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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBJECT: Correcting the Record: Providers' Disinformation Campaigns Are Designed to Tarnish the Reputation of Medicare Advantage for Their Own Financial Gain

Dear Administrator Brooks-LaSure:

Every American deserves access to affordable, high-quality coverage and care – especially our seniors and people with disabilities. Many of these Americans have significant health care needs, as well as limited resources to pay for health care. That is why Medicare is so essential to protect our older and vulnerable citizens and our communities – and why Medicare Advantage (MA) plans are resolute in the commitment they share with you to ensure MA delivers affordability, access, quality, value, and satisfaction for everyone they serve while striving to improve health equity.

Unfortunately, certain provider organizations are targeting the MA program and its sustained success to advance their own political agenda and secure financial gains for their members. As the largest advocacy organization representing health insurance providers, including MA plans that today serve tens of millions of Americans, I am writing on behalf of AHIP to correct the record, refute false and misleading reports being spread by these disinformation campaigns, and reaffirm our strong commitment to put patients and consumers first.

Nearly 30 Million Americans Rely on MA's Value

The successes and popularity of the MA program are well known. Study after study demonstrates that – as intended with the program's design – MA leverages the strength and stability of the federal government with the competition and innovation of the private market to deliver better services, better access to care, and better value. Along with the clinical excellence that MA plans consistently deliver¹, about 60% have no monthly premium², while payments to MA plans remain on par with original Medicare spending³.

¹ <https://pubmed.ncbi.nlm.nih.gov/29130269/>

² <https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/>

³ https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf

This strong value proposition has led to tremendous growth in the program and overwhelming consumer satisfaction. Today, 29 million Americans choose MA, including nearly half of all racial and ethnic minorities eligible for Medicare⁴. About 40% of MA enrollees make less than \$25,000 a year⁵, and nearly 60% of MA enrollees are women⁶.

Within these statistics are millions of personal health journeys that have been supported by the MA program:

- Violeta Quintero-Escamilla of Los Angeles, CA, was highly satisfied with how much her MA plan covered during and after an extensive hospital stay.
- Jorge Moran of Los Angeles, CA, relies on the better services, access, and value that MA provides, including integrated coverage for his prescription drugs and eyeglasses.
- Maureen Barnhart of Portland, OR, leaned on her MA plan to connect her with bereavement support and other services she needed after her sister passed away to help her cope during this very difficult time.

It's no wonder that 93% of senior voters are satisfied with their MA plan, and 9 out of 10 would recommend MA to their family and friends⁷.

With such robust evidence of sustained improvement, quality, and value, what would motivate provider organizations like the American Hospital Association and American Medical Association to undermine the MA program, challenge its broad bipartisan support, and tarnish the program's reputation? The answer is both evident and simple: They seek to undermine the valuable quality-improving, cost-saving, and waste-reducing tools of the program for their own financial benefit. Nowhere is that more evident than their unfounded attacks on evidence-based medical management tools like prior authorization.

Prior Authorization Prevents Harm and Reduces Waste and Costs

We all agree: Doctors provide essential care and life-saving treatment. They help us get healthy when we are sick and keep us healthy when we are well. But even doctors agree that variations in treatment can lead to unnecessary, costly, or inappropriate medical treatments that can harm patients:

⁴ <https://us.milliman.com/en/insight/comparing-the-demographics-of-enrollees-in-medicare-advantage-and-fee-for-service-medicare>

⁵ Ibid.

⁶ <https://us.milliman.com/en/insight/comparing-the-demographics-of-enrollees-in-medicare-advantage-and-fee-for-service-medicare>

⁷ <https://medicarechoices.org/americans-like-ma-2022/>

- A study from Johns Hopkins suggests that medical errors, including “unwarranted variation in physician practice patterns that lack accountability,” are now the third leading cause of death in the United States⁸.
- A 2019 study in *JAMA* found that “the estimated cost of waste in the U.S. health care system ranged from at least \$760 billion [to] potentially as much as \$935 billion, approximately 25% of total health care spending.”⁹
- A survey of physicians in the American Medical Association showed that two-thirds of physicians themselves believed that at least 30% of the health care services they delivered was unnecessary¹⁰.

We must all work together to do better to improve affordability, access, quality and value in America’s health care system. With a comprehensive view of the health care system and each patient’s medical claims history, health insurance providers work with physicians to ensure that medications and treatments prescribed are safe, effective, and affordable to meet each patient’s health care needs. Prior authorization requirements are based on medical evidence: 98% of insurance providers use peer-reviewed, evidence-based studies, and 89% use federal studies or guidelines when designing their prior authorization programs.¹¹

In some cases, the prior authorization request starts a dialogue between the provider and health insurance provider on the optimal treatment, test, or service. Unsafe or unnecessary treatment is not approved when it could harm a patient or make them pay for care or services they don’t need. That is part of health insurance providers’ commitment to patients’ health and well-being. In many cases, health insurance providers will recommend an alternative treatment that has been proven to be just as effective, or to deliver greater value.

