

MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage

September 20, 2021

Introduction

Starting in the Fall of 2017, the Center for Medicare Advocacy (the Center) and other advocacy organizations highlighted that, in a marked change from previous practice, the Trump Administration’s Centers for Medicare & Medicaid Services’ (CMS) outreach and enrollment materials promoted enrollment in private Medicare Advantage (MA) plans, while downplaying the drawbacks of such plans. At the same time, these materials – including revisions to recent editions of *Medicare & You*, online comparison tools (including the Medicare Plan Finder and associated materials), and education and outreach materials – tended to downplay (or in the case of some email campaigns, entirely leave out), the option of traditional/Original Medicare. Instead of objectively presenting enrollment options, some of this material went as far as encouraging beneficiaries to choose a private MA plan over traditional Medicare. (For a catalogue of such bias in Medicare materials in recent years, see the Addendum to this report, below.)

While there were some general improvements in the 2021 *Medicare & You* handbook, bias towards Medicare Advantage remained, and in some ways, was worse. Enrollment in MA plans was promoted at the same time that important restrictions and challenges faced when enrolling in MA plans were downplayed or omitted. Regrettably, when we had an opportunity to review the 2022 draft – along with a number of other stakeholders – we found that much of this bias remained.

CMS recently posted the final [Medicare & You 2022 Handbook](#) on their website. We reviewed the new handbook with an eye toward assessing the balance of information provided about traditional Medicare vs. Medicare Advantage, and the accuracy of information regarding coverage. **We are pleased to report that while there is still work to do, the new Handbook makes important strides towards reversing the bias in favor of MA that was prevalent in recent editions.** In this report, we examine the improvements, and highlight where more attention is needed.

In addition to making an effort to reverse this bias, we applaud CMS for translating the Handbook into new languages other than English and Spanish for the first time – Chinese, available now, and Vietnamese and Korean, which will be available in early October.

Reversal of Bias Towards MA

As we noted in our analysis of the 2021 Handbook, word choice matters, especially in a document that is widely read by beneficiaries who often use this as their sole or primary source

of information about Medicare. Changes and distinctions in language that may, at first glance, appear innocuous, can significantly alter the meaning and interpretation of certain concepts.

We recognize that an educational document geared towards Medicare beneficiaries is not the place to air grievances about health care policy relating to Medicare Advantage (e.g., overpayments, oversight) – we wage this battle in other arenas. But the *Medicare & You* Handbook is precisely the place to present accurate, unbiased and unvarnished information about the trade-offs between different Medicare coverage options.

In the final version of *Medicare & You 2022*, it is evident that CMS has given greater attention to objectivity rather than painting Medicare Advantage in the most favorable light. This change is clear when reviewing the comparison charts at the beginning of the Handbook (pp. 5-7), a section readers are most likely to pay attention to, and, because of its brevity, is most susceptible to improper shortcuts or abbreviation of critical information.

CMS has removed promotional or advertising sounding language describing MA, such as painting it as an “all in one” alternative to traditional Medicare, and instead retains language describing MA as “bundled” plans that include Part A, B and usually Part D. Further, CMS revised several comparative scales throughout the Handbook, meant to grab attention and highlight the differences between traditional Medicare and MA plans, to more accurately and fairly reflect such differences.

Below we outline specific issues relating to comparisons between MA and traditional Medicare where CMS has worked to reverse the bias towards MA, and where more work is required.

Limited Provider Networks

One of the hallmarks of managed care is that plans rely on a network of providers with whom they contract; in general, enrollees must see providers that are part of this network. While some plan types, such as PPOs, allow enrollees to go out-of-network, usually with higher cost-sharing, HMOs usually employ limited networks (other than point of service, or POS plans). Medicare Advantage HMOs continue to enroll the most beneficiaries (e.g., according to the Medicare Payment Advisory Commission (MedPAC), as of July 2020, there were 15 million MA HMO enrollees (24% of all Medicare beneficiaries) vs. 9.2 million in PPOs (local and regional) enrollees (15% of all Medicare beneficiaries – [MedPAC](#), March 2021).

