

# Medicare Advantage Policy Roadmap

Solutions to drive affordability, expand access and promote high-quality care for Medicare Advantage beneficiaries.



## THE CHALLENGE

# Building a stronger, more stable Medicare Advantage program

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Medicare Advantage has never been more popular with seniors than it is today. More than 35 million seniors and people with disabilities — over half of the entire Medicare population — now choose Medicare Advantage for affordable, comprehensive care with better health outcomes. With a 95 percent satisfaction rate, Medicare Advantage is no longer simply an alternative to traditional Fee-For-Service Medicare; it is the backbone of the Medicare program.

In recent years, however, aggressive policymaking has ushered in sweeping changes to Medicare Advantage — with significant disruption for providers, health plans, and particularly seniors. In 2025 alone, nearly 3 million beneficiaries needed to enroll in new Medicare Advantage plans after theirs exited markets or closed. Average out-of-pocket costs have climbed. And important health benefits have been scaled back.

**In short, seniors have been compelled to carry the weight of Washington's policy changes. We think there is a better way.**

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### 35M+

seniors and people with disabilities enrolled in Medicare Advantage

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### 55%+

of the entire Medicare population now chooses Medicare Advantage

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### 2.9M

beneficiaries forced into new plans in 2025 after exits and closures

Better Medicare Alliance has long been committed to strengthening and protecting Medicare Advantage, working alongside policymakers to achieve results-oriented reforms that protect beneficiaries. In 2023, BMA released a comprehensive policy package recommending changes in prior authorization, in-home health assessments, data collection around supplemental benefits, and more. Since then, our coalition has advocated for these reforms with Congress and two successive administrations.

Now it is time to update and expand those policy recommendations to meet a new moment in Medicare Advantage. This new policy roadmap is designed with one guiding principle in mind: to secure affordable healthcare for seniors.

These reforms would not only strengthen Medicare Advantage by advancing transparency and accountability for taxpayers. They would also make the program work better for seniors — without raising their healthcare costs or disrupting their coverage. It's a win-win, and we can begin acting immediately.

#### ONE GUIDING PRINCIPLE

## To secure affordable healthcare for seniors.

Ten reforms make that principle actionable:

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|--------------------------------------------------------|----------------------------------------------------------|
| <b>01</b> Streamline prior authorization               | <b>06</b> Promote program integrity                      |
| <b>02</b> Advance next-generation risk adjustment      | <b>07</b> Protect beneficiaries from deceptive marketing |
| <b>03</b> Expand transparency in supplemental benefits | <b>08</b> Strengthen provider network accuracy           |
| <b>04</b> Modernize in-home health assessments         | <b>09</b> Improve MA-VA payment alignment                |
| <b>05</b> Ensure predictability in Star Ratings        | <b>10</b> Support value-based care                       |



# Protecting high-quality, affordable care for seniors

## 01 Streamlining prior authorization

**ACTION** Regulatory (CMS oversight of AI use); legislative support

Health plans have already made voluntary commitments to reduce prior authorization burden — including AHIP's June 2025 pledge, signed by more than 50 insurers, to reduce the volume of services subject to review, standardize electronic submissions by 2027, and honor existing authorizations for beneficiaries who switch plans. Meanwhile, CMS's Interoperability and Prior Authorization Final Rule (CMS-0057-F) shortened the standard decision timeframe from 14 to 7 days beginning in 2026. BMA's recommendations would convert this progress into enforceable, durable standards.

- **Reduce the CMS-mandated decision deadline for expedited prior authorization requests from 72 hours to 24 hours for urgently needed care.**
- **Codify a prohibition on Artificial Intelligence-only denials without licensed clinician review.** As health plans increasingly use algorithmic tools to support utilization review workflow, a licensed clinician should remain accountable and at the center of decision-making for making every adverse determination.
- **Incorporate a mechanism for real-time decisions on routinely approved drugs and services.** CMS should collaborate with health plans and providers to identify services with consistently high approval rates that are appropriate for real-time, rather than multi-day, prior authorization decisions, reducing unnecessary delay for both beneficiaries and providers.
- **Require health plans to make coverage policies and prior authorization criteria clear, accessible, and publicly available.** This should build on the disclosures plans are already providing, and should extend to network providers, who should receive disclosures identifying which services are subject to review.

