Testimony of Brian J. Miller, M.D., M.B.A., M.P.H.

Associate Professor of Medicine and Business (Courtesy),
Johns Hopkins University

Nonresident Fellow,
American Enterprise Institute

Before the

U.S. House Committee on Ways & Means
Subcommittees on Health and Oversight

On

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

July 22, 2025

Chairman Buchanan, Chairman Schweikert, Ranking Member Doggett, Ranking Member Sewell and distinguished members of the Subcommittees on Health and Oversight.

My name is Brian Miller, and I practice hospital medicine at the Johns Hopkins Hospital. As an academic health policy analyst, I serve as an Associate Professor of Medicine and Business (Courtesy) at Johns Hopkins University and as a Nonresident Fellow at the American Enterprise Institute. My research focuses on how we can build a more competitive and vibrant health sector to make healthcare more efficient, flexible, and personalized for patients. This perspective is based upon my prior regulatory experience at four federal regulatory agencies. Through my current role as a faculty member, I regularly engage with regulators, policymakers, and businesses in search of solutions to help create a better healthcare system for all. Today I am here in my personal capacity, and the views expressed are my own and do not necessarily reflect those of the Johns Hopkins University or the Johns Hopkins Health System, the American Enterprise Institute, the North Carolina State Health Plan, or the Medicare Payment Advisory Commission.

The Medicare program represents a sacred promise to Americans dating back to 1965 and the administration of President Johnson. Today over 68 million Americans are enrolled in Medicare with the program costing over an estimated $800 billion annually. Recognizing the positive potential of innovation, over 40 years ago Congress and President Reagan passed and signed the Tax Equity and Fiscal Responsibility Act (TEFRA) into law in 1982, representing the initial policy chassis for today's Medicare Advantage (MA) program, a product of continued legislative and policy innovation. Today roughly half of Americans are enrolled in Medicare Advantage and half in Fee For Service (FFS) Medicare.

With the federal government facing increasing financial pressures from entitlement spending counterbalanced by Medicare's critical role as a safety net program for elderly and disabled Americans, getting Medicare policy right is critical. In my testimony today I will focus on three areas of challenges and opportunities for improvement in the MA program that would simultaneously improve FFS Medicare:

1. Improvements for taxpayers
2. Improvements for beneficiaries
3. Improvements for providers (i.e. doctors, hospitals, etc.)

1. Improvements for taxpayers

The debate around the cost of the two formulations of Medicare health benefits is an important policy question. Policymakers and analysts need to take a holistic view of Medicare to compare programmatic spending.[1] In this sense, the three salient comparison to evaluate are:

[1] Miller BJ, Parente ST, Wilensky GR. Comparing spending across Medicare programs. *Am J Manag Care*. 2022;28(12):635–637. doi:10.37765/ajmc.2022.89213

1. Comparing the per component costs for A/B benefits, Medigap or Medicare supplemental coverage, and Part D prescription drug coverage along with the actuarial value of supplemental benefits from the perspective of the taxpayer and the beneficiary
2. Comparing the total cost to society for a holistic health benefits package for seniors, recognizing that some components are privately or publicly financed depending upon the beneficiary (e.g. Supplemental coverage can come from Medicaid, TRICARE, or a Medigap plan, etc.)
3. Comparing statutory program spending across FFS Medicare and MA

Unfortunately, traditional comparisons of program expenditure frequently ignore the differential benefits package across the two programs. Fundamentally, Medicare Advantage includes Part A and B benefits in additional to Medicare supplemental coverage (through the provision of a maximum out of pocket cap or MOOP, reduced A/B cost sharing, Part B premium reduction), Part D prescription drug coverage (frequently with a bonus over the counter drug benefit), and a range of other supplemental benefits at no additional cost for 75% of beneficiaries beyond their monthly part B premium.[2] For the beneficiary, this fundamental tradeoff exists in return for accepting a provider network and utilization review, features that reduce programmatic costs and are present through the ACA Exchanges, Employer-Sponsored Insurance, Medicaid, and virtually all other insurance markets.

Feature/Benefit	FFS Medicare	MA
Network	Any Willing Provider	Private Plans Design Network
Utilization review	Minimal	Yes
Part A (Hospital/SNF care)	Included	Included
Part B (Physician care)	Included	Included
Supplemental Coverage (MOOP)*	Purchase separate *Medigap* coverage	Included
Part D coverage	Purchase separate rx coverage	Included
Other (Vision, dental, etc.)	Not available	Included

Figure 1: Medicare benefit packages. *MOOP = annual maximum out of pocket expenditure

Historical comparisons of programmatic expenditures remain incomplete as they fail to consider the three primary comparisons mentioned above. Recent governmental estimates comparing FFS Medicare to MA program expenditures[3] require methodological improvements along with stress testing for internal and external validity while both governmental and industry[4,5] estimates remain incomplete.

Two primary analytical issues arise when comparing programs: coding intensity and favorable selection. Analysts, journalists, and others including the Medicare Payment Advisory Commission[6] (MedPAC) have long noted the challenges of coding intensity. FFS Medicare pays *providers* and lacks incentive for accurate and complete coding of diagnosis and disease intensity, as ambulatory care services (or Evaluation & Management i.e. "E/M" services) are reimbursed based upon time spent or medical decision-making complexity resulting in relative value units converted[7] to dollars while hospitalizations are paid based upon diagnosis-related groups with a primary and secondary diagnoses.[8] In FFS, providers are not incentivized to capture all diagnoses, with a single study examining a narrow timespan and a handful of diagnosis codes noting that FFS undercoding accounts for one-fifth of the FFS Medicare/MA risk score gap.[9]

---

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

[3] Medicare Payment Advisory Commission. *Chapter 11: The Medicare Advantage Program: Status Report. In: Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy.* March 13, 2025. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf

[4] Seiguer E, Loudermilk J, Seiguer H. *Reviewing Methodological Issues in MedPAC's Analysis of Medicare Advantage Coding Intensity*. FTI Consulting. February 2025. https://www.fticonsulting.com/-/media/files/insights/white-papers/2025/feb/reviewing-methodological-issues-medpac-analysis.pdf

