

United States Senate

WASHINGTON, DC 20510

April 1, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz:

We write today to urge you to hold insurance companies accountable for persistent abuses in the Medicare Advantage (MA) program that raise costs and lower quality of care for millions of seniors and people with disabilities. This work takes on greater urgency in light of troubling comments from Medicare Director Chris Klomp that the administration may be exploring options to *automatically* enroll seniors and people with disabilities into MA,¹ subjecting enrollees to more frequent care denials and higher out-of-pocket costs, while likely costing taxpayers billions of dollars. Aside from the numerous financial problems and patient care concerns such a proposal raises, it also very likely violates the requirements for any Centers for Medicare and Medicaid Services Innovation Center models to reduce taxpayer spending. We instead urge you to focus on reining in abuses by MA insurers.

As Administrator of the Centers for Medicare and Medicaid Services (CMS), you have withheld essential funding for seniors and people with disabilities and slashed Medicaid under the guise of rooting out waste, fraud, and abuse.² However, legitimate fraud, waste, and abuse in MA remains largely unchecked. While we acknowledge that the Calendar Year (CY) 2027 Advance Notice of Methodological Changes for MA Capitation Rates and Part D Payment Policies proposes to increase payments to MA plans by 0.09 percent next year and exclude unlinked chart reviews from MA risk adjustment calculations,³ CMS must do more to preserve the Medicare program's mission of providing older adults and people with disabilities with affordable, high quality health care. We express below the need for the following actions:

1. Further reducing overpayments from risk adjustment and favorable selection;
2. Preventing insurance companies from denying medically necessary services; and
3. Holding MA insurers accountable for engaging in anti-competitive behavior and evading regulatory protections.

¹ Stat News, "Automatic enrollment in Medicare Advantage plans under consideration, top Trump health official says," Tara Bannow, March 20, 2026, <https://www.statnews.com/2026/03/20/medicare-advantage-default-enrollment-chris-klomp-project-2025>.

² KFF Health News, "Oz Escalates Medicaid Fraud Claims Against States After Focus on Minnesota," Bram Sable-Smith, March 20, 2026, <https://kffhealthnews.org/news/article/medicaid-fraud-dr-oz-minnesota-california-maine-new-york-florida>.

³ Centers for Medicare and Medicaid Services, "CMS Proposes 2027 Medicare Advantage and Part D Payment Policies to Improve Payment Accuracy and Sustainability," press release, January 26, 2026, <https://www.cms.gov/newsroom/press-releases/cms-proposes-2027-medicare-advantage-part-d-payment-policies-improve-payment-accuracy-sustainability>.

Further Reduce Overpayments from Risk Adjustment and Favorable Selection

On January 26, 2026, CMS released a proposed payment rate that would increase payments to MA insurers by 0.09 percent, or \$700 million, in CY 2027.⁴ When accounting for underlying coding trends in MA, which have been included in calculations since 2023, CMS expects payments to increase by an additional 2.45 percent, on average, for a combined increase of 2.54 percent.⁵ This follows an additional 5.06 percent payment bump (7.16 percent inclusive of underlying coding trends) to MA plans finalized for CY 2026 worth \$25 billion dollars, as well as another \$13.2 billion in bonus payments to insurance companies that CMS proposed in an overhaul to the MA star ratings system in November 2025.⁶ Meanwhile, the nonpartisan Medicare Payment Advisory Commission (MedPAC) estimates that overpayments to MA insurers are estimated to reach \$76 billion in 2026 and will total \$1.3 trillion over the next decade,⁷ all while seniors and people with disabilities enrolled in MA experience “worse functional outcomes compared with traditional Medicare,” greater delays in receiving care, and higher costs.⁸ Indeed, Medicare Part B premiums exceed \$200 per month this year for the first time ever in what is just one more example of this administration’s failure to address Americans’ soaring health care costs.⁹ Importantly, a Joint Economic Committee report prepared by Republican majority staff found that overpayments to MA insurers are directly responsible for the growth of Part B premiums.¹⁰

While we appreciate that CMS has proposed to exclude diagnoses from risk score calculations that are not linked to specific provider encounters,¹¹ additional steps are needed to eliminate risk score gaming. In fact, MedPAC reports that MA insurers often view all chart reviews and health risk assessments as an independent revenue stream, with these practices making up about eight percent of all payments to MA plans (or \$34 billion) in 2023 alone.¹² For this reason, MedPAC has recommended excluding these diagnoses from risk score calculations altogether.