- **Finalize the proposed CY2027 Physician Fee Schedule requirement making electronic prior authorization reporting mandatory under MIPS starting in 2028.** This remains a proposal, not a final rule; finalizing it would give CMS reliable, comparable data on provider electronic prior authorization submissions.
- **Support passage of the Improving Seniors' Timely Access to Care Act.** First introduced in 2022, the bill remains unenacted; BMA continues to support its electronic prior authorization standards and real-time decision-making protections.

## 02 Promoting next-generation risk adjustment

**ACTION** Regulatory (Advance Notice / Rate Announcement process); technical and legislative

Policymakers have voiced sustained interest in modernizing Medicare Advantage risk adjustment, and CMS has already taken meaningful steps by phasing in the V28 model. BMA views a thoughtful transition toward an encounter data-calibrated model as an accurate and durable path forward, one that offers policymakers a constructive alternative to blunter measures, such as further across-the-board increases to the coding intensity adjustment, that would not address the underlying drivers of risk score growth.

- **Transition toward an encounter data-only calibrated Medicare Advantage risk model.** This should be phased in over a multi-year period to support a stable transition.
- **Require CMS to publish regional actuarial impact analyses alongside any proposed model change.** These analyses should accompany the Advance Notice and be updated at the final Rate Announcement, giving plans and policymakers a clear view of how a proposed change would affect specific markets before it takes effect.
- **Move to a multi-year risk adjustment model update cycle.** Model updates should occur no more frequently than every three years, except for limited technical corrections, paired with an extended, dedicated stakeholder comment process run separately from the annual rate notice.

## GUIDING PRINCIPLES

# Considerations for Risk Adjustment in Medicare Advantage

### Reflect the full spectrum of beneficiary needs and health status

Risk adjustment must account for the wide range of physical, behavioral, functional, and social factors that affect health status and influence outcomes and costs. This includes all beneficiaries with complex chronic conditions, disabilities, dual eligibility, and those from underserved communities.

Risk adjustment should reduce, not reinforce, longstanding differences in care, access, and payment. Models must include adjustments for non-medical drivers of health, geography, and demographic factors to ensure communities and populations are not under-resourced.

### Support fair and sustainable participation

Risk adjustment should enable fair competition and participation for plans and providers of all sizes and capacities. Models must not disproportionately benefit those with greater administrative or technical resources and should avoid reinforcing existing access or outcome gaps.

### Promote transparency and stakeholder engagement

Changes to risk adjustment must follow transparent processes, including public notice, data availability, and meaningful opportunities for stakeholder input. Clear communication and collaborative development are essential to building confidence and ensuring informed implementation.

### Test and phase-in model changes carefully

Any significant update such as inferred risk should be tested through demonstrations or “shadow models” that run alongside the current model before full implementation. This allows policymakers have adequate time to evaluate performance, understand impacts, and make adjustments without disrupting care or introducing unintended consequences.

### Minimize administrative burden and focus on care

Risk adjustment should be efficient and streamlined and reduce unnecessary administrative requirements, thus allowing providers and plans to prioritize high-quality, patient-centered care. Systems should reward accurate reflection of beneficiary needs.

### Ensure integrity and guard against unintended incentives

Models must be carefully designed to avoid incentivizing inappropriate coding practices, unnecessary utilization, or other strategies aimed at inflating risk scores. Risk adjustment should align payment with actual beneficiary needs and expected costs and not strategies to drive utilization and diagnostics.

## 03 Expanding transparency in supplemental benefits

**ACTION** Regulatory (CMS Plan Finder and data standards); legislative support



Nearly every plan now offers benefits beyond fee-for-service Medicare — from dental and vision to healthy food. Beneficiaries still cannot compare them plan to plan.

BMA believes transparency in the Medicare Advantage program is critical to helping beneficiaries make informed decisions and better understand the affordability, coverage options, and benefits available to them. Increased transparency can also help inform policymaking by providing policymakers, regulators, and stakeholders with better information to evaluate the program and ensure any future changes continue to meet the needs of beneficiaries while balancing the broader priorities and sustainability goals of the Medicare program.

Nearly every Medicare Advantage plan now offers supplemental benefits beyond what fee-for-service Medicare covers, and CMS has progressively broadened what qualifies as a primarily health-related benefit since 2019, including a 2020 expansion allowing benefits like healthy food for beneficiaries with chronic illness. Beginning in plan year 2024, health plans have also been required to report baseline supplemental benefit cost and utilization data to CMS. BMA supports further reform to help beneficiaries understand their supplemental benefits.