[5] Heinrich A, Smetek S, Swanson B. *Value of Medicare Advantage to the Federal Government*. Milliman. April 29, 2024. https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2024-Articles/4-29-24_Value-of-MA-to-the-federal-government.pdf

[6] Medicare Payment Advisory Commission. *Chapter 4: Issues for Risk Adjustment in Medicare Advantage. In: Report to the Congress: Medicare and the Health Care Delivery System*. June 15, 2012. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/june-2012-report-chapter-4-issues-for-risk-adjustment-in-medicare-advantage.pdf

[7] Medicare Payment Advisory Commission. *Payment Basics: Physician and Other Health Professional Payment System*. Revised October 2023. https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf

[8] Medicare Payment Advisory Commission. *Payment Basics: Hospital Acute Inpatient Services Payment System*. Revised October 2023. https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_hospital_FINAL_SEC.pdf

[9] Ghoshal-Datta N, Chernew ME, McWilliams JM. Lack of persistent coding in traditional Medicare may widen the risk-score gap with Medicare Advantage. *Health Aff (Millwood)*. 2024;43(12):1638–1646. doi:10.1377/hlthaff.2024.00169

In contrast in MA, *plans* are paid a risk-adjusted capitated amount, adjusted for health status thus creating an incentive for plans to more accurately and completely code disease prevalence, incidence, acuity, and complications. Coding differentials in MA likely arise from three phenomena: clinically appropriate coding intensity, diagnostic upcoding, and outright fraudulent coding. While the latter two represent areas for oversight and enforcement, the first component represents appropriate clinical communication. Recent MedPAC estimates comparing FFS Medicare and MA coding intensity do not account for nor measure FFS undercoding nor differentiate between the three components of coding intensity, instead *assuming* that all differential payment represents inappropriate payment.

To address differential coding in both FFS Medicare and MA, regulators should encourage and plans and providers should utilize AI-driven software to suggest appropriate and accurate diagnosis codes from charting, labs, and imaging.[10] This would address concerns about differential coding across programs, decrease documentation burdens on physicians, and also ensure appropriate clinical oversight of coding. Automation could be deployed in other arenas such as time-based billing to support evaluation & management services. The current practice on the part of both health plans and hospitals to use physicians and other clinicians as secretaries is a fundamental and profound misuse of the profession and with the deployment of technology will become unnecessary. Additionally, it is worth examining and considering a transition to an encounter-based risk adjustment system for MA, which would address many concerns regarding administratively-driven coding practices by large health plans.

Favorable selection – or the selection of healthier or lower cost beneficiaries who are multi-morbid – remains a policy question when comparing FFS Medicare and MA program spending. Recent estimates ignore a series of regulator- and policymaker-driven reforms, including the Trump administration's improved operationalization of existing regulations,[11] the Biden administration's updated marketing guidelines,[12] and the requirement of regulator review of all plan marketing materials. Assertions of favorable selection[13] also fail tests of internal validity. The passage of the 21st Century Cures Act represents a natural experiment for testing the internal validity of favorable selection estimates, as it changed policy by permitting end stage renal disease (ESRD) beneficiaries to elect MA plans when previously they were only able to stay in MA if they were previously enrolled and subsequently developed renal failure. The MA penetration of the ESRD market (a population likely representing negative selection into MA)[14] rose from 27% in 2020 to 47% in 2022,[15] near the general MA market share of 51%, suggesting a favorable selection of 4% as opposed to a projected MedPAC favorable selection of 10%.[16] In light of years of appropriate aggressive policing of health plan marketing practices across administrations, policy analysts must also stress test estimates of favorable selection for external validity, validating models by connecting them to real-world business practices. Multiple policy options to address favorable selection exist and include studying the potential of the integration of hospice into MA, which would address concerns about selection at the end of life and decrease beneficiary friction of switching between the two different formulations of Medicare benefits.

Additional analytical concerns around FFS Medicare and MA program spending comparisons include the selection of the population used to study favorable selection and coding intensity.

---

[10] Miller BJ. *Reducing Waste, Fraud and Abuse Through Innovation: How AI & Better Data Can Improve Government Efficiency. Testimony before the Joint Economic Committee, United States Congress*. April 9, 2025. https://www.jec.senate.gov/public/_cache/files/61ff3480-92d4-4798-abbb-35fa2360a278/dr.-brian-j.-miller-testimony.pdf

[11] Code of Federal Regulations. 42 CFR § 422 Subpart V – Medicare Advantage Risk Adjustment Data Validation Requirements. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422#subpart-V.

[12] Centers for Medicare & Medicaid Services. *Medicare Communications and Marketing Guidelines*. March 16, 2022. https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf.

[13] Medicare Payment Advisory Commission. *Chapter 13: Estimating Medicare Advantage coding intensity and favorable selection. In: Report to the Congress: Medicare Payment Policy.* March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch13_MedPAC_Report_To_Congress_SEC.pdf.

[14] America's Health Insurance Plans. *Value of Medicare Advantage Compared with Fee-for-Service: Response to MedPAC.* Wakely Consulting Group; January 18, 2024. https://ahiporg-production.s3.amazonaws.com/documents/Value-of-MA-_Response-to-MedPAC_01.18.2024.pdf.

[15] Medicare Payment Advisory Commission. *Chapter 5: Outpatient dialysis services. In: Report to the Congress: Medicare Payment Policy*. March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch5_MedPAC_Report_To_Congress_SEC.pdf.

[16] Medicare Payment Advisory Commission. *Chapter 12: The Medicare Advantage program: Status report. In: Report to the Congress: Medicare Payment Policy.* March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf.