Recent versions of the Handbook have tended to both downplay the application of limited provider networks and conflate PPO-type out-of-network access with access to providers in all MA plan types. For example, language in the draft 2022 version (at p. 5) and previous editions stated that "In many cases, you'll need to use doctors who are in the plan's network". CMS has now changed "many" back to "most," as it was in the 2020 Handbook. Readers will likely pay closer attention to a more accurate warning that states "most" rather than "many".

Similarly, draft 2022 language and previous versions (pp. 6-7) stated "In many cases, you'll need to use doctors and other providers who are in the plan's network and service area for the lowest costs. Some plans won't cover services from providers outside the service area." As we stated in comments to CMS, this is highly misleading; for the majority of MA enrollees in HMOs, there

are no covered services outside of the network or service area (except for urgent or emergent services). The qualifier of "for the lowest" costs only applies to PPOs and preferred networks; most plans, not "some", won't cover costs outside of the plan's network or service area. In response, CMS revised the final language to: "In many cases, you'll need to only use doctors and other providers who are in the plan's network (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost." Correspondingly, CMS also revised similar language in a both a scale comparing traditional Medicare with MA and text describing MA coverage (at p. 60-61), eliminating "many" and "for the lowest costs" so that the language now reads "If you have a Medicare Advantage Plan, in most cases, you'll need to use doctors and other providers who are in the plan's network."

Extra Benefits

MA plans often use rebate dollars, essentially the difference between a plan's bid and the local benchmark payment rate, to provide benefits not covered by traditional Medicare. Previous editions of the Handbook tended to overpromise the availability and extent of such extra benefits or services. As noted by the Kaiser Family Foundation in a June 2021 [report](#), while many extra benefits are "widely available, the scope of specific services vary [... and] [p]lans also vary in terms of cost sharing for various services and limits on the number of services covered per year and many impose an annual dollar cap on the amount the plan will pay toward covered services."

Draft 2022 language (p. 5) stated "Most plans offer extra benefits that Original Medicare doesn't cover— like vision, hearing, dental". We urged CMS not to over-sell these extra benefits since most supplemental benefits offered by MA plans are limited. In turn, CMS revised the final language to: "Plans may offer some extra benefits that Original Medicare doesn't cover—like vision, hearing, and dental services." Similarly, CMS revised draft language at p. 55 stating that MA plans "cover extra benefits" with examples to "may cover some extra benefits" – a more accurate description.

Within a discussion of long-term care, and the general lack of coverage for such services in Medicare, previous versions (and the 2022 draft) had had a comparative scale highlighting Special Needs Plans (SNPs) as a type of MA plan that "may be able to cover long-term care if you have Medicare and Medicaid." In response to concerns that eligibility for SNPs is limited to those dually eligible for Medicare and Medicaid, and that this statement may over-promise what long-term services are actually available through such plans, CMS appropriately removed the comparison scale.

As discussed below, however, CMS did not go far enough in explaining the limitations of new, expanded supplemental benefits available in MA plans.

Other MA Changes

In addition to making these subtle, yet important, changes to language generally describing access to care and the scope of benefits available through MA plans, CMS further improved upon other MA-related information in the Handbook. For example, the draft version had a comparative scale addressing Medicare Medical Savings Account (MSA) plans as an option for

people interested in health savings accounts. Given that in 2020 only about 8,000 people across the country were enrolled in such plans ([MedPAC](#), March 2021), out of over 26 million MA enrollees and over 62 million Medicare beneficiaries, CMS appropriately de-emphasized such plans by changing the comparative scale to a “note” (p. 20).

Elsewhere, the Handbook was revised to clarify that individuals in an MA plan who make a hospice election can still have some curative services covered by the MA plan (p. 27). Also, with respect to skilled nursing facility (SNF) coverage, CMS appropriately added language clarifying that while there is no cost-sharing for the first 20 days under traditional Medicare, MA plans may charge copayments during the first 20 days (see p. 29). As discussed below, however, CMS generally missed opportunities to better describe cost-sharing in MA plans.

