Testimony of Sachin H. Jain, MD, MBA
President & CEO, SCAN Group
Before the House Ways and Means Committee
Hearing on the Past, Present, and Future of the Medicare Advantage Program
July 22, 2025

Introduction

Chairman Buchanan, Chairman Schweikert, Ranking Member Doggett, Ranking Member Sewell, and distinguished members of the subcommittees:

Thank you for the opportunity to testify before you today on the past, present, and future of the Medicare Advantage program. It is a subject that goes far beyond reimbursement formulas and regulatory frameworks. It is a subject about values: about how we care for older adults, how we direct public resources, and how we structure a healthcare system that meets the needs of the people who rely on it.

I offer this testimony not only as the President and CEO of SCAN Group, one of the nation's largest nonprofit, mission-driven Medicare Advantage organizations, but as a physician, a former policymaker, and the son of a proud Medicare beneficiary.

SCAN has one of the most compelling origin stories in health care. In 1977, a group of older adults – known as the "Twelve Angry Seniors" – banded together out of frustration with a fragmented system that failed to meet their needs. They founded the Senior Care Action Network, or SCAN, to help older adults age safely and independently in their communities.

Today, SCAN is one of the nation's largest mission-driven, not-for-profit, MA organizations. Our plans serve over 300,000 beneficiaries across California, Arizona, Nevada, New Mexico, and Texas. We specialize in caring for frail and vulnerable older adults, and we offer a range of special needs plans (SNPs).

Among those plans is California's only fully integrated dual-eligible SNP, through which SCAN covers thousands of people who are dually enrolled in Medicare and Medicaid, two programs that must complement each other. As recent changes to Medicaid unfold, it is important that we ensure beneficiaries in those programs can access the care they need at an affordable cost. A successful health care system relies on all payers working together to deliver high-quality, affordable care to patients.

Unlike many of the largest players in Medicare Advantage, SCAN operates as a not-for-profit, mission-driven organization. This distinction matters. While much of the public discourse tends to treat all MA plans as interchangeable, our structure and values set us apart. As a regional, community-based plan, we prioritize the long-term well-being of our members over short-term financial returns. We are careful stewards of federal resources, directing CMS payments toward high-value benefits for our members and fair, sustainable compensation for our providers. Our commitment to quality and equity is reflected in our performance: SCAN has earned a 4.5-Star rating in seven of the last twelve years, making us the only MA plan in California to demonstrate this level of consistency.

This hearing's framework – past, present, and future – is not only fitting, it is essential. For Medicare Advantage to live up to its original promise, we must take an honest look at what has

worked, where we have gone astray, and how we can restore the delicate balance between cost and quality.

Traditional Medicare: A Foundation That Requires Strengthening

In 1965, President Lyndon B. Johnson signed Medicare into law, with President Harry S. Truman – one of the program's earliest and most passionate advocates – standing by his side. At the signing, President Johnson declared, "No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years." These words captured the moral clarity and urgency that gave rise to Medicare. Since its enactment in 1965, Medicare has stood as one of the great moral achievements of American democracy. It has transformed the lives of older adults and people with disabilities, lifting millions out of poverty and ensuring that aging does not mean abandonment. It is the very definition of a safety net.

Yet traditional Fee-for-Service (FFS) Medicare, while indispensable, now struggles to meet the needs of 21st-century seniors.

1. High Out-of-Pocket Costs.

Despite paying into the system for decades, beneficiaries can face tens of thousands of dollars in annual expenses. Medicare Part A has a deductible over $1,600, and Part B charges 20% coinsurance for most services, with no cap. The cost of Part B, D, and supplemental policies can reach $1000/month for a senior household with an average annual income of $51,400. For the average household living on a fixed income, this creates unacceptable financial exposure.

2. Limited Emphasis on Prevention.

The FFS model pays for transactions, not health. Providers are reimbursed for doing more—not for improving health or preventing illness. While preventive benefits have expanded over time, they are often underutilized and poorly integrated into care delivery.

3. Incomplete Coverage.

Vision, hearing, and dental care remain outside Medicare's standard benefits. These are not luxuries; they are necessities. Moreover, FFS Medicare offers little flexibility to address non-medical drivers of health: transportation, nutrition, home support, or social connection. These omissions leave too many older adults struggling with basic daily needs that directly impact their health.

4. Fragmentation of Care.

FFS Medicare beneficiaries often receive care across multiple, uncoordinated providers. Transitions between hospital, primary care, specialists, and post-acute settings are disjointed. There is no single entity accountable for outcomes or costs.

None of these critiques should be read as an argument against traditional Medicare. Rather, they are an appeal to strengthen its core through innovation and alternative models—of which Medicare Advantage is the most prominent.