A complete analysis would examine multiple study populations:

1. Program entry: a comparison of MA v. FFS Medicare populations (in CY 2023, this represents 2.8 million beneficiaries)
2. Switchers (≤5% of the total Medicare population in a given year)[17,18,19]
   a. FFS Medicare beneficiaries who switch to MA (as compared to beneficiaries who stay in the MA program)
   b. MA beneficiaries who switch to FFS (as compared to beneficiaries who stay in FFS Medicare)
3. Stickers: beneficiaries who stay within FFS or MA program in a given year (~95% of the total Medicare population)

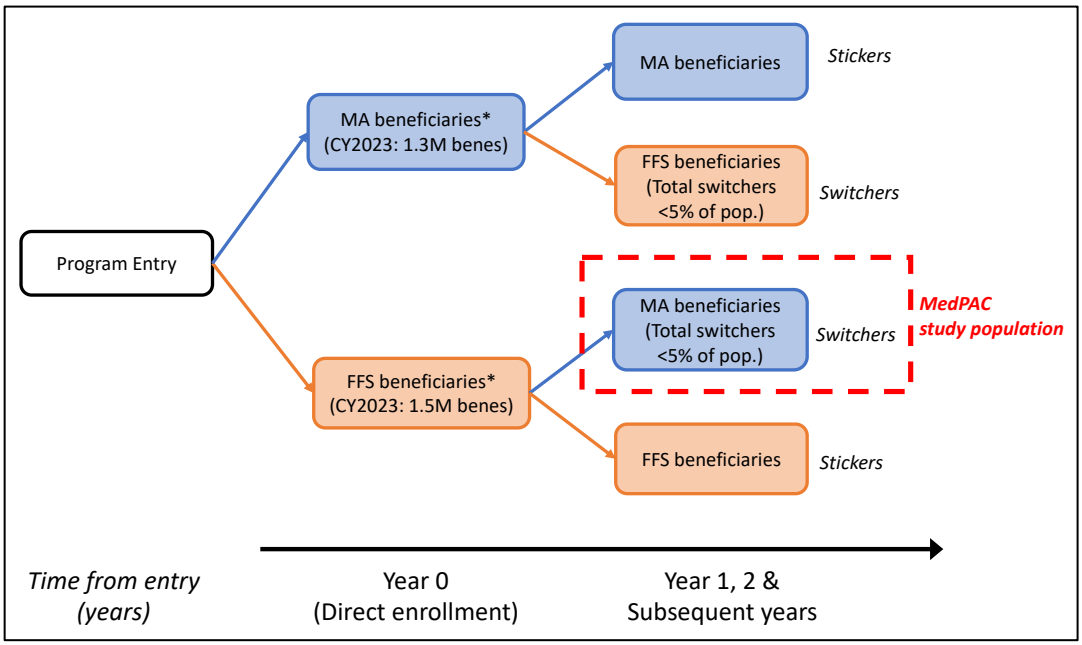

Figure 2: Diagram of Medicare population for MedPAC analysis. *Data from KFF[20]

The MedPAC analysis only examined 1 part of 3 critical comparisons and was conducted without any control group, thus representing a highly limited view as to the comparison cost of FFS Medicare v. MA.

Analytical opportunities exist to better measure the cost and quality of the FFS Medicare and MA in tandem:

1. Comparing FFS Medicare v. MA using the 3 salient policy questions (per benefit component spending, total holistic health benefits spending, and statutory program spending). Neither MedPAC, aligned academics, nor industry has undertaken this staged analysis.
2. Comparing FFS Medicare v. MA examining the 3 key populations (direct entry, switchers, stickers). Neither MedPAC, aligned academics, nor industry has undertaken this staged analysis. *A control group should be used for stickers and switchers*, something not done by MedPAC nor non-peer reviewed academic analyses.
3. Models of coding intensity and favorable selection should undergo tests of internal and external validity, including connection to real world business practices as appropriate. This is a best analytical practice.
4. Coding intensity measurement must be parsed and measured by its 3 components of clinically appropriate coding intensity, abusive coding intensity, and fraudulent coding intensity.
5. Require transparency of MedPAC statistical coding and de-identified data so that researchers can stress test governmental analysis.

[17] Unuigbe A, Cintina I, Koenig L. Beneficiary switching between Traditional Medicare and Medicare Advantage between 2016 and 2020. *JAMA Health Forum*. 2022;3(12):e224896. doi:10.1001/jamahealthforum.2022.4896
[18] Kwon Y, Jazowski SA, Hu X, et al. Medigap protection and plan switching among Medicare Advantage enrollees with cancer. *JAMA Health Forum*. 2025;6(6):e252018. doi:10.1001/jamahealthforum.2025.2018
[19] Unpublished data by Lisa Grabert, Ph.D., et al.
[20] Freed M, Cubanski J, Biniek JF, Neuman T. *5 questions about the idea of default enrollment into Medicare Advantage plans*. KFF. Published April 29, 2025. https://www.kff.org/medicare/issue-brief/5-questions-about-the-idea-of-default-enrollment-into-medicare-advantage-plans/

2. Improvements for beneficiaries

Created originally as a vehicle to drive private market innovation in health benefits and as a chassis for population-based budgeting for Medicare expenses, today's Medicare Advantage program has transformed into a safety net for lower middle class and middle class retirees, or the large segment of population who do not qualify for Medicaid and who may not be wealthy enough to purchase standalone Medigap coverage. With the federal poverty limit (FPL) for a household of two set at $21,150 for CY2025[21] and Medicaid eligibility in most states set at 133% of FPL ($28,129.5 for a 2-person household),[22] the population of elderly poor and lower middle class beneficiaries who are not dual eligibles is roughly half the Medicare population.

Evidence from the Kaiser Family Foundation[23] demonstrates that half of all Medicare beneficiaries lived on pretax incomes below $36,000 per person and that half of all households had savings below $103,800. With the estimated life expectancy of 17.48 years for men and 20.12 years for women at age 65,[24] beneficiaries have limited financial resources to pay for an integrated health benefits package.