Other Non-MA Improvements

While the primary focus of our review was on MA bias, CMS also improved information on other topics. For example, in a chart describing how Medicare interacts with other health insurance coverage (p. 21), CMS both: made it clearer that for folks with ESRD, employer-based coverage can include former employment for purposes of a 30-month coordination of benefits period during which such coverage is primary to Medicare; and added an important warning concerning employer-based coverage: “Important! If you’re still working and have employer coverage through work, contact your employer to find out how your employer’s coverage works with Medicare.”

In addition, CMS improved the description of the Medicare home health benefit on p. 44. For example, the description includes coverage of home health aide and other services more prominently and makes it more clear that there is no duration of time limitation on Medicare-covered home health coverage, as long as an individual continues to meet applicable coverage criteria. An accurate and full description of the home health benefit in Medicare materials, along with enforcing such coverage, is of great importance to Medicare beneficiaries and the Center for Medicare Advocacy. (See, e.g., the Center’s April 2021 [Issue Brief](#)).

Further Improvement Needed re: Accuracy of MA Information

Despite the improvements, outlined above, towards reversing the trend of Medicare materials reflecting bias towards (or at least accurately describing), Medicare Advantage plans, there are a few areas in which CMS fell short in the final 2022 Handbook. For example, CMS did not follow suggestions to make it clear that prior authorization is widely used by MA plans; and that MA enrollees can pay more than they would in traditional Medicare, despite a required cap on such expenses.

Out-of-Pocket Costs

MA plans have the discretion to alter their cost-sharing as long as what they charge is actuarially equivalent to what an individual in traditional Medicare (without any supplemental insurance) would face. Cost-sharing is limited to the same limits in traditional Medicare for chemotherapy, kidney dialysis, and skilled nursing facility stays (except, as noted above, unlike traditional Medicare, MA plans can charge cost-sharing for the first 20 days). Further, MA plans are

required to impose a maximum out-of-pocket cap (MOOP) for Part A and B covered services (according to the [Kaiser Family Foundation](#), the average MOOP for enrollees in 2021 is \$5,091 for in-network services and \$9,208 for both in-network and out-of-network services).

What is often lost in cost-benefit analyses regarding the choice between MA and traditional Medicare, as well as in educational materials such as the *Medicare & You Handbook*, is that despite the MOOP, people in MA plans can pay more for their care than those in traditional Medicare. As we have noted in [analyses of previous versions](#) (also see Addendum, below), such materials often promote MA plans as an opportunity to have lower out-of-pocket costs than those in traditional Medicare, but downplays variables that could make the opposite true. The cost of monthly Medigap premiums, for example, can often total less than an annual MOOP for a given MA plan. A recent Kaiser Family Foundation (KFF) [report](#) (June 2021) found that rates of cost-related problems are higher among MA enrollees than those in traditional Medicare with supplemental coverage and “[a]mong Black beneficiaries specifically, a larger share of those in Medicare Advantage reported cost-related problems than those in traditional Medicare (32% vs. 24%).” A separate KFF [report](#) issued the same month found that slightly more than half of all MA enrollees would incur higher costs than beneficiaries in traditional Medicare for a 6-day hospital stay.

Although improved, the final 2022 Handbook (and other CMS materials) can and should do better to more accurately describe and educate people about potential out-of-pocket costs that MA enrollees can face, and how other non-MA supplemental coverage (Medigap, Medicaid) can often better protect individuals from such costs. For example, rather than follow our suggestion to revise a comparison scale discussing the MA MOOP to note that before this limit is reached MA plans may charge more cost-sharing for certain services than is allowed under traditional Medicare, and that certain types of supplemental coverage, such as Medigaps, can also limit yearly out-of-pocket costs, CMS removed the comparison scale altogether. This was a missed opportunity to provide more balance in information concerning MA and traditional Medicare.