⁴ Centers for Medicare and Medicaid Services, “2027 Medicare Advantage and Part D Advance Notice,” January 26, 2026, <https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice>.

⁵ *Id.*

⁶ Centers for Medicare and Medicaid Services, “2026 Medicare Advantage and Part D Rate Announcement,” April 7, 2025, <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-rate-announcement>; STAT, “Medicare Advantage plans to gain \$13 billion under Trump changes to star ratings,” Bob Herman, November 28, 2025, <https://www.statnews.com/2025/11/28/medicare-advantage-rules-change-13-billion-windfall-insurers>.

⁷ Committee for a Responsible Budget, “Medicare Advantage in the Hot Seat,” March 20, 2026, <https://www.crfb.org/blogs/medicare-advantage-hot-seat>.

⁸ JAMA Health Forum, “Differences in Home Health Services and Outcomes Between Traditional Medicare and Medicare Advantage,” Rachel A. Prusynski, Anthony D’Alonzo, Michael P. Johnson, et al., March 1, 2024, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2815745>; Stat News, “Medicare Advantage is bad for patients and bad for investors,” Wendell Potter and Philip Verhoef, February 28, 2024, <https://www.statnews.com/2024/02/28/medicare-advantage-traditional-overpayment-patient-dissatisfaction-investors>.

⁹ Letter from U.S. Senators Warren, Schumer, Wyden, et al. to Secretary of Health and Human Services Robert F. Kennedy Jr., November 4, 2025, https://www.warren.senate.gov/imo/media/doc/letter_on_rising_health_care_costs.pdf; Yahoo Finance, “Medicare Part B Just Crossed \$200 a Month for the First Time. Here’s What That Means for Retirees,” Austin Smith, March 18, 2026, <https://finance.yahoo.com/news/medicare-part-b-just-crossed-100034477.html>.

¹⁰ Joint Economic Committee, “JEC Brief Finds Medicare Advantage Overpayments Causing Increased Premiums for All Seniors,” March 10, 2026, <https://www.jec.senate.gov/public/index.cfm/republicans/2026/3/jec-brief-finds-medicare-advantage-overpayments-causing-increased-premiums-for-all-seniors>.

¹¹ CMS, “CMS Proposes 2027, Medicare Advantage and Part D Payment Policies to Improve Payment Accuracy and Sustainability,” press release, January 26, 2026, <https://www.cms.gov/newsroom/press-releases/cms-proposes-2027-medicare-advantage-part-d-payment-policies-improve-payment-accuracy-sustainability>.

¹² MedPAC, “The Medicare Advantage program: Status report,” March 2025, p. 361, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf.

CMS should also take steps to curb overpayments from favorable selection. Every month, MA plans receive a capitated payment from CMS that is the product of a base payment rate and a risk score.¹³ One of the factors used to calculate the base payment is a county benchmark, which is “based on Medicare spending for the county’s beneficiaries enrolled in Medicare’s traditional fee-for-service (FFS) program.”¹⁴ However, MA enrollees tend to be healthier than traditional Medicare enrollees, meaning it typically costs insurers *less* to cover MA enrollees.¹⁵ By overlooking the favorable selection of healthier individuals in MA, CMS’s payments to MA insurers systematically overpredict MA enrollees’ actual spending, leading to substantial overpayments.¹⁶ MedPAC estimates favorable selection will raise CMS spending by 11 percent in 2026 – and by \$730 billion over the next decade.¹⁷