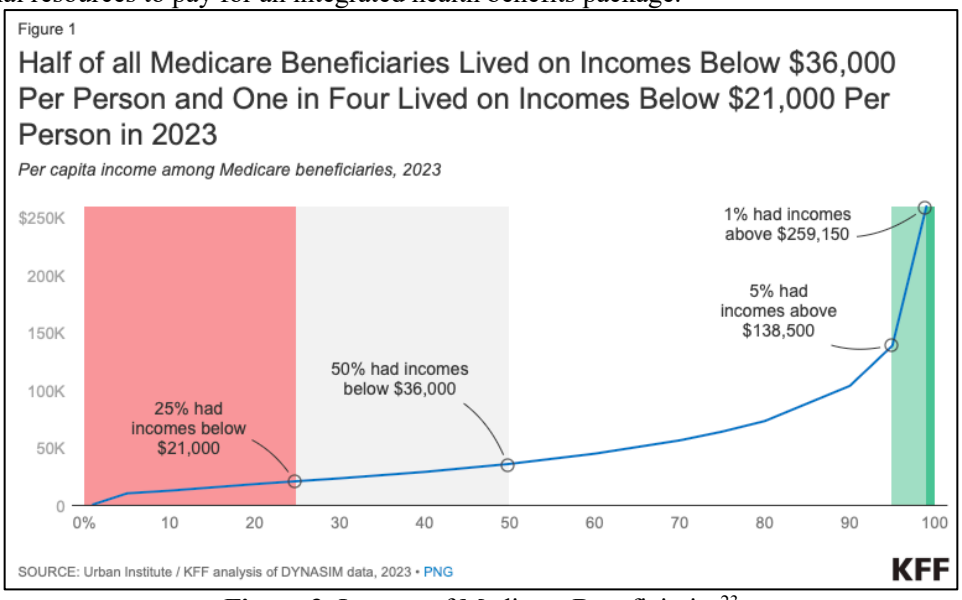

Figure 3: Income of Medicare Beneficiaries[23]

The FFS Medicare beneficiary – if not a dual-eligible enrolled in Medicaid or with a source of supplemental retiree health coverage – has to purchase Medicare supplemental coverage or so-called "Medigap" coverage and Part D prescription drug coverage on top of their monthly Part B premium.

If the beneficiary elects MA, they receive all of these benefits as an integrated benefits package, and for 75% of beneficiaries an integrated plan with a holistic benefits package is available at no additional cost beyond their Part B premium. Enhanced financial protections for beneficiaries enrolled in MA are significant, with data from conventional or so-called general MA plans analyzed by MedPAC staff[25] demonstrating that *72% of rebate dollars are used on reducing the beneficiary cost or premium for routine Medicare services* with 43% of rebate dollars spent on reduced A/B cost sharing, 6% on Part B premium reductions, and 23% on Part D benefits (15% on enhanced coverage and 8% on reduced basic premium).

---

[21] US Department of Health and Human Services. *Poverty guidelines.* Assistant Secretary for Planning and Evaluation (ASPE). Published 2025. https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

[22] "2025 Poverty Guidelines: 48 Continguous States (all states except Alaska and Hawaii). Assistant Secretary for Planning and Evaluation (ASPE), 2025. https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf

[23] Cottrill A, Cubanski J, Neuman T, Smith K. Income and assets of Medicare beneficiaries in 2023. KFF. Published February 5, 2024. https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023/

[24] Social Security Administration. Period life table, 2022, as used in the 2025 Trustees Report. Office of the Chief Actuary. Published 2024. https://www.ssa.gov/oact/STATS/table4c6.html

[25] Medicare Payment Advisory Commission (MedPAC). *Chapter 2: Supplemental Benefits in Medicare Advantage. In: Report to the Congress: Medicare and the Health Care Delivery System.* Published June 2025. See Table 2-1 on page 68. https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch2_MedPAC_Report_To_Congress_SEC.pdf

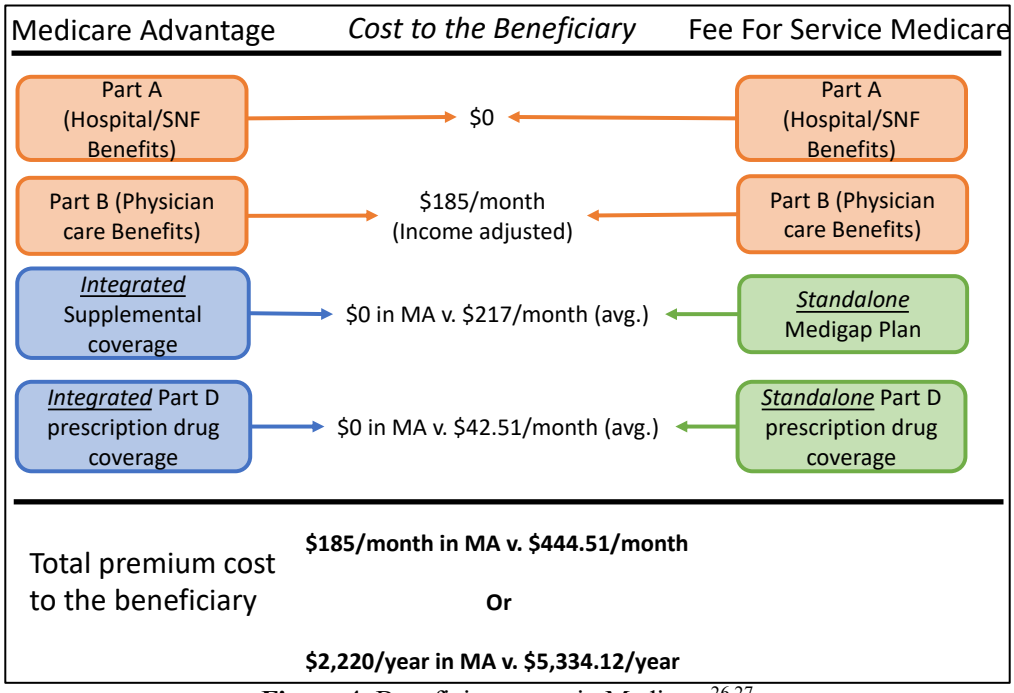

Figure 4: Beneficiary costs in Medicare[26,27]