- **Standardize the language and descriptions used across plans for supplemental benefits.** Aligning with efforts such as the Gravity Project's coded, FHIR-based standards for social health data would let beneficiaries meaningfully compare offerings during enrollment, rather than parsing plan-specific terminology.

- **Display more detailed supplemental benefit information on Medicare Plan Finder.** Current listings show little beyond broad service categories; CMS should also expand the definition of primarily health-related supplemental benefits to include healthy food as a standard offering, not only for beneficiaries with chronic illness.
- **Build on the plan year 2024 utilization reporting requirement with standardized, stratified data.** CMS should collect and publish data stratified by subpopulation and condition, and evaluate benefit impact on social, emotional, and physical health outcomes, which the current baseline reporting does not yet do.
- **Designate high-value supplemental benefits on Plan Finder.** A symbol or tier rating based on impact evaluations would increase beneficiary awareness and encourage plans to offer the benefits with the greatest impact.
- **Strengthen beneficiary support and accountability for supplemental benefits.** Plans should actively assist beneficiaries in understanding, accessing, and utilizing available supplemental benefits through dedicated support channels, beneficiary advocates, and transparent grievance and appeals processes. This would help close the gap between benefits offered and benefits actually received.

## 04 Modernizing in-home health assessments

**ACTION** Legislative (statutory follow-up requirement; encounter data transparency); regulatory (best-practices compliance, RADV audits, program integrity)



In-home health risk assessments reach beneficiaries where clinic visits often cannot — surfacing housing risks, food insecurity, and medication issues in the setting where they actually occur.

Millions of in-home health risk assessments (in-home HRAs) are performed each year for Medicare Advantage beneficiaries by licensed physicians, nurse practitioners, and physician assistants. These visits — a critical part of the health care experience to foster care coordination, address chronic disease, and address the personalized needs of MA beneficiaries — deliver clinical assessments and preventive care, while surfacing needs that a traditional clinic visit often misses, such as housing risks and unmet social needs. CMS's 2016 best practices already establish a clinical model for these visits, and beginning in CY2024, CMS required Special Needs Plans specifically to include screening questions on food, housing, and transportation in their HRAs. Beneficiaries need support navigating and accessing the health care system, and the in-home HRA is well positioned to be that vehicle as more beneficiaries age into Medicare with chronic conditions. BMA's recommendations focus on three goals: Strengthening follow-up care, enhancing program integrity and oversight, and standardizing HRA requirements and the clinical model itself.

#### A. PROMOTE ENHANCED FOLLOW-UP CARE

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- **Enact a new requirement directing plans to follow up with beneficiaries after every HRA based on evidence-based clinical guidelines.** Qualifying follow-up actions should be defined broadly to match the flexibility Medicare Advantage plans have to complete them: weight management support, mobility and fitness support, home safety modifications, dietician services, care management services, securing follow-up care with existing PCPs or specialists, telehealth visits, connection to MA supplemental benefits and community-based resources, online education, support groups, a medication therapy management visit with a pharmacist, remote patient monitoring, and fall prevention.
- **Set a minimum outreach standard for member follow-up.** Congress or CMS could require a minimum number of outreach attempts, for example five, unless the beneficiary opts out, using the channels beneficiaries actually use: text messaging, phone calls, audio/visual telemedicine, email, mail, and application-based communication.

- **Require plans to identify or make an appointment with a primary care provider for every beneficiary and attempt to schedule a follow-up visit.**

Plans should attempt to help the beneficiary schedule an Annual Wellness Visit or evaluation and management visit to address the beneficiary's identified conditions, and share a summary of the HRA — diagnoses, medications, scheduled follow-up appointments, the care coordination plan, and community resource contact information — with that PCP.

#### SUPPORTING EVIDENCE

Independent Johns Hopkins research found Medicare Advantage enrollees were 4.4 percentage points more likely to receive an Annual Wellness Visit than traditional Medicare enrollees, with the largest gaps among dual-eligible beneficiaries (11.8 points), Black beneficiaries (9.0 points), those with Alzheimer's and related dementias (6.6 points), and beneficiaries 85 and older (5.8 points).

