AI-GENERATED DENIALS: MEDICAL NECESSITY IN MEDICARE ADVANTAGE TODAY

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Medicare Advantage insurers hold vast power over access to care for Medicare beneficiaries enrolled in their plans. Among other things, these insurers make the all-important determination as to whether care is "medically necessary" and thus warrants coverage under Medicare. Recently, these insurers have turned to artificial intelligence to help with these determinations. This trend has yielded concerning results, exacerbating both inaccuracy and opacity in the coverage determination process. This Note describes the current state of determinations. Taking an outcomes-focused approach, it argues that the government must demand greater information sharing from Medicare Advantage insurers and enhance beneficiaries' access to the appeals process. Such reforms are an important first step in ensuring beneficiaries have access to the care they are entitled to.

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INTRODUCTION

On December 28, 2023, Carol Clemens received an alarming notice: Only ten days after she had entered a skilled nursing facility following a life-threatening collapse, her health insurance company was refusing to pay for her continued stay.[1] Given that Clemens was unable to eat solid foods, speak more than a few words at a time, or walk without assistance, she immediately appealed the decision, asking the insurer to reconsider letting her finish the rehabilitation program.[2] Clemens's doctor had prescribed a stay until at least January 18, 2024.[3] The insurer, however, was not convinced. Just one day after Clemens submitted her appeal, the company denied the request, stating that a continued stay was "not medically necessary."[4] With no one to pay for her stay, Clemens returned home on January 3.[5] Just three days later, no longer having access to the supervision of the skilled nursing facility staff, Clemens fell again, this time resulting in a "traumatic subarachnoid hemorrhage . . . [and] severe brain bleed."[6] She needed to be readmitted to the hospital, where she spent over two weeks recovering before returning to the skilled nursing facility to restart her rehabilitation, this time with a traumatic head injury.[7]

Clemens is not alone in her experience. Clemens serves as one of multiple plaintiffs in a class action suit filed in Minnesota against insurance giant UnitedHealth Group that makes multiple claims related to Medicare Advantage plans incorrectly denying coverage to aging adults.[8] How did

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1. First Amended Class Action Complaint at 24–25, Estate of Lokken v. UnitedHealth Grp., Inc., No. 0:23-cv-03514-JRT-DTS (D. Minn. filed Apr. 5, 2024), 2024 WL 2853368 [hereinafter Lokken Amended Complaint].

2. Id. at 25.

3. Id.

4. Id.

5. Id.

6. Id. at 26.

7. Id. The devastating health consequences that Clemens has faced due to this denial are further compounded by financial consequences. At the time of filing, Clemens owed over sixteen thousand dollars in out-of-pocket expenses for care that her insurer would not cover. See id. at 27.

8. The lawsuit names UnitedHealth Group and two of its subsidiaries—UnitedHealthcare and naviHealth—as defendants. Id. at 8–9. There is a similar lawsuit in Kentucky against Humana. See Class Action Complaint at 1, Barrows v. Humana, Inc., No. 3:23-cv-00654-RGJ (W.D. Ky. filed Apr. 22, 2024), 2024 WL 4132639 [hereinafter Barrows Complaint] ("Humana employs [AI] to summarily deny elderly patients care owed to them under Medicare Advantage Plans on false pretenses."). Another lawsuit in California makes similar claims against Cigna, although it involves Cigna's employer-sponsored plans rather

anyone seeing the facts of Clemens's case—her inability to eat, talk, and walk—determine that continued rehabilitation was "not medically necessary?" Well, Clemens claims, no one did. As the plaintiffs allege, UnitedHealth Group is not relying on human expertise to make these determinations but is instead deploying "artificial intelligence (AI) in place of real medical professionals[,] . . . overriding . . . physicians' determinations as to medically necessary care."[9]

The Minnesota lawsuit is not the first time that Medicare Advantage insurers have been accused of inappropriately deploying AI to make medical necessity determinations. In 2023, journalists Casey Ross and Bob Herman released a four-part investigative series about Medicare Advantage insurers' widespread use of algorithms to deny care to vulnerable seniors.[10] After the series, over fifty members of Congress wrote to the Centers for Medicare and Medicaid Services (CMS), urging increased oversight of Medicare Advantage plans and stating that the insurers "continue to use AI tools to erroneously deny care and contradict provider assessment findings."[11] The Senate Permanent Subcommittee on Investigations investigated the nation's three largest Medicare Advantage insurers—UnitedHealthcare, Humana, and CVS—and concluded that more intervention was necessary.[12] While CMS promulgated a new rule in

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than its Medicare Advantage plans. See Third Amended Class Action Complaint at 1, Kisting-Leung v. Cigna Corp., No. 2:23-cv-01477-DAD-CSK (E.D. Cal. filed June 14, 2024) [hereinafter Kisting-Leung Third Amended Complaint] ("This action arises from Cigna's illegal scheme to systematically, wrongfully, and automatically deny its insureds the thorough, individualized physician review of claims guaranteed to them and, ultimately, the payments for necessary medical procedures owed to them under Cigna's health insurance policies."). 29% of all Medicare Advantage beneficiaries are enrolled in a UnitedHealthcare plan, 18% are enrolled in a Humana plan, and 2% are enrolled in a Cigna plan. Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico & Tricia Neuman, Medicare Advantage in