As a result, the demographics of the MA program are very different with greater enrollment of retired working class and middle class beneficiaries and greater Hispanic and African-American beneficiaries. With a holistic health benefits package constructed from FFS Medicare costing the beneficiary twice as much as Medicare Advantage, it is no surprise that the population enrolled in FFS Medicare who has purchased a separate Medigap plan are far wealthier and more likely to be Caucasian. Of the estimated 29.7 million enrolled in FFS Medicare in CY2022, 12.5 million purchased a Medigap plan with 91% being Caucasian.[28] Thus, policy interventions favoring FFS Medicare and the Medigap market over MA implicitly favor wealthier, Caucasian beneficiaries over poorer, minority beneficiaries. Recognizing that FFS Medicare spending currently serves to help determine the MA benchmark, it is worth examining Medigap's impact on FFS benchmarks for MA, which would recognize that Medigap drives induced demand and that Medigap plans do not have to modify price based upon changes in FFS utilization, representing an implicit subsidy for wealthier Medicare beneficiaries

MA also serves an important role as a vehicle for affordable retiree health benefits for employers, including public sector and union retirees. So-called group MA plans or Employer Group Waiver Plans (EGWPs)[29] allow employers to purchase retiree health benefits above the traditional FFS Medicare A/B benefits package,[30] and have them delivered as an integrated benefits package. An estimated 48 states and DC offer retiree health benefits for public sector works, with 22 offering a choice of MA and supplemental insurance and 13 offering MA only compared to 14 offering supplemental insurance only.[31] From the beneficiary perspective, EGWP offers an affordable retiree package for 5.4 million public sector workers, including a large number of public sector and union retirees.

[26] KFF. Weighted average monthly premium for Medicare Part D stand-alone prescription drug plans. Published 2024. https://www.kff.org/medicare/state-indicator/average-premium-for-pdps/?currentTimeframe=0
[27] Druckman J, Tabor L. *Preliminary Work on Medigap.* Medicare Payment Advisory Commission (MedPAC). Presented March 6, 2025. https://www.medpac.gov/wp-content/uploads/2024/08/Medigap-MedPAC-03.25sec.pdf
[28] Ochieng N, Cubanski J, Neuman T. *A snapshot of sources of coverage among Medicare beneficiaries.* KFF. Published September 23, 2024. https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/
[29] Centers for Medicare & Medicaid Services (CMS). *Employer Group Plans.* Published July 2024. https://www.cms.gov/files/document/slides-employer-group-plans-july-2024.pdf
[30] Centers for Medicare & Medicaid Services (CMS). *Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies*. Published January 10, 2025. See page 49. https://www.cms.gov/files/document/2026-advance-notice.pdf
[31] Freed M, Cottrill A, Patel S, Biniek JF, Neuman T. *In 2024, a majority of states offer Medicare Advantage plans to their state retirees, with 13 offering Medicare Advantage exclusively.* KFF. Published July 2, 2024. https://www.kff.org/medicare/issue-brief/in-2024-a-majority-of-states-offer-medicare-advantage-plans-to-their-state-retirees-with-13-offering-medicare-advantage-exclusively/

As an example, the North Carolina State Health Plan (SHP), on whose Board of Trustees I serve, faces a $500 million shortfall across its $4.5 billion in combined spending by the plan and members. Retirees are a particular concern, as many have limited income and financial resources. For public sector worker retiree health benefits, the SHP offers a supplemental insurance plan plan and an EGWP plan, the latter of which due to the innovations of managed care will have no fundamental change in benefit design from CY2025 to CY2026[32] maintaining an open network, enriched benefits and cost-sharing, and some utilization review. Of the 207,126 SHP Medicare retirees, 86.5% have elected the EGWP plan which provides enriched benefits in addition to financial certainty for the SHP, facilitating budgetary planning. *As retiree health benefits are often negotiated in conjunction with pay but paid out years or decades later, a significant cut to EGWPs would be a pay cut for work that has already been performed*.

Yet, there are still significant opportunities to improve the MA program for beneficiaries. With research from CMS and HHS showing that there are over 2 million disease combinations in the Medicare population[33] that change over time,[34] suggesting that the Medicare program must promote customization to meet the future needs of the population. An evolving market, special needs plans offer customized health benefits for chronic disease (C-SNPs), dual-eligibles (D-SNPs), and institutionalized beneficiaries (I-SNPs). CMS should look to customize the network adequacy, star rating, and marketing/advertising regulation for SNP plans:[35] a diverse Medicare population needs a diversity of health benefits.

Other potential reforms include improving the shopping experience for Medicare beneficiaries. While some proponents have promoted MA plan standardization as a matter of policy, this would result in significant disruption for beneficiaries with 70% of enrollees forced to change plans,[36] a policy shift that would be insensitive to elderly and disabled retirees with fixed incomes who not only desire but need financial stability. Central planning of benefit design has continued to fail, with 84.7% of Medicare HMO enrollees having prescription drug coverage in 1986,[37] a benefit not part of FFS Medicare until Congress passed the Medicare Modernization Act in 2003. In fact, FFS Medicare has been without benefits innovation in nearly twenty years, while MA has continued to experiment in benefit design and value creation for its beneficiaries.

Some policy analysts have expressed concern about the role of agents and brokers, noting that they are financially conflicted intermediaries.[38] Research from the Commonwealth Fund suggests that Medicare beneficiaries utilize input from a variety of information sources, including SHIP counselors (9%), their physician (10%), relatives and friends (27%), and agents and brokers (22%).[39] As a consumer, evidence suggests that older adults adapt and are able to handle complex decisions,[40] that cognitive choice overload is not an age-specific overload,[41] and that in other health insurance markets that competitive broker/agent markets facilitate plan competition and lower premiums.[42]

Medicare beneficiaries have agency and successfully make many complex purchases every year with financially-conflicted intermediaries (i.e. the principal-agent problem) and are aware of the tradeoffs and conflict of interest, which are ameliorated through reputation, consumer learning, competition and regulation:

---

[32] North Carolina State Health Plan. Board of Trustees Meeting Presentation. May 20, 2025. https://www.shpnc.gov/documents/board-trustees/board-trustees-presentation-5202025/download?attachment

[33] Sorace J, Wong HH, Worrall C, Kelman J, Saneinejad S, MaCurdy T. The complexity of disease combinations in the Medicare population. *Popul Health Manag*. 2011;14(4):161-166. doi:10.1089/pop.2010.0044