## B. STRENGTHEN PROGRAM INTEGRITY AND OVERSIGHT

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- **Mandate documentation of follow-up.** Medicare Advantage plans should be required to document that specific follow-up actions were completed, or that specific attempts to initiate them were made, whenever clinically indicated.
- **Require clinicians to use evidence-based clinical guidelines and established standards of care when making diagnoses during an HRA.**
- **Require data integration between HRA visits and the beneficiary's broader care team.** Plans should integrate HRA data into their case management systems and provide electronic HRA data to PCPs wherever the PCP has the capability to receive it.
- **Require CMS to develop, collect, and publish a defined set of HRA metrics in collaboration with stakeholders.** These should include the number of HRA encounters; medication reviews conducted and any adverse determinations identified and corrected; provider encounters within 90 days of an in-home visit; HRA reports delivered to the beneficiary's PCP; beneficiaries enrolled in disease or case management programs to address needs identified in the medical visit; and gaps closed, including quality measures and unmanaged social drivers of health barriers to care per member.

- **Deploy HRA-focused audits.** Once CMS finalizes rules standardizing its 2016 in-home HRA best practices, its annual program audit should include a review of plan compliance with those practices, and CMS should conduct a RADV audit specifically targeted at in-home HRAs to examine the accuracy of diagnoses submitted as a result of these visits.

#### C. STANDARDIZE HRA REQUIREMENTS AND THE CLINICAL MODEL

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- **Require all in-home HRAs to address CMS' 2016 best practice guidelines.** Every HRA visit is a medial encounter and performed by a provider type that has the authority to diagnose and perform and bill for evaluation and management visits. These providers are only physicians (M.D. or D.O.), nurse practitioners, physician assistants, or certified clinical nurse specialists.
  - These visits must include, at a minimum, all components of the Medicare Annual Wellness Visit, as well as the following:
    - A standardized health assessment such as the one developed by the CDC
    - Medication review and reconciliation
    - A process to schedule appointments and make referrals or connections to appropriate community resources
    - An environmental scan of the beneficiary's home for safety risks and potential adaptive equipment needs
    - A beneficiary-facing summary of diagnoses identified and explained to the beneficiary, current medications and any medication concerns to address with their community provider, dates of upcoming known medical appointments made, medical and other follow-up recommended, the care coordination plan, community resource contacts; and disease or case management programs patient is enrolled in or recommended based on the assessment.
    - A process to verify that needed follow-up care is provided
    - A process to verify that information obtained during the assessment is provided to the appropriate plan provider
  - The visit should also include:
    - Use of a standardized and validated falls risk assessment tool
    - Use of a standardized tool for identifying social risk factors for all beneficiaries, not just those in Special Needs Plans as is currently required

- **Extend standardized questions on food security, housing stability, and transportation access to all in-home HRAs.** CMS currently requires this only of Special Needs Plans; BMA recommends extending the same standard to every Medicare Advantage HRA.
- **Develop best practices governing the frequency and channel of beneficiary outreach for scheduling the in-home HRA itself.**
- **Ensure encounter data clearly flags when an in-home HRA was performed and by which entity.** This change is currently pending in H.R. 9392, the Medicare Advantage Cost Transparency Act, rather than already in place.

## 05 Ensuring stability and predictability in Star Ratings

**ACTION** Legislative (statutory cliff and rebate thresholds); regulatory (measure design)

Policymakers should prioritize clinical outcome measures when developing new Star Ratings metrics, and greater stability and predictability should guide the program going forward. The final 2027 Star Ratings are scheduled for release this October, yet questions remain about the underlying methodology. Health plans and providers build quality improvement initiatives, value-based care incentives, and chronic disease management strategies years in advance based on their understanding of the program; unpredictable changes to program rules make those investments difficult to sustain, and beneficiaries ultimately bear the consequences.

- **Prioritize stability and hold-harmless protections in the near term.** With measure methodology disputes still unresolved, CMS should mitigate unintended disruption to plans and beneficiaries rather than layering additional changes onto an already unsettled rating cycle.
- **Eliminate the hard cliffs in the Star Ratings bonus and rebate structure, particularly between 3.5 and 4.0 stars.** Because the 3.5/4.0 threshold and the rebate tiers tied to it are set in statute, this is a legislative fix rather than a CMS rulemaking opportunity. Spreading financial incentives across smaller, quarter-point increments and meaningfully lowering rebate percentages at the bottom of the performance scale would reward incremental quality gains rather than forcing disproportionate cuts to beneficiary rebates over fractional differences in performance.