Preventing Insurance Companies from Denying Medically Necessary Services

Addressing Barriers Created by Prior Authorization

We are deeply concerned by MA insurers’ use of practices, like prior authorization, to cut costs at the expense of enrollees’ access to necessary care. In 2024, MA insurers either fully or partially denied around 4.1 million prior authorization requests – over 27 times the number of denials in traditional Medicare.¹⁸ Alarming, nearly 81 percent of appealed MA denials were overturned.¹⁹ Unlike traditional Medicare, which infrequently requires prior authorization for services,²⁰ nearly all MA enrollees are “required to obtain prior authorization for some services.”²¹ MA insurers claim this helps reduce unnecessary costs; however, prior authorization requirements often impose additional administrative burdens on providers and, more importantly, delay or deny medically necessary services for patients.²² In fact, 93 percent of physicians have reported that prior authorization delayed patients’ access to critical care, and over three quarters of physicians reported that these requirements likely contributed to patients abandoning their treatment.²³

¹³ MedPAC, “Favorable selection and future directions for Medicare Advantage payment policy,” June 2023, pp. 153-154, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch4_MedPAC_Report_To_Congress_SEC.pdf.

¹⁴ *Id.*

¹⁵ *Id.*, pp. 162-163.

¹⁶ *Id.*, pp. 153-154.

¹⁷ Committee for a Responsible Federal Budget, “New Data Suggests MA Overpayments of \$1.3 Trillion Over the Next Decade,” January 23, 2026, <https://www.crfb.org/blogs/new-data-suggests-ma-overpayments-12-trillion-over-next-decade>.

¹⁸ KFF, “Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024,” Jeannie Fuglesten Biniek, Nolan Sroczyński, Meredith Freed, and Tricia Neuman, January 28, 2026, <https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024>.

¹⁹ *Id.*

²⁰ JAMA Health Forum, “Coverage Denials in Medicare Advantage—Balancing Access and Efficiency,” Suhas Gondi, Kushal T. Kadakia, and Thomas C. Tsai, March 1, 2024, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2815743>.

²¹ KFF, “Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024,” Jeannie Fuglesten Biniek, Nolan Sroczyński, Meredith Freed, and Tricia Neuman, January 28, 2026, <https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024>.

²² *Id.*

²³ American Medical Association, “2024 AMA prior authorization physician survey,” 2025, <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>.

You have recognized the barriers prior authorization creates, saying it causes care to be “significantly delayed,” “erodes public trust in the health care system,” and cannot be “tolerated in this administration.”²⁴ Although you have solicited commitments from insurers to streamline prior authorization practices,²⁵ these commitments are voluntary and may be revoked at any time. Rather than hold insurers accountable through regulation, your agency has proposed to remove multiple administrative measures from the star ratings system that indicate complaints regarding the timeliness or accuracy of prior authorizations, while also expanding prior authorization in traditional Medicare.²⁶ Barely three months into the launch of the administration’s WISeR model – which applies artificial intelligence-driven prior authorization to select services in traditional Medicare – patients are already reportedly “experience[ing] pain” as they wait “longer than usual for services” and causing doctors in some states to consider no longer “offering seniors [certain] treatments.”²⁷ We urge CMS to protect MA enrollees from inappropriate delays and denials and safeguard access to care.

