National Organization of Rheumatology Management

April 03, 2025

Paul Masi
Executive Director
Medicare Payment Advisory Commission (MedPAC)
425 I Street, NW, Suite 701
Washington, DC 20001

Dear Mr. Masi:

On behalf of the National Organization of Rheumatology Management (NORM), thank you to you and your staff for your efforts to study the marketing practices of Medicare Advantage (MA) plans and to hear directly from stakeholders on this important topic. We greatly appreciate MedPAC's commitment to understanding how misleading marketing tactics and inadequate provider networks affect beneficiary decision-making and access to timely, high-quality care—especially for patients living with complex chronic diseases—and make recommendations to address those issues.

Misleading Marketing Leads to Disrupted Care

The National Organization of Rheumatology Management (NORM) has consistently expressed concerns to Congress and the Centers for Medicare & Medicaid Services (CMS) regarding misleading Medicare Advantage (MA) marketing practices that contribute to care disruptions—particularly for individuals managing chronic rheumatologic conditions. Rheumatology practices frequently encounter patients who were assured by MA plan representatives that there would be no changes to their care or provider access, only to later discover that their rheumatologist is out-of-network or that prescribed therapies are no longer covered, have been placed on non-preferred formulary tiers, or require prior authorization or step therapy.

Practice administrators and staff are often the first to inform patients—typically after the plan has taken effect—that the information they received was inaccurate. Patients may learn this only when attempting to schedule an appointment or obtain a medication refill. By that time, they are often locked into the plan until the next open enrollment period, with limited options to restore access to their established care and treatment regimen.

These concerns were echoed and elevated in the U.S. Senate Committee on Finance's November 2022 report, *Deceptive Marketing Practices Flourish in Medicare Advantage*, which highlighted NORM members' accounts of beneficiaries being told they could continue seeing their current providers—only to later learn this was not the case. The Committee confirmed that such misleading claims about provider networks are both widespread and harmful, leading to significant disruptions in patient care.

This issue is especially troubling for beneficiaries who switch from original Medicare with a Medigap (supplemental) policy to a Medicare Advantage (MA) plan. These enrollees find it difficult, if not impossible, to return to Original Medicare because, due to their pre-existing

conditions, they may be denied Medigap coverage or charged significantly higher premiums as a result of medical underwriting. As a result, they are left "trapped" in plans that don't meet their care needs, often facing significant and unexpected out-of-pocket costs.

Finally, a particularly confusing aspect for beneficiaries is the difference between coverage of provider-administered (Part B) and self-administered (Part D medications). Our Medicare patients tell us that MA plans often obscure these distinctions, leaving them unaware of which medications are covered under each benefit and what their financial responsibilities will be. This can lead to unexpected out-of-pocket expenses—potentially reaching the Medicare Advantage plan's maximum of $9,350 per year—for provider-administered therapies. This financial burden is especially concerning given that the vast majority of MA enrollees are economically vulnerable and are drawn to these plans by the promise of zero-dollar premiums and low or no copays for medications. However, these cost-sharing protections often do not extend to high-cost biologics, leaving patients unprepared for the true financial impact. Moreover, there is little evidence that enrollees are meaningfully utilizing the supplemental benefits touted by MA plans—an area that warrants further study to assess whether these benefits deliver actual value to enrollees.

Network Adequacy Concerns Remain

Inadequate access to specialty care within MA plans is an ongoing challenge that has become even more difficult in the rheumatology field. Although CMS's network adequacy criteria may be technically met, these standards are largely designed around primary care and behavioral health access—not the specialty care needs of patients with chronic and complex conditions.

Our members frequently hear from patients who enrolled in an MA plan only to find that their former rheumatology practice is no longer in-network. Despite meeting time-and-distance standards on paper, beneficiaries often struggle to access necessary treatments in practice. As an example, our members in Florida report that a significant number of rheumatologists were terminated from a large MA plan's network, drastically reducing access for permanent residents, seasonal "snowbirds," and Employer Group Waiver Plan (EGWP) enrollees. The impact has included longer wait times, fragmented care, and avoidable disease progression due to delays.

These challenges highlight a critical shortcoming in the current network adequacy framework and underscore the need for reforms that meaningfully account for specialist availability and timely access to care.

Recommendations for MedPAC Consideration

NORM respectfully urges consideration of the following policy ideas—many of which NORM has previously submitted in response to CMS rulemaking and requests for information—as it prepares to make recommendations to Congress on these issues.

Marketing

First, MedPAC should consider recommending that Congress direct CMS to finalize and fully implement provisions in the CY 2026 MA and Part D proposed rule aimed at strengthening

oversight of MA marketing practices. These include expanding the definition of "marketing" to bring more materials under prior review and enhancing audit protocols. NORM also urges the Commission to recommend that Congress direct CMS to impose steep penalties—including contract termination—for plans that mislead beneficiaries during the enrollment process.

In addition, MedPAC should consider recommending that Congress direct CMS to finalize its proposals to expand the Pre-Enrollment Checklist (PECL), and further, to direct CMS to require plans to provide clear, detailed information about the differences in coverage and cost-sharing for self-administered versus provider-administered medications, and any applicable utilization management requirements. This will help ensure beneficiaries understand the clinical and financial implications of their coverage decisions *before* enrolling.

Network Adequacy

We also urge MedPAC to consider recommending that Congress direct CMS to take action to improve MA plan networks. Specifically, MedPAC should consider recommending that Congress instruct CMS to:

- Adjust physician-to-beneficiary ratios and time/distance standards to better reflect the needs of beneficiaries, particularly in specialties with increasing rates of chronic illness and workforce shortages, such as rheumatology;
- Establish and enforce standards for specialist wait times to ensure timely access to care;, and
- Enforce accurate, real-time provider directories, by requiring MA plans to populate directories using information from the Provider Enrollment Chain and Ownership System (PECOS), and impose penalties for non-compliance.

Conclusion

Deceptive marketing and inadequate networks undermine beneficiary care, limit access to specialty care, and contribute to growing beneficiary dissatisfaction —particularly those managing complex, chronic rheumatologic conditions. We appreciate MedPAC's continued focus on these issues and urge the Commission to advance recommendations that will help ensure MA plans deliver on their promise —and original intent—of high-quality, cost-effective care.

We appreciate MedPAC's ongoing attention to these critical issues. Should you have any questions or would like to set a time to discuss our feedback and recommendations in more detail, please contact Andrea Zlatkus, CMPM, CRMS, CRHC, Executive Director, NORM, at andrea@normgroup.org.

Sincerely,

Michelle A. Owen, CPC
President, NORM