Similarly, CMS did not follow our recommendation on p. 61 to replace the draft language about MA plans "These plans set a limit on what you'll have to pay out-of-pocket each year for covered services, to help protect you from unexpected costs" with a more balanced and accurate description of cost-sharing in an MA plan, such as "These plans set a limit on what you'll have to pay out-of-pocket each year for covered services, which may help protect you from high or unexpected costs, but your out-of-pocket expenses may still be higher than with Original Medicare."

Other opportunities were missed, for example, on p. 64 under “What do I pay?” - the fourth bullet notes that MA plans can't charge more than Original Medicare for certain services. It should be amended to note that while Original Medicare does not require any copays for the first 20 days of a SNF stay, MA plans can charge cost-sharing during the first 20 days (as CMS helpfully added to the section re: SNFs). On the same page, CMS could have added, as we suggested "Medicare Advantage Plans can charge more than Original Medicare for certain services, such as co-pays for home health services."

Prior Authorization

As noted by the Kaiser Family Foundation in a June 2021 [report](#), virtually all MA enrollees are in plans that require prior authorization:

Medicare Advantage plans can require enrollees to receive prior authorization before a service will be covered, and nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services in 2021. Prior authorization is most often required for relatively expensive services, such as inpatient hospital stays, Part B drugs, and skilled nursing facility stays, and is rarely required for preventive services. Prior authorization is also required for the majority of enrollees for some extra benefits (in plans that offer these benefits), including comprehensive dental services, hearing and eye exams, and transportation. [...] In contrast to Medicare Advantage plans, traditional Medicare does not generally require prior authorization for services and does not require step therapy for Part B drugs.

Such widespread use of prior authorization often leads to problems accessing care. A 2018 Department of Health & Human Services, Office of Inspector General (OIG) [report](#) found “widespread and persistent problems related to denials of care and payment in Medicare Advantage’ plans”. The report’s findings included that when beneficiaries and providers appealed preauthorization and payment denials, MA plans “overturned 75 percent of their own denials.” At the same time, “beneficiaries and providers appealed only 1 percent of denials to the first level of appeal.” As summarized in the report’s conclusion, and quoted in a [CMA Alert](#), MA plans:

“may have an incentive to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits. High overturn rates when beneficiaries and providers appeal denials, and CMS audit findings about inappropriate denials, raise concerns that some beneficiaries and providers may not be getting services and payment that MAOs [Medicare Advantage Organizations] are required to provide. These findings are particularly concerning because beneficiaries and providers rarely use the appeals process designed to ensure access to care and payment, and CMS has repeatedly cited MAOs for issuing incorrect or incomplete denials letters, which can impair a beneficiary’s or provider’s ability to mount a successful appeal. Additionally, because audit violations will no longer be reflected in Star Ratings, beneficiaries may be unaware of MAO performance problems when selecting a plan. Although CMS uses several compliance and enforcement tools to address MAO performance problems, more action is needed to address these widespread and persistent problems in Medicare Advantage.”

In short, prior authorization and other utilization management tools serve as significant barriers to care that both current and prospective MA enrollees are often unaware of until they need to access services. At the very least, CMS must make the prevalence of these barriers more clear in the Handbook, but missed the opportunity to do so in the final 2022 version.

For example, in the “At a Glance” chart on pp. 6-7, CMS did not follow our suggestion to change “some” to “many” in the following sentence: "In some cases you have to get a service or

supply approved ahead of time for the plan to cover it". Downplaying the possibility that an MA enrollee will run into prior authorization fails to give proper warning. Similarly, on p. 62, under a heading describing that MA plans must follow Medicare's rules, the third sentence references plans' discretion to set rules for how an enrollee gets services. CMS did not follow our suggestion to highlight (e.g., with an "Important" flag or something similar) the prevalence of prior authorization, with language along the lines of "Almost every plan requires prior approval for at least some of the services they cover." A similar warning should have been – but was not – inserted on p. 65 after reference to the use of prior authorization.