Addressing Barriers Created by Restricted Networks

Whereas seniors and people with disabilities enrolled in traditional Medicare can receive care from any Medicare provider, individuals enrolled in MA face restricted networks that create significant barriers to care. The average MA enrollee has access to “just under half of all physicians available to traditional Medicare beneficiaries in their area,”²⁸ and it’s even worse for certain populations. In counties with a higher proportion of people of color, just 37 percent of physicians are in-network for MA enrollees.²⁹

For cancer patients, limited provider networks can be a matter of life or death. MA plans often exclude cancer research centers – which provide access to critical clinical trials and advanced cancer treatments – from their networks.³⁰ Seniors and people with disabilities enrolled in MA are also less likely to receive care from National Cancer Institute-designated cancer centers or hospitals accredited by the Commission of Cancer since MA insurers often exclude these top-tier hospitals from their networks.³¹ The same is true for radiation treatment: MA enrollees are less likely to

²⁴ KFF Health News, “AI Will Soon Have a Say in Approving or Denying Medicare Treatments,” Lauren Sausser and Darius Tahir, September 25, 2025, <https://kffhealthnews.org/news/article/ai-medicare-prior-authorization-trump-pilot-program-wiser>.

²⁵ CMS, “HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System,” press release, June 23, 2025, <https://www.cms.gov/newsroom/press-releases/hhs-secretary-kennedy-cms-administrator-oz-secure-industry-pledge-fix-broken-prior-authorization>.

²⁶ 90 FR 54894; KFF, “Examining the Potential impact of Medicare’s New WISeR Model,” Alex Cottrill, Jeannie Fuglesten Biniek, Juliette Cubanski, et al., February 10, 2026, <https://www.kff.org/medicare/examining-the-potential-impact-of-medicare-new-wiser-model>.

²⁷ Washington Post, “Exclusive: Medicare’s AI experiment leads to delayed care for some seniors,” Rebecca Adams, March 17, 2026, <https://wpintelligence.washingtonpost.com/topics/2026/03/18/exclusive-medicare-ai-experiment-leads-delayed-care-some-seniors>.

²⁸ KFF, “Medicare Advantage Enrollees Have Access to About Half of the Physicians Available to Traditional Medicare Beneficiaries,” Matthew Rae, Jeannie Fuglesten Biniek, Tricia Neuman, and Karen Pollitz, October 27, 2025, <https://www.kff.org/medicare/medicare-advantage-enrollees-have-access-to-about-half-of-the-physicians-available-to-traditional-medicare-beneficiaries>.

²⁹ *Id.*

³⁰ The Hill, “Medicare Advantage is not an advantage for many seniors with cancer,” Harlan Levine, March 21, 2023, <https://thehill.com/opinion/healthcare/3963071-medicare-advantage-is-not-an-advantage-for-many-seniors-with-cancer>.

³¹ *Id.*

receive advanced radiation therapies due to network restrictions, increasing both the cost and duration of treatment for individuals enrolled in MA compared to traditional Medicare.³²

In addition to “limit[ing] which doctors, specialists, and other health care providers are available” to MA enrollees, restricted networks also raise costs for seniors and people with disabilities enrolled in MA who are forced to pay higher out-of-network rates to keep seeing their same doctors or find new providers.³³ These obstacles put American seniors and people with disabilities at risk. We urge CMS to strengthen network adequacy requirements in MA and penalize insurers that are out of compliance.

Hold MA Insurers Accountable for Engaging in Anti-Competitive Behavior and Evading Regulatory Protections

Increasingly, MA insurers are owned by giant health care conglomerates that also own medical providers. By owning the entities that both pay for and provide health care services, these vertically-integrated corporations can pressure their subsidiaries to engage in practices like upcoding diagnoses or patient steering to disadvantage competitors and drive higher payments to themselves. Giant health care conglomerates appear to use these vertical integration strategies to generate a significant portion of their revenue. For example, UnitedHealth Group’s intercompany eliminations – the amount of money that the company effectively gave to itself – reached \$150.9 billion, or 27.4 percent of the company’s total revenue in 2024.³⁴ A recent study further revealed that UHG pays its own providers far more than competitors, with providers under UHG’s subsidiary Optum receiving payments 17 percent higher than non-Optum providers.³⁵