## 06 Promoting program integrity

**ACTION** Regulatory (RADV methodology, CRUSH RFI rulemaking, FWA infrastructure)

Medicare Advantage plans are active partners with CMS in identifying and addressing fraud, waste, and abuse. BMA recommends a program integrity agenda calibrated to where risk actually concentrates.

- **CMS should RADV audits of all Medicare Advantage plans annually**, greatly increasing oversight of the program with a well-designed methodology that includes a Medicare FFS adjuster.
- **Extend mandatory payment suspension authority to Medicare Advantage and Part D plans.** This authority should apply on the same terms already required in traditional Medicare, including the ability to link a suspension across Parts C and D when suspicious activity is identified in either program.
- **Strengthen upfront provider enrollment validation.** CMS should confirm that a provider has an actual office, lab, or equipment site rather than accepting self-reported information at face value, paired with more frequent revalidation for high-risk provider types.
- **Limit Fee-For-Service enrollment requirements to high-risk supplemental-benefit vendors.** Many Medicare Advantage supplemental-benefit partners, including grocers, fitness centers, and utility providers, are not eligible for or face significant barriers to Fee-for-Service enrollment. BMA supports a risk-based oversight framework and looks forward to collaborating with CMS on standards tailored to these vendors.
- **If CMS expands the preclusion list, urge phased implementation.** Any expansion should come with advance outreach, clear communication of the basis for preclusion, and adequate lead time for claims processing and beneficiary notification, alongside earlier plan visibility into FFS-suspended or under-investigation providers.
- **Educate Independent Review Entities on fraud patterns in appealed claims.** IREs currently overturn a meaningful share of plan denials of fraudulent claims from non-participating providers.

- **Strengthen the Healthcare Fraud Prevention Partnership.** More consistent execution and vendor continuity, paired with real-time, standardized data sharing between CMS and Medicare Advantage plans on high-risk providers, death data, and emerging fraud schemes, would close a persistent visibility gap.

## 07 Protecting beneficiaries from deceptive marketing practices

**ACTION** Regulatory (CMS marketing oversight); rulemaking on agent compensation



Consent rules and complaint tracking have improved visibility. The compensation structure driving misleading marketing is still in place.

CMS has made significant progress in modernizing oversight of Medicare Advantage marketing by advancing policies that strengthen beneficiary protections, improve transparency and accountability among marketing entities, and enhance CMS's ability to monitor, investigate, and respond to potential compliance concerns.

The CY2025 Final Rule established one-to-one consent requirements for third-party marketing organizations' (TPMOs) use of beneficiary data, a protection retained through the CY2027 rulemaking cycle even as other marketing restrictions were rolled back; and CMS enhanced its Complaints Tracking Module in September 2025 to capture structured agent- and broker-level complaint data. BMA supports further action to eliminate deceptive marketing practices and to ensure marketing and agent and broker interactions support beneficiary decision-making.

- **Align updates to the maximum Fair Market Value compensation amounts for agents and brokers to the Consumer Price Index or a comparable labor-based index.** This offers CMS a durable alternative to medical-trend-based updates.
- **Prohibit TPMO resale of beneficiary data,** closing the loophole in the existing consent requirement. Pair this prohibition with compliance monitoring to ensure enforcement.
- **Establish a formal code of conduct for TPMOs, with continued CMS oversight.** CMS should also enhance ongoing enforcement of misleading marketing practices more broadly, including a graduated set of consequences for plans and marketing partners found out of compliance.
- **Protect and increase dedicated federal funding for State Health Insurance Assistance Programs and the Senior Medicare Patrol.** This need has grown more urgent with proposed FY2026 budget changes that would eliminate dedicated SHIP funding and the Administration for Community Living, both of which independently monitor and report on misleading marketing.
- **Engage health plans, agents, brokers, and beneficiaries in developing performance metrics that incentivize high-value engagement.** Metrics should reward agents and brokers for helping beneficiaries select the plan that best fits their needs, rather than rewarding enrollment volume alone.

#### SUPPORTING EVIDENCE

CMS's Complaints Tracking Module, enhanced in September 2025, now captures structured agent- and broker-level attribution, giving CMS and stakeholders a new ability to identify which distribution channels generate disproportionate complaint volume.

