20Payments%20in%20Medicare%20Advantage.pdf
[47] Adele Shartzer, Avani Pugazhendhi, and Bowen Garrett, "Quality Bonus Payments in Medicare Advantage," Urban Institute, July 2024, https://www.urban.org/sites/default/files/2024-07/Quality%20Bonus%20Payments%20in%20Medicare%20Advantage.pdf **;** See also, Erin Fuse Brown, Travis C. Williams, Roslyn Murray, et al, "Legislative and Regulatory Strategies for Revitalizing Medicare Advantage," Center for Advancing Health Policy Through Research Brown University School of Public Health, https://cahpr.sph.brown.edu/sites/default/files/documents/Policy_Options_MA.pdf
[48] MedPAC, "Chapeter 11: The Medicare Advantage Program: Status Report," March 2025, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf
[49] Adele Shartzer, Avani Pugazhendhi, and Bowen Garrett, "Quality Bonus Payments in Medicare Advantage," Urban Institute, July 2024, https://www.urban.org/sites/default/files/2024-07/Quality%20Bonus%20Payments%20in%20Medicare%20Advantage.pdf ; See also, Erin Fuse Brown, Travis C. Williams, Roslyn Murray, et al, "Legislative and Regulatory Strategies for Revitalizing Medicare Advantage," Center for Advancing Health Policy Through Research Brown University School of Public Health, https://cahpr.sph.brown.edu/sites/default/files/documents/Policy_Options_MA.pdf ; MedPAC, "Chapeter 11: The Medicare Advantage Program: Status Report," March 2025, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf
;Robert Berenson and Laura Skopec, "The Medicare Advantage Quality Bonus Program," Urban Institute, March 2024.
[50] Ibid.
[51] MedPAC, "Chapter 3: Replacing the Medicare Advantage quality bonus program," June 2020. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf
[52] CMS, Final Rule, 89 Federal Register 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.
[53] Avni Gupta, Gretchen Jacobson, and Faith Leonard, "Could Notifications Help Medicare Advantage Beneficiaries Utilize Their Unused Benefits?," The Commonwealth Fund, October 2025, https://www.commonwealthfund.org/blog/2025/could-notifications-help-medicare-advantage-beneficiaries-utilize-their-unused-benefits
[54] MedPAC, "Chapter 2: Supplemental benefits in Medicare Advantage," June 2025, https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch2_MedPAC_Report_To_Congress_SEC.pdf; See also, Faith Leonard, Gretchen Jacobson, Lauren Haynes, and Sara Collins, "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why," the Commonwealth Fund, October 2022, https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose

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

[56] Administration for Community Living, "Justification of Estimates for Appropriations Committees," HHS, March 2024, https://acl.gov/sites/default/files/about-acl/2024-03/FY2025ACL-CJ-508.docx

[57] Andrea Callow and Cristina Boccuti, "The State health Insurance Assistance Program (SHIP): Trusted Medicare Assistance and Education," AARP, December 2025, https://www.aarp.org/content/dam/aarp/ppi/topics/health/coverage-access/state-health-insurance-assistance-program-ship-trusted-medicare-assistance-education.doi.10.26419-2fppi.00390.001.pdf

[58] Faith Leonard, Gretchen Jacobson, Lauren Haynes, and Sara Collins, "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why," The Commonwealth Fund, October 2022, https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose; See also, 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

[59] Ibid.