In practice, this is forcing Medicare beneficiaries to either find new MA plans or new doctors. In Washington, UnitedHealth Group’s Optum – which has 63 subsidiaries in the state – announced it will no longer accept Humana MA plans in 2026, meaning patients seeing Optum physicians must switch plans or seek care elsewhere.³⁶ As one local broker explained, “her affected Humana clients have all switched to the only other MA plan covering Optum that she sells: UnitedHealthcare.”³⁷

We are particularly concerned that MA insurers may be using profit-shifting strategies to evade the Medical Loss Ratio (MLR), which is intended to cap the amount of health care premium dollars that MA insurers may spend on profits and administrative costs.³⁸ When an MA insurer acquires a medical practice that determines diagnoses, bills for services, or otherwise sets the prices for health

³² Harvard T.H. Chan School of Public Health, “Medicare Advantage may limit radiation treatment options for cancer, increase cost and duration of care,” Maya Brownstein, April 24, 2025, <https://hsph.harvard.edu/news/medicare-advantage-may-limit-radiation-treatment-options-for-cancer-increase-cost-and-duration-of-care>.

³³ KFF, “Medicare Advantage Enrollees Have Access to About Half of the Physicians Available to Traditional Medicare Beneficiaries,” Matthew Rae, Jeannie Fuglesten Biniak, Tricia Neuman, and Karen Pollitz, October 27, 2025, <https://www.kff.org/medicare/medicare-advantage-enrollees-have-access-to-about-half-of-the-physicians-available-to-traditional-medicare-beneficiaries>.

³⁴ Center for Health and Democracy, “Sunlight Report on UnitedHealth Group,” 2025, <https://www.sunlightreportinsurance.com/about>.

³⁵ Health Affairs, “UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers,” Daniel R. Arnold and Brent D. Fulton, November 2025, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00155?journalCode=hlthaff>.

³⁶ Healthcare Dive, “Goliath v. Goliath,” Rebecca Pifer Parduhn, December 16, 2025, <https://www.healthcaredive.com/news/optum-humana-medicare-advantage-contract-dispute-washington/807944>.

³⁷ *Id.*

³⁸ Centers for Medicare & Medicaid Services, “Medical Loss Ratio,” <https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio>.

care services, MA insurers can inflate costs for medical services and keep more premium dollars within the parent company, undermining the MLR requirement.³⁹ Additionally, once the insurer acquires clinical subsidiaries, they can steer patients in their insurance plans to those practices. We urge CMS to crack down on these profit-shifting strategies, including by collecting better ownership data of MA plans and providers and requiring insurers to identify payments to related parties and the profit margins those entities realize. We also urge CMS to consider establishing benchmarks for common health care services to compare transfer prices.

Conclusion

As Americans struggle to keep up with rising health care costs, MA insurers continue to rake in billions in overpayments, abusing taxpayer dollars, while inappropriately obstructing enrollees from accessing medical care. While we support finalizing the CY 2027 proposed payment rate for MA plans, we urge CMS to turn its focus to the legitimate fraud, waste, and abuse in Medicare Advantage and address the program's longstanding problems that prevent seniors and people with disabilities from receiving medically necessary care.⁴⁰

Thank you for your attention to this important matter.

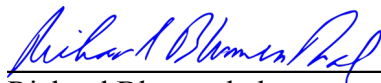
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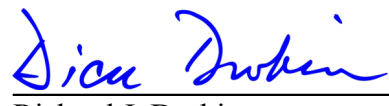
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Jeffrey A. Merkley
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Bernard Sanders
United States Senator

³⁹ American Economic Liberties Project, "Medicare Advantage and Vertical Consolidation in Health Care," Hayden Rooke-Ley, April 2024, p. 33, <https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf>.

⁴⁰ Stat News, "Automatic enrollment in Medicare Advantage plans under consideration, top Trump health officials says," Tara Bannow, March 20, 2026, <https://www.statnews.com/2026/03/20/medicare-advantage-default-enrollment-chris-klompp-project-2025>.

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