A May 2026 Brown University analysis published in JAMA Internal Medicine found that Medicare Advantage broker commissions more than doubled between 2014 and 2022, from about \$3.9 billion to roughly \$10 billion a year, with renewal payments now driving the majority of that spending; the researchers cautioned that it remains unclear whether the current commission structure serves beneficiaries' best interests.

CMS's 2024 attempt to cap broker compensation was stayed and later vacated in litigation in the Northern District of Texas, leaving BMA's CPI-indexing proposal as a durable alternative CMS could pursue on remand.

## 08 Strengthening provider network accuracy

**ACTION** Regulatory implementation; CMS–industry coordination

Provider directory accuracy is both a consumer protection and healthcare access issue, pairing implementation of the REAL Health Providers Act with continued investment in a national provider directory to deliver lasting, system-wide improvements. The REAL Health Providers Act gives policymakers a legislative vehicle for provider directory accuracy, including new real-time update requirements that respond directly to longstanding beneficiary complaints about outdated directories. In addition to implementing this Act, policymakers should continue prioritizing work toward a national provider directory.

- **Ensure plans and providers are coordinated on REAL Health Providers Act implementation.** The Act already addresses BMA's recommendation to shorten timelines for updating directory data. CMS implementation of the Act should address the development of standardized data elements, clear definitions of accuracy, and recognition when best efforts are made to update and verify data.
- **Require health plans to standardize their processes for requesting personnel changes from providers.** Provider groups have long reported that health plans use inconsistent processes for reporting personnel changes, adding administrative burden that a standardized process would meaningfully reduce.
- **Engage a broad range of providers in directory accuracy efforts.** Behavioral health, post-acute care, and advanced practice providers should be included alongside physician practices, which have historically received the most attention.
- **Require periodic independent audits of health plan provider directories, with results posted publicly.** Independent verification would reinforce accountability alongside the Act's real-time update requirements, closing the compliance-monitoring gap that remains even after enactment.

- **Work toward a comprehensive, interoperable national provider directory.**

Such a directory should be fully searchable, offer an API for third-party tools that support beneficiary decision-making, exchange data seamlessly with existing directories maintained by health insurers, Medicaid, state licensing boards, CAQH, and NPPES, and include providers beyond physician practices — dental, vision, behavioral health, pharmacy, and post-acute care. This remains a longer-term build; efforts should align with ongoing plan and provider interoperability efforts.

## 09 Improving alignment between Medicare Advantage and Veterans Affairs (VA) payments

**ACTION** New priority; regulatory and legislative support



Veterans enrolled in Medicare Advantage draw on both systems for their care. How the two programs pay for it should be settled with evidence, not a single rate change.

BMA supports ways to ensure federal funding is properly allocated for beneficiaries who are enrolled in a Medicare Advantage plan but also receive care through the Veterans Administration. BMA believes this should be done in a measured way that supports coordination between plans and the VA.

- **Establish data exchange infrastructure between Medicare Advantage plans and the VA.** Plans need timely, standardized visibility into VA-furnished care, referrals, and cost data for their enrollees — the same kind of infrastructure BMA is separately recommending for program-wide fraud, waste, and abuse detection.

- **Ensure Medicare Advantage benchmark calculations are appropriately adjusted to capture the expected cost of care provided in VA facilities.** Without this adjustment, plans would be made financially responsible for a category of cost the current benchmark methodology was never designed to reflect.

## 10 Supporting value-based care

**ACTION** Regulatory (CMMI alignment)

Medicare Advantage engages providers in value-based care partnerships that promote care coordination, chronic disease management, and social needs navigation, supporting CMS' stated goal of moving all Medicare beneficiaries into an accountable care relationship. Enhancing the partnership between health plans and providers on the design of value-based care arrangements ensures providers have the support to be successful as they take on more risk and engage in care transformation.

- **Protect the stability of Star Ratings and risk adjustment policy.** Minimizing the downstream impact that unpredictable changes to either could have on existing value-based provider contracts ensures plans and providers can maintain multi-year value-based care arrangements.
- **Ensure plans and providers retain the ability to design value-based arrangements suited to a specific provider, specialty, condition, or region.** A one-size-fits-all model would undercut the flexibility that has made these arrangements effective in the first place.