One instance in which CMS did make an improvement between the draft and final 2022 versions concerns a reference to prior authorization in the appeals section, and articulating the right to obtain an organization determination from an MA plan. The draft version included a comparison scale that, similar to the draft 2019 version of the handbook (discussed in this [CMA Alert](#)), characterized prior authorization requirements in MA plans as a benefit, rather than a barrier to care. The draft comparison scale noted that MA enrollees “have the right to an organization determination to see if your plan covers a service, drug, or supply.” In our comments to CMS, we noted that this information should not be included in a comparative scale. Although it is important to include this information, to do so in a comparative box that is meant to help one understand Medicare coverage options and shows comparisons between traditional Medicare and Medicare Advantage, without including further information, is highly misleading. Without adding that in traditional Medicare such prior approval is rarely needed, highlighting this right here suggests that this is in fact a benefit available only in MA plans – rather than a necessary safety measure to mitigate against MA plan restrictions. MA appeals, specifically the right to get an organization determination, remains a source of so much confusion for MA enrollees, particularly since the appeals process for MA enrollees differs from those who have traditional Medicare.

We noted that this section should be expanded upon in the standard text (instead of a comparative scale). Specifically, people in MA plans should be told they have a right to an organization determination and should call their plan to request one to see if a service, drug, or supply is covered. In the final version, CMS did change this language on p. 101 to a “Note” which more appropriately contextualizes this issue: “Note: If you have a Medicare Advantage Plan, you have the right to ask the plan in advance if it covers a certain service, drug, or supply. Contact your plan to request and submit a pre-service organization determination. The plan’s response will include instructions to file a timely appeal, if you want one.”

Other Issues

There are other areas in which CMS could have improved the information provided about MA plans. For example, while CMS did a better job of explaining the availability of extra benefits in MA, as discussed above, they continue to fall short with respect to appropriately tempering expectations about the new flexibilities MA plans have to offer supplemental benefits, including the Special Supplemental Benefits for the Chronically Ill (SSBCI). Under the heading “Plans can offer extra benefits” on p. 62, CMS did not follow our recommendation that when describing SSBCI, e.g., second to last sentence, it should be made clearer that not everyone will

have access to all services offered. In addition, eligibility for SSBCI will not actually be determined until someone is enrolled in a plan and they are both confirmed to have a chronic condition and an individualized assessment has been performed concerning whether the services for this individual have a reasonable expectation of improving or maintaining their health or overall function (as discussed, e.g., in this CMA [Issue Brief](#)). Therefore, we suggested adding the phrase: "this means that not all of the services offered by the plan will be available to everyone who enrolls in the plan, and you might not find out if you qualify until you are actually enrolled in the plan." Correspondingly, we suggested that the last sentence should be revised; people should not be advised to check with a prospective plan to see if they qualify for such services because such determinations will not be able to be made prior to enrollment. CMS did not follow these recommendations. We urge them to do so in the 2023 edition.

Other places where we suggested that CMS could have improved information about MA, but did not, include: at p. 63, under "What should I know about MA plans?" We recommended that to the sentence "Each year [MA] plans can choose to leave Medicare or make changes to the services they cover and what you pay" the following should be added "and change the providers they contract with, including doctors"; ("What do I pay, p. 64"), an additional bullet should be added that says "Whether the plan determines that the services received in network meet Medicare's coverage criteria" in order to account for MA plans that use overly restrictive criteria to deny medically necessary Part A and Part B services (see, e.g., OIG 2018 report discussed above). At p. 72, when discussing Special Enrollment Periods (SEPs), CMS could have included a more comprehensive list of SEPs, or at least information about the SEP available for material misrepresentation of a plan's provisions during marketing the plan and for reliance on misinformation on Medicare Plan Finder, similar to the "Note" on the www.medicare.gov [webpage](#) concerning SEPs that states: "If you believe you made the wrong plan choice because of inaccurate or misleading information, including using Plan Finder, call 1-800-MEDICARE and explain your situation. Call center representatives can help you throughout the year with options for making changes."

Conclusion

In order to resume its critical role as a neutral source of information for the public about Medicare coverage options, CMS must actively and aggressively scrub its resources of its recent ideological bias towards the private Medicare Advantage program, and engage in future outreach activities with a conscious effort to providing unbiased information.