[34] Sorace J, Millman M, Bounds M, et al. Temporal variation in patterns of comorbidities in the medicare population. *Popul Health Manag*. 2013;16(2):120-124. doi:10.1089/pop.2012.0045

[35] Miller BJ, Zima SC, Wilensky GR. "Customized Care for Complex Conditions in Medicare Advantage." *AEI Economic Perspectives*. August 25, 2022. https://www.aei.org/wp-content/uploads/2022/08/Customized-Care-for-Complex-Conditions-in-Medicare-Advantage.pdf

[36] Blue Cross Blue Shield Association. Comments to MedPAC Regarding the January 2024 Public Meeting. January 26, 2024. https://www.medpac.gov/wp-content/uploads/2023/10/BCBSA-MedPAC-January-meeting-comments.pdf

[37] McMillan A. Trends in Medicare health maintenance organization enrollment: 1986-93. *Health Care Financ Rev*. 1993;15(1):135-146.

[38] Clark C. Obama CMS chief: Medicare Advantage plans game the system. MedPage Today. March 1, 2024. https://www.medpagetoday.com/special-reports/exclusives/108980

[39] Jacobson G, Leonard F, Sciupac E, Fisch-Friedman M, Rapoport R. *The Private Plan Pitch: Seniors' Experiences with Medicare Marketing and Advertising.* The Commonwealth Fund. Published September 12, 2023. See Exhibit 7. https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/private-plan-pitch-seniors-experiences-medicare-marketing-advertising

[40] Mata R, Schooler LJ, Rieskamp J. The aging decision maker: cognitive aging and the adaptive selection of decision strategies. *Psychol Aging.* 2007;22(4):796-810. doi:10.1037/0882-7974.22.4.796

[41] Tanius BE, Wood S, Hanoch Y, Rice T. Aging and choice: Applications to Medicare Part D. *Judgment and Decision Making*. 2009;4(1):92-101. doi:10.1017/S1930297500000735

[42] Karaca-Mandic P, Feldman R, Graven P. The role of agents and brokers in the market for health insurance. *NBER Working Paper Series*. Working Paper No. 19342. Published August 2013. https://www.nber.org/papers/w19342

- Home purchases: buyers aged 70-99 represent 20% of home purchases, with one-quarter being single females, nearly 40% looking online at properties for sale, and nearly 90% using a real estate agent or broker.[43] Homes are typically the largest financial asset and have significant transaction costs.
- Car purchases: among buyers aged 65 years or older, 83% of purchases were through a dealer and 15% were online.[44] This age demographic is responsible for 26.4% of new car sales in Q1 2024.[45]
- Auto insurance shopping: According to McKinsey, while 80% of consumers use direct channels to gather information, 60% use agency channels to purchase coverage.[46]

In many areas, technology has transformed the shopping experience and transformed the role of intermediaries. In the 1980s, travel could not be planned without the assistance of a travel agent – today, travel agents have moved into a more specialized marketplace and are used to assist with procuring complex international travel, cruises and other excursions while consumer-directed shopping via the internet has supplanted their role. In other markets such as real estate, the role of agents and brokers has changed, with consumers reporting significant technology use to gather information while still ultimately using a knowingly financially-conflicted human intermediary to effect a final purchase. As technology continues to increase the accessibility and transparency of information, human-assisted sales will similarly evolve in the Medicare marketplace with technology supporting the agency and independence of the elderly and disabled Medicare beneficiary and (for those with significant cognitive impairments) their healthcare proxies. Brokers could also expand into new roles. As my colleague SCAN CEO Sachin Jain, M.D., M.B.A. has suggested, we should examine expanding the role of brokers as suggested by to include care navigation, preventive service and community health worker roles as part of an earned renewal fee.[47]

Instead of plan standardization, some policy options to consider could focus on improve the shopping experience for beneficiaries by providing more tools to filter and interpret choice and market complexity. To make plan products more differentiated, CMS could restore the meaningful difference regulation[48,49] to ensure that MA plans have distinct and distinguishable benefits. To assist consumers, CMS could improve the plan finder[50] to provide both cost, drug availability, and provider networks information to the beneficiary and allow them compare a holistic medical and drug benefits package across FFS Medicare + Medigap/Supplemental insurance + Prescription drug coverage and MA options. To build upon this and simultaneously improve the distribution of quality bonuses across the Medicare program, researchers, regulators, industry, and other stakeholders could study the design of and implantation barriers to a unified star quality rating program based upon two-sided risk, inclusive of FFS Medicare, ACOs, and MA to more fairly and transparently assess quality and distribute bonuses across Medicare.[51] Overall, improving the plan finder would mirror best practices in other insurance markets, including the Affordable Care Act exchanges wherein consumers can input their physician and prescription drugs and search for the plan that best fits them. Doing so would force plans as a matter of course to improve provider directories, addressing valid consumer protection policy concerns about ghost networks.[52]

3. Improvements for providers

Prior authorization (PA) workflow places a significant burden on physicians and hospitals.[53] PA relies on outdated processes involving paper-based and fax-dependent submission systems, redundant information submission

---

[43] National Association of REALTORS® Research Group. *2025 Home Buyers and Sellers Generational Trends Report*. Published April 1, 2025. https://www.nar.realtor/sites/default/files/2025-04/2025-home-buyers-and-sellers-generational-trends-04-01-2025.pdf

[44] Fernandes J. How Americans shop for cars: What drives decisions across age groups. *YouGov.* Published April 2, 2025. https://business.yougov.com/content/51922-how-americans-shop-for-cars-what-drives-decisions-across-age-groups

[45] S&P Global Mobility. Demographic buying is leaving car customers on the side of the road. *S&P Global Mobility Blog*. Published June 4, 2024. https://www.spglobal.com/mobility/en/research-analysis/demographic-marketing-automotive-industry.html