Medicare Advantage: The Original Vision

Medicare Advantage was born from a simple, compelling idea: that the private sector, properly incentivized, could deliver Medicare-covered benefits more efficiently than the federal government. The savings from that efficiency could then be shared across three groups:

1) Beneficiaries, in the form of enhanced benefits and lower out-of-pocket costs;

2) CMS, in the form of reduced federal spending;

3) Health Plans, in the form of a fair, sustainable margin.

In the program's early years, that promise largely held. CMS paid MA plans approximately 95% of the expected cost of providing care in FFS Medicare. Plans managed care through provider networks and utilization controls. Beneficiaries received modest supplemental benefits, chiefly reduced cost-sharing and limited dental or vision services. The federal government saved money, many seniors had an alternative to original Medicare, and plans operated in a competitive environment. But as the program evolved, so did its complexity—and with it, a growing set of distortions that have strayed from the program's founding logic.

Risk Adjustment: From Equity to Competitive Advantage

Originally, MA payments varied only by age and gender—an approach that created incentives to avoid high-risk enrollees. To correct this, CMS introduced a risk adjustment model that pays plans more for sicker beneficiaries.

This was a critical step toward fairness in MA payment methodology to avoid adverse selection, in which plans "cherry-picked" the healthiest beneficiaries. In practice, it created an opportunity for plans to seek a competitive advantage over other health plans through better coding. More revenue allows for more member benefits over and above Medicare, which drives membership growth.

Star Ratings: Moving Away from Distinguishing True High Performance

CMS introduced the Star Ratings system to reward high-performing plans with bonus payments. Initially, this encouraged genuine quality improvement. Over time, however, the system's rigidity and incentive structure invited manipulation.

Some plans discovered that consolidating contracts could improve Star Ratings for underperforming entities through consolidation with other higher performing entities. Plans also began to "teach to the test," or focus on improving measures that sometimes have little value, as opposed to attempting to genuinely improve quality for patients. The ratings methodologies became robust over time. For example, as in the case of SCAN, a single outlier performance metric could cause a plan's rating to fall below 4 stars, leading to massive financial penalties—even when overall quality remained strong.

The system grew increasingly gameable and divorced from real patient outcomes. In response, CMS has introduced reforms, but the need for a more rational, outcome-driven framework

remains. The year-to-year volatility of star ratings related to minor changes in insignificant measures results in excessive fluctuations in payments to plans, and thus, benefits to beneficiaries.

The Present: Progress, Popularity—and Peril

Today, Medicare Advantage serves over 30 million Americans—more than 55% of all Medicare beneficiaries. It is especially popular among low-income individuals and communities of color.

This is not accidental. MA plans offer:

- Out-of-pocket caps not found in FFS;
- Integrated Part D prescription drug coverage;
- Zero-premium options in most markets;
- Expanded supplemental benefits: transportation, OTC drugs, post-discharge meals, home modifications, and digital health tools;
- More coordinated care models, often built around primary care.

These benefits matter. They are real. They change lives.

But this expansion has come at a cost. CMS now pays MA plans, on average per beneficiary, significantly more than it did at the program's inception.

The driver of this spending increase is not just upcoding or Star Ratings. It is also the expanding benefit design arms race. Plans compete for market share by adding supplemental offerings, some of which are high-value, others of which are underutilized or more marketing than medicine.

Meanwhile, administrative complexity grows. Members must navigate narrow networks, shifting formularies, and confusing plan designs. Providers contend with prior authorization hurdles. And CMS struggles to contain cost while maintaining the program's broad appeal.

The Future: Opportunities to Improve

We do not need to abandon Medicare Advantage. We need to reground it. We need to recover the program's founding promise: coordinated, high-quality care that delivers value to beneficiaries and taxpayers alike. If Medicare Advantage is to fulfill its promise for future generations, we must face ten structural problems that limit its potential.

1. Risk Adjustment Gaming

Today's system rewards detailed coding, not necessarily better care. Risk adjustment should reflect actual complexity, not aggressive documentation practices. Risk adjustment models should incorporate pharmacy, functional, and social data, and include guardrails against unstainable coding growth. Artificial intelligence and large language models have the potential to increase the accuracy of risk adjustment models and decrease provider burden.

2. Star Ratings Misalignment

The CMS Star Ratings system was designed to help beneficiaries make informed choices about their Medicare Advantage plans. By evaluating plans on a range of quality and performance measures, the system aims to reward those that deliver high-value care and penalize those that fall short. In theory, this is a sound approach. In practice, however, the current structure of the Star Ratings program is in urgent need of reform. Star Ratings, originally designed to reward quality, now often penalize plans due to single-metric volatility or statistical anomalies. Star ratings should reflect consistent, incremental progress and provide greater emphasis on beneficiary experience and patient reported outcomes. There must be protection for plans and beneficiaries against ratings cliffs, and plans should be rated and rewarded on a continuum.