### LEGISLATIVE PRIORITIES

## Bipartisan solutions to strengthen Medicare Advantage

Better Medicare Alliance is proud to support the following bills, which would advance the priorities outlined in this roadmap and help strengthen Medicare Advantage for taxpayers and seniors:

## **H.R. 9393**

### **Lower Cost, More Transparency Act**

H.R. 9393, the Lower Costs, More Transparency Act of 2026, is the legislative vehicle for a package of six bills cleared by the Energy and Commerce Committee and positioned for potential House floor action. The base bill is joined by five amendments in the nature of a substitute: H.R. 5243 (MA Supplemental Benefits Data Transparency Act), H.R. 3514 (Improving Seniors' Timely Access to Care Act of 2025), H.R. 9392 (Medicare Advantage Cost Transparency Act), and H.R. 9397 (Premium Transparency Act), H.R. 9396 (Prior Authorization Accountability Act).

#### **BMA POSITIONS ON OTHER LEGISLATION JOINED TO H.R. 9393**

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## **H.R. 3514 / S. 1816**

### **Improving Seniors' Timely Access to Care Act**

Establishes electronic prior authorization requirements, transparency and accountability standards, and real-time decision-making protections for Medicare Advantage plans. BMA continues to endorse this bill which would improve the prior authorization process for providers and beneficiaries.

## **H.R. 5243**

### **MA Supplemental Benefits Data Transparency Act**

Requires CMS to provide a de-identified public-use file containing data on supplemental benefits, including data on utilization and payments for each benefit. BMA recommends CMS seek technical assistance on data definitions, confidentiality safeguards, and public reporting design.

## **H.R. 9395**

### **Agent and Broker Compensation Transparency and Limitation Act**

Advances transparency and anti-steering goals for agent and broker compensation. BMA supports the bill's transparency and reporting intent; any compensation reporting should build on existing CMS data infrastructure and reporting requirements.

## **H.R. 9392**

### **Medicare Advantage Cost Transparency Act**

Would require encounter data to flag when an at-home health risk assessment was performed by a specified assessment entity. BMA supports the bill's intent, while asking that the Secretary retain discretion in defining the specific data elements needed to implement this data collection, alongside a clearer definition of "specified assessment entity" and a carve-out for new-to-plan members who received an in-home HRA under a different carrier in a prior plan year.

**H.R. 9396**

## **Prior Authorization Accountability Act**

Would require commercial and Medicare Advantage plans that impose prior authorization to publicly post the list of items and services subject to review, approval and denial rates in aggregate and by service, appeal and overturn rates, and average and median processing times, including disclosure on state and federal exchanges beginning in 2029. BMA recommends the bill explicitly align with CMS-0057-F reporting fields and timelines to avoid a second, differently structured reporting process.

### **OTHER LEGISLATION BMA SUPPORTS**

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**H.R. 4093 / S. 3848**

## **Apples to Apples Comparison Act**

Directs CMS to publish a standardized annual comparison of Medicare spending and health outcomes for Medicare Advantage versus comparable traditional fee-for-service beneficiaries, making MA-versus-FFS comparisons more transparent and analytically comparable rather than relying on aggregates that may reflect differing enrollee characteristics.

### **BMA's four implementation principles**

As these bills advance, BMA asks Congress and CMS to carry the same four principles into implementation:

1. Sequence new requirements behind existing CMS rules where they overlap, rather than layering a second reporting stream.
2. Centralize CMS-collected data, such as Section 1857 filings, in one public place rather than requiring redundant plan-level postings.
3. Provide precise statutory definitions and CMS technical assistance for undefined terms such as “spread pricing.”
4. Preserve health plan flexibility to use real-world examples and visuals in beneficiary-facing disclosures rather than imposing rigid templates that reduce comprehension.



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THE PATH FORWARD

## Securing the future of Medicare Advantage

Medicare Advantage has become a cornerstone of coverage for millions of seniors because it delivers affordable, coordinated, and personalized care. As beneficiary needs continue to evolve, policymakers have an opportunity to strengthen the program's long-term sustainability while preserving the stability, choice, and value beneficiaries rely on today. By advancing thoughtful, targeted reforms, Congress and CMS can ensure Medicare Advantage continues to meet the needs of current and future generations of beneficiaries.

BMA looks forward to partnering with policymakers to support a stronger, more responsive Medicare program.