[46] McKinsey & Company. *Winning Share and Customer Loyalty in Auto Insurance: Insights from McKinsey's 2012 Auto Insurance Customer Insights Research.* Financial Services Practice. 2012. https://www.mckinsey.com/~/media/mckinsey/dotcom/client_service/financial%20services/latest%20thinking/insurance/winning_share_and_customer_loyalty_in_auto_insurance.ashx

[47] Jain SH. Could health insurance brokers heal our broken healthcare system? *Forbes*. Published July 9, 2024. https://www.forbes.com/sites/sachinjain/2024/07/09/could-health-insurance-brokers-heal-our-broken-healthcare-system

[48] https://www.appliedpolicy.com/cms-makes-proposed-changes-to-medicare-advantage-that-look-to-encourage-innovation-and-plan-choices/

[49] https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-policy-changes-and-updates-medicare-advantage-and-prescription-drug-benefit-program

[50] Grabert LM, McCormack G, Trish E, Wagner KL. Fostering Flexibility: How Medicare Advantage Potentially Accelerated Telehealth Benefits. *Inquiry.* 2024;61:469580241238671. doi:10.1177/00469580241238671

[51] Miller BJ, Grabert LM, Hargan ED. Medicare modernization—the urgent need for fiscal solvency. *JAMA Health Forum*. 2023;4(6):e231571. doi:10.1001/jamahealthforum.2023.1571

[52] Senate Committee on Finance. Ghost Network Hearing – Secret Shopper Study Report. Published May 3, 2023. https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf

[53] Sahni NR, Istvan B, Stafford C, Cutler D. Perceptions of prior authorization burden and solutions. *Health Aff Sch*. 2024;2(9):qxae096. Published 2024 Aug 6. doi:10.1093/haschl/qxae096

requirements, and largely a purely manual review process. According to the American Medical Association's 2024 physician survey, 94% of physicians reported that prior authorization delays patient care, 19% said it led to patient hospitalization, and 78% stated that it often or sometimes results in patients abandoning recommended treatments.[54] Specialty-specific concerns continue this story, with 71% of allergy-immunologists describing the PA process as "extremely high" in burden and over 96% reporting that it negatively impacts clinical outcomes.[55] Sectoral trade associations have expressed similar concerns, including the inpatient rehabilitation facilities (IRFs) which provide acute rehabilitation services to Medicare beneficiaries. The American Medical Rehabilitation Providers Association (AMRPA) noted that a study sample of two months of prior authorization requests from 367 IRFs from 48 states and Puerto Rico representing nearly 19,000 licensed beds and one-third of IRFs nationwide exhibited an average wait time of 2.5 days for an initial decision, representing 67,247 acute hospital days spent waiting for initial decision.[56] Recognizing these burdens, the Federation of American Hospitals (representing tax-paying hospitals) recommended a quality measure related to prior authorization for MA plans.[57]

Recognizing that prior authorization is likely to expand as a practice and tool into the FFS Medicare program, the Trump Administration's recently announcement of the CMS Innovation Center's WISeR Model,[58] which focuses on process improvement and reducing burden for physicians, hospitals, and other health care providers. Prior authorization reforms date back years, with recent efforts during the Biden Administration to improve the prior authorization process for medical items and services.[59] The Trump Administration has continued to push the insurance industry for process improvements, securing a commitment to standardize e-PA, reduce the scope of claims subject to PA, provide clear explanations of determinations, ensure continuity of PA for a 90-day transition period when beneficiaries change plans, and set a goal of 80% real-time PA adjudication responses by 2027.[60,61]

Generally from a first principles perspective, policy options to consider could focus on solutions that can be executed in the real world with a focus on reducing burdens on patients and physicians. Future prior authorization process reform inclusive of medical services and outpatient prescription drugs could aim to push the prior authorization process to the point of service in order to improve Medicare FFS and MA for beneficiaries and clinicians. Key considerations include easily accessible and availability of medical criteria in EHRs for medical or prescription drug PA, automation of data submission in EHRs with one-click submission for clinicians, automation of PA approval – not denial – to ensure appropriate and efficient access to services, and a functional, automated "gold card" program for clinicians providing fast track PA approval and when appropriate, prioritized rapid human-driven medical review

Physicians face significant administrative and documentation burdens resulting in burnout[62,63] and added downstream costs.[64] Documentation burdens related to billing and medical coding drive excessive screen time,[65,66]

---

[54] American Medical Association. *2024 AMA Prior Authorization Physician Survey.* 2024. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[55] Bernstein JA, Gadde D, Yassin M, et al. The Impact of Prior Authorization on Clinical Practice and Patient Care Outcomes: A Work Group Report of the AAAAI Prior Authorization Task Force. *J Allergy Clin Immunol Pract*. 2024;12(7):1719-1726. doi:10.1016/j.jaip.2024.01.051
[56] American Medical Rehabilitation Providers Association. *Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices in 2024.* 2024. https://amrpa.org/wp-content/uploads/2025/04/2024-AMRPA-Prior-Auth-Survey-Full-Results_FINAL.pdf
[57] Federation of American Hospitals. FAH quality measure recommended to CMS for bringing transparency and accountability to MA plan denials. *FAH Hospital Policy Blog.* Published February 1, 2024. https://www.fah.org/blog/fah-quality-measure-recommended-to-cms-for-bringing-transparency-and-accountability-to-ma-plan-denials/
[58] Centers for Medicare & Medicaid Services. CMS launches new model to target wasteful, inappropriate services in Original Medicare. *CMS Newsroom.* Published June 27, 2025. https://www.cms.gov/newsroom/press-releases/cms-launches-new-model-target-wasteful-inappropriate-services-original-medicare
[59] Centers for Medicare & Medicaid Services. CMS finalizes rule to expand access to health information and improve the prior authorization process. *CMS Newsroom.* Published January 17, 2024. https://www.cms.gov/newsroom/press-releases/cms-finalizes-rule-expand-access-health-information-and-improve-prior-authorization-process
[60] U.S. Department of Health and Human Services. HHS Secretary Kennedy, CMS Administrator Oz secure industry pledge to fix broken prior authorization system. *HHS Press Room.* Published June 23, 2025. https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html
[61] AHIP. Health plans take action to simplify prior authorization. *AHIP Newsroom.* Published June 23, 2025. https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[62] Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med.* 2012;172(18):1377-1385. doi:10.1001/archinternmed.2012.3199
[63] Li C, Parpia C, Sriharan A, Keefe DT. Electronic medical record-related burnout in healthcare providers: a scoping review of outcomes and interventions. *BMJ Open.* 2022;12(8):e060865. Published 2022 Aug 19. doi:10.1136/bmjopen-2022-060865
[64] Han S, Shanafelt TD, Sinsky CA, et al. Estimating the Attributable Cost of Physician Burnout in the United States. *Ann Intern Med.* 2019;170(11):784-790. doi:10.7326/M18-1422
[65] Arndt BG, Beasley JW, Watkinson MD, et al. Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations. *Ann Fam Med*. 2017;15(5):419-426. doi:10.1370/afm.2121
[66] Chaiyachati KH, Shea JA, Asch DA, et al. Assessment of Inpatient Time Allocation Among First-Year Internal Medicine Residents Using Time-Motion Observations [published correction appears in JAMA Intern Med. 2019 Aug 1;179(8):1152. doi: 10.1001/jamainternmed.2019.2822.]. *JAMA Intern Med*. 2019;179(6):760-767. doi:10.1001/jamainternmed.2019.0095