As the Center for Medicare Advocacy has written, the recent "MA steering" occurred at a time when there is also a growing imbalance between Medicare Advantage and the traditional Medicare program with respect to payment, coverage, and choice of coverage (see, generally, the Center's website [here](#)).

We are encouraged by the edits to the 2022 *Medicare & You* handbook. We hope this trend continues in other Medicare outreach and enrollment materials. More broadly, we hope both Congress and CMS will work to address the growing imbalance between traditional Medicare

and Medicare Advantage , and work to improve the Medicare program for all of its enrollees, not just those who choose, or are enrolled, in private plans.

Addendum: A Recent History of Bias Towards Medicare Advantage in Medicare Materials

In this section, we provide a catalogue of links to documents in which bias towards Medicare Advantage (MA) evident in CMS materials is observed, spanning from recent versions of the *Medicare & You* handbook, to other educational materials and email campaigns. This includes analyses and observations made by the Center for Medicare Advocacy, some of our partners, the media, and policymakers, organized chronologically.

2020

- *CMA Alert* “Medicare’s Annual Enrollment Season Enters Final Weeks: Few People Compare Options, and the Means of Comparison are Often Flawed” (Nov. 19, 2020): <https://medicareadvocacy.org/medicares-annual-enrollment-season-enters-final-weeks-few-people-compare-options-and-the-means-of-comparison-are-often-flawed/>
- *CMA Alert* “Updates | Medicare Open Enrollment Period, Starting October 15” (Oct. 1, 2020): <https://medicareadvocacy.org/updates-medicare-open-enrollment-period-starting-october-15/>
- *CMA Issue Brief* “*Medicare & You* 2021 – An Assessment of Bias in Favor of Medicare Advantage”(Sept. 18, 2021): <https://medicareadvocacy.org/medicare-you-2021-an-assessment-of-bias-in-favor-of-medicare-advantage/>
- *New York Times* [article](#) by Mark Miller “Medicare’s Private Option Is Gaining Popularity, and Critics” (Feb. 21, 2020, updated Sept. 18, 2020) noted, among other things, that “communications from [CMS] during last fall’s Medicare enrollment period do appear to promote Advantage plans.”

2019

- *CMA Alert* “Two Weeks Left in Medicare Enrollment Period” (Nov. 12, 2019): <https://medicareadvocacy.org/two-weeks-left-in-medicare-enrollment-period/>
- *CMA Alert* “Medicare Enrollment Problems Persist” (Nov. 7, 2019): <https://medicareadvocacy.org/medicare-enrollment-problems-persist/>
- *CMA Alert* “Senator Brown Leads Call for Better Oversight of Medicare Advantage Plans” (Sept. 19, 2019): <https://medicareadvocacy.org/senator-brown-leads-call-for-better-oversight-of-medicare-advantage-plans/>
 - [Letter](#) to CMS from Senators Brown, Stabenow, Klobuchar, Sanders, Blumenthal and Murphy (Sep. 13, 2019), among other things, references CMS actions “to steer people into these privately run plans” and “inappropriate ‘tilting of the scales’ through repeated emails to individuals highlighting the benefits of MA over traditional Medicare”
- *CMA Alert* “*Medicare & You* 2020 – Better Than Draft, But Room for Improvement” (Sept. 12, 2019): <https://medicareadvocacy.org/medicare-you-2020-better-than-draft-but-room-for-improvement/>

- *CMA Alert* “Improve and Expand Medicare: CMS Should Provide Objective Information About Medicare Options” (Feb. 14, 2019): <https://medicareadvocacy.org/improve-and-expand-medicare-cms-should-provide-objective-information-about-medicare-options/>