We are quite aware that certain provider organizations would prefer that all clinicians be given a blank check to order any test or procedure at any time, regardless of the expected value or expense to the patient. But giving clinicians carte blanche is no way to improve health care affordability and access for every American – and we have known for decades that more medical care does not equate to better care. Further, giving clinicians complete latitude with no consideration of value to the patient means that we remain in a health care system that rewards clinicians based on the volume of treatments, services, and procedures they deliver, instead of advancing a value-based system.

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https://www.hopkinsmedicine.org/news/media/releases/study_suggests_medical_errors_now_third_leading_cause_of_death_in_the_us

⁹ <https://jamanetwork.com/journals/jama/article-abstract/2752664>

¹⁰ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970>

¹¹ <https://www.ahip.org/news/press-releases/ahip-survey-prior-authorization-grounded-in-clinical-evidence-and-selectively-used>

Nor are consumers served by the ever-growing consequences of hospital monopolies in local markets across the country, extreme mark-ups of provider-administered medications, or hospitals' opposition to payment for services on a site-neutral basis, each of which are done solely so that hospitals can continue to bilk the system for their own profit. These actions drive up costs for everyone and result in fewer Americans being able to afford coverage – including seniors and people with disabilities on MA – and it is why many of these practices have been, and continue to be, under their own federal investigations.

We are also aware that dozens of hospitals are, themselves, part of organizations that own MA plans. These provider-sponsored plans use the same medical management and prior authorization tools that groups like the American Hospital Association attack. They clearly recognize that prior authorization is an essential tool that ensures value and high-quality care while saving costs and preventing waste.

The Recent HHS-OIG Report on Prior Authorization Is Being Misrepresented

As CMS knows very well, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released a report on prior authorization in MA. The OIG acknowledged that the overwhelming majority (95%) of prior authorization requests in 2018 were approved, and that there were no concerns raised by nearly the entirety of the small sample of prior authorization requests that were denied. Further, none of the requests for payment that were denied had any impact on access to care for a patient.

But since then, self-interested provider organizations and other special-interest groups have made wild generalizations and pulled information out of context to misrepresent the report's findings for their own political gain. Here are the facts:

- The OIG looked at 247 prior authorization requests that were denied during a single week in June 2019. It found that nearly all (87%) coverage determinations where prior authorization requests were denied raised no concerns for the OIG.
- Of the remaining 13% of prior authorization requests that were denied – only 33 cases in the OIG's sample – 7 of them were reversed within 3 months, often as part of the plan's appeals process.
- The main concern about many of those cases was not that they were improper, but rather that more guidance from the government was needed on criteria that plans can use to make coverage determinations. CMS indicated that it will provide such guidance – and we agree that this is an important next step.

In the end, the full findings of the OIG report are not an indictment of prior authorization, but rather a compelling story of value and access.

Working Together Toward Solutions That Work

We appreciate CMS' commitment through your leadership and your team's efforts to advance policies that recognize the critical role of MA plans for millions of Americans while continuing to improve administrative processes. We all should be working together to improve health care for all seniors and people with disabilities. In MA plans' focus on their mission of excellence, hospitals and health care systems are a frequent and relied-on partner.

This partnership was on clear display during the COVID-19 crisis, when insurance providers and hospitals came together to break down every barrier to ensure that patients received the care they needed: paying for COVID-19 testing, treatment, and vaccines before required by federal legislation; emphatically supporting emergency federal funding for hospitals and health systems through the pandemic; accelerating processes to treat, transfer, and discharge patients from acute care settings to increase capacity; and rapidly expanding access to and payment for telehealth services.

These industry-wide actions are in addition to billions of dollars of further investments health insurance providers have made to help hospitals keep their doors open, support clinicians in the adoption of technologies and electronic processes, and support for community-based programs to increase care access and correct COVID-19 misinformation.

We should be on the same side now in the pursuit of quality, value, and cost savings. CMS recognized this in its recent policies to add prior authorization for certain services in original Medicare. Health insurance providers, doctors, hospitals, and health care systems all agree that seniors should have access to medically needed care, and that they should be protected from bad actors. Our focus now should be on streamlining and automating prior authorization and similar medical management tools through national interoperability standards to ensure patient protections while easing administrative burdens.

We remain committed to working together with CMS, providers, and other health care leaders to ensure affordability, access, and value in MA, and in all of the plans and programs we deliver.

Sincerely,



Matthew Eyles
President & Chief Executive Officer