with notes becoming bloated,[67] and errors.[68] Burdens cross medical specialties, with one study demonstrating that trauma surgeons spend 1,760.5 hours to document for one year's worth of billing/coding.[69] Automation of diagnosis coding and billing – subject to clinician review – at the point of care would improve the completeness, accuracy, and precision of diagnosis coding in both programs and reduce physician documentation burdens.

Finally, MA is a platform for expanding competition in care delivery. During a time when FFS Medicare dominated the Medicare program and risk-adjusted capitation was a minority of the program, policymakers passed and revised the Stark Law – executed as series of laws and rules[70,71,72] – prohibiting physician self-referral for designated health services in the Medicare program. Prohibited self-referral services include physical and occupational therapy, home health services, radiology, and a litany of other services[73] due to valid concerns about physician-induced demand in a FFS setting. However, with the advent and increasing dominance of managed care and accompanying dynamic tools to address health care overutilization including utilization review, prior authorization, and network tiering, the concerns that drove the passage of Stark Law can be addressed by market forces. In a massively consolidated health system with 90% of metropolitan statistical areas highly concentrated for hospital services,[74] preferencing one form of ownership and integrated care delivery – that of non-profit and for-profit corporations who can construct integrated care delivery and self-refer or even require self-referral – over physician ownership is nonsensical.

Recognizing that FFS Medicare with its inherent incentives and taxpayer funding is distinct from the risk-adjusted capitation model of MA, policymakers should consider a Stark Law waiver in the setting of managed care, invigorating competition and combatting consolidation in the marketplace for half of Medicare beneficiaries, supporting independent clinical practice and playing physician-owned and -operated care delivery on an equal competitive footing with corporate-owned and -operated care delivery.[75]

4. Conclusions

At its core, having different formulations of Medicare benefits allows beneficiaries to choose the health benefits package that works best for them. Policymakers should require improved comparisons of FFS Medicare and MA, support better tools to filter choice and complexity for beneficiaries, and improve the prior authorization process for providers. Policy interventions must recognize that FFS Medicare is a static program changed only through law, while MA is a dynamic program that responds to incentives. Finally, policy analysts and regulators would be well-served by recognizing the positive long term political economy of MA as it will eventually break the toxic cycle of central planning and advocacy around setting payment levels for thousands of items and services, freeing health policy to consider other long unaddressed critical issues such as interoperability, privacy, or facilitating technological innovation to improve the efficiency and accessibility of care.

---

[67] Bartelt K, Joyce B, McCaffrey K, Butler S, Deckert J, Gates C. Two years after coding changes sought to decrease documentation, notes remain 'bloated'. *Epic Research*. Published July 6, 2023. https://epicresearch.org/articles/two-years-after-coding-changes-sought-to-decrease-documentation-notes-remain-bloated

[68] Zhu C, Attaluri PK, Wirth PJ, Shaffrey EC, Friedrich JB, Rao VK. Current Applications of Artificial Intelligence in Billing Practices and Clinical Plastic Surgery. *Plast Reconstr Surg Glob Open*. 2024;12(7):e5939. Published 2024 Jul 1. doi:10.1097/GOX.0000000000005939

[69] Golob JF Jr, Como JJ, Claridge JA. The painful truth: The documentation burden of a trauma surgeon. *J Trauma Acute Care Surg*. 2016;80(5):742-747. doi:10.1097/TA.0000000000000986

[70] 42 U.S.C. §1395nn (2014). Limitations on certain physician referrals. https://www.govinfo.gov/content/pkg/USCODE-2014-title42/pdf/USCODE-2014-title42-chap7-subchapXVIII-partE-sec1395nn.pdf

[71] Centers for Medicare & Medicaid Services. Medicare program; physicians' referrals to health care entities with which they have financial relationships (Phase I). Fed Regist. 2001;66(3):856-965. https://www.govinfo.gov/content/pkg/FR-2001-01-04/html/01-4.htm

[72] Centers for Medicare & Medicaid Services. Medicare program; physicians' referrals to health care entities with which they have financial relationships (Phase III). Fed Regist. 2007;72(171):51012-51432. https://www.govinfo.gov/content/pkg/FR-2007-09-05/pdf/07-4252.pdf

[73] Centers for Medicare & Medicaid Services. Physician Self-Referral. CMS.gov. https://www.cms.gov/medicare/regulations-guidance/physician-self-referral.

[74] Fulton BD. Health Care Market Concentration Trends In The United States: Evidence And Policy Responses. *Health Aff (Millwood).* 2017;36(9):1530-1538. doi:10.1377/hlthaff.2017.0556

[75] Miller BJ, Ehrenfeld JM, Wu AW. Competition or Conflict of Interest-Stark Choices. *JAMA Health Forum*. 2021;2(2):e210150. Published 2021 Feb 1. doi:10.1001/jamahealthforum.2021.0150