2018

- *CMA Alert* “Today Ends the Medicare Annual Enrollment Period; Does it Begin a New Private Era for Medicare?” (Dec. 7, 2018): <https://medicareadvocacy.org/today-ends-the-medicare-annual-enrollment-period-does-it-begin-a-new-private-era-for-medicare/>
- *CMA Alert* “In Her Own Words: A Beneficiary’s Take On Medicare Advantage Steering” (Dec. 6, 2018): <https://medicareadvocacy.org/in-her-own-words-a-beneficiarys-take-on-medicare-advantage-steering/>
- *New York Times* [article](#) by Robert Pear “Trump Administration Peppers Inboxes With Plugs for Private Medicare Plans” (Dec. 1, 2018) noted that MA plans have been getting “an unpublicized boost from the Trump administration, which [during the Fall enrollment period] extolled the virtues of the private plans in emails sent to millions of beneficiaries.” According to the article, a former chief actuary of CMS “said the emails sounded ‘more like Medicare Advantage plan advertising than objective information from a public agency.’”
- *CMA Alert* “As Medicare Enrollment Period Draws to a Close, MA Steering Continues – Advocates & Members of Congress Write Letters of Concern to CMS” (Nov. 30, 2018): <https://medicareadvocacy.org/as-medicare-enrollment-period-draws-to-a-close-ma-steering-continues-advocates-members-of-congress-write-letters-of-concern-to-cms/>
- [Letter](#) from members of Connecticut congressional delegation to CMS re: concern that CMS “is inappropriately working to steer Medicare beneficiaries to Medicare Advantage plans” (Nov. 19, 2018)
- Joint [letter](#) from CMA and Medicare Rights Center to CMS (Nov. 16, 2018) re: “education and outreach materials for the current Medicare Annual Coordinated Election Period (ACEP), which together seem to promote Medicare Advantage (MA) over traditional Medicare”
- *CMA Alert* “Medicare Enrollment Updates” (Oct. 5, 2018): <https://medicareadvocacy.org/medicare-enrollment-updates/>
- *CMA Alert* “Tipping the Scales Toward Medicare Advantage (at the Expense of Medicare)” (June 21, 2018): <https://medicareadvocacy.org/tipping-the-scales-toward-medicare-advantage-at-the-expense-of-medicare/>
- House Ways & Means Committee Chairman Neal and House Energy & Commerce Committee Chairman Pallone [letter](#) to CMS re: concerns about Draft 2019 *Medicare & You* (June 14, 2018)
- *CMA Alert* “Advocates Raise Concerns About Inaccuracies and Bias in Draft MEDICARE & YOU Handbook” (May 31, 2018): <https://medicareadvocacy.org/advocates-raise-concerns-about-comparisons-between-traditional-medicare-and-medicare-advantage-in-draft-2019-medicare-you-handbook/>
- *PBS Newshour* online [article](#) by Philip Moeller “Senior advocates say new draft guide to Medicare distorts facts. Here’s what you need to know” (May 25, 2018) notes our organizations’ concerns, and concludes “The bottom line – The handbook also creates the impression that MA plans are less costly to seniors than original Medicare. This may or may not be true”

- *Axios* [article](#) by Bob Herman “Subtle but consequential changes to Medicare's handbook” (May 24, 2018) notes that “The Trump administration is promoting policies that are favorable for the health insurance industry and private doctors through a set of new, discreet changes to the annual Medicare handbook.”
- Joint [letter](#) from CMA, Medicare Rights Center and Justice in Aging to CMS re: Draft 2019 *Medicare & You* Handbook (May 15, 2018)
 - Accompanying Joint [Press Release](#) re: letter from CMA, Medicare Rights Center and Justice in Aging
- *CMA Alert* “Tipping the Scales Toward Medicare Advantage” (March 21, 2018): <https://medicareadvocacy.org/tipping-the-scales-toward-medicare-advantage/>

2017

- Leadership Council of Aging Organizations (LCAO) [letter](#) to CMS (Nov. 9, 2017) urging CMS to “take steps to correct misleading public outreach and education around the current Medicare open enrollment” signed by 29 member organizations, including CMA
- *CMA Alert* “You Can Choose Original Medicare: CMS Over-Emphasizes Private Medicare Advantage Plans in Open Enrollment Roll-Out” (October 25, 2017), available at: <https://medicareadvocacy.org/cma-alert-remember-you-can-choose-original-medicare-equitable-relief-this-weeks-sabotage-news/#1>