3. Unsustainable Supplemental Benefits

Some benefits are impactful. Others are misunderstood, underutilized, or designed more for marketing than impact. With rationalization of risk adjustment and payments to plans that is more aligned to current Fee-For-Service payments levels, many benefits offered today will be financially unsustainable in the future. Benefit standardization and simplification – not unlike that which exists in Medicare Supplemental policies offered under traditional Medicare – could help force plans to compete on quality rather than benefit difference. With greater transparency on benefit utilization rates, Medicare Advantage beneficiaries will have the opportunity to better understand their own real access to benefits. However, in the quest to simplify, we must be careful not to stifle innovation.

4. Utilization Management Barriers

Prior authorization, while intended to curb low-value care, too often delays high-value, necessary treatments, especially for the most vulnerable. The industry would benefit richly from transparent, auditable, national, evidence-based standards for utilization management; "gold carding" for trusted providers; and consumer transparency in denial and delay metrics.

5. Fragmented Provider Accountability

Delegated, capitated models are popular in some regions of the country and align incentives toward whole-person care; they take utilization decisions away from plans and place them in the hands of the provider groups that deliver care. Yet such models are rare nationally. The program could be improved by delivering infrastructure support for emerging value-based groups to take full-risk for the health of defined populations of patients; risk corridors and technical assistance; and national policies that reward accountable care.

6. Short-Term Churn Undermining Long-Term Investment

Annual enrollee churn discourages long-term investment in prevention, behavioral health, and social care. True value-based care cannot be delivered in one-year increments as plans cannot rely on the stability of the beneficiary population; as a result, plans often don't make investments in health in year one of a patient's enrollment in a plan that would lead to health benefits in years three and four. Multi-year voluntary enrollment models for high-need individuals could help increase investments in prevention and better reward patient outcomes.

7. Medicare Advantage Distribution

Roughly one-third of Medicare beneficiaries rely on brokers to help them choose a health plan. When we discuss brokers, the health care system often misunderstands their role. Brokers are not merely salespeople. The best among them are deeply knowledgeable about the health care system and skilled at influencing behavior change. They help beneficiaries navigate complex coverage options, schedule appointments, connect with nutritious food resources, and even lead community workshops on topics like drug costs and palliative care. Broker commissions (as high as $780 for the first year) and renewals (as high as $390 for each subsequent year) are not tied to brokers assisting members with basic health needs. We favor a model where broker renewals are aligned to helping support member health through primary care, specialty, and supplemental benefit navigation and health promotion.

8. Medicare and Medicaid Integration

D-SNPs were authorized by Congress to help beneficiaries – many of whom have complex needs – navigate the Medicare and Medicaid programs. For almost two decades, SCAN has been California's only health plan to integrate low-income seniors' Medicare and Medicaid benefits under the Fully Integrated Dual Eligible SNP (FIDE SNP) model. Unfortunately, despite the advantages that FIDE SNPs provide, they remain an underutilized tool. It is in the interest of our most vulnerable community members to make more integrated D-SNP plan choices available to them.

9. Provider Data Accuracy

Another area in which the relationship between beneficiaries, providers, and plans struggles is when beneficiaries look to provider directories to find care. These directories are often inaccurate, largely because the process of updating them is remarkably complicated. To update information in a provider directory, MA organizations (MAOs) engage in a process best described as "call and chase." After an MAO becomes aware of an inaccuracy in a provider directory, the MAO chases confirmation through phone calls, emails, and even Google Street View searches. These administrative processes impose significant burdens and costs on both MAOs and providers. This inefficiency not only strains provider capacity but also detracts from time that could be spent delivering care.

10. The Principal: Agent Problem

Plans would be better if their executives had to use the plans themselves. Because most executives are not-Medicare eligible, they can't enroll in their own companies' plans. Every executive leading a Medicare Advantage organization should be required to enroll in their own plan. If we expect beneficiaries to trust these plans with their health and financial security, then those of us who lead them should be willing and compelled to do the same.

Conclusion: Reclaiming the Promise

Medicare Advantage reflects one of the most ambitious experiments in American healthcare policy: a public-private partnership with the goal of delivering more for less.

It has achieved much. It has made healthcare more accessible, more coordinated, and more personalized for millions of Americans. But it has also grown unwieldy, costly, and at times more focused on optimizing revenue than improving outcomes.

Reform is not a rejection of MA. It is a reaffirmation of its purpose.

Let us work together to:

- Restore balance between stakeholders;
- Elevate transparency and accountability;
- Reinforce the moral compact that brought Medicare into being.

We owe it to the generations who built this country and to those who will shape its future.

Thank you for the opportunity to testify. I welcome your questions and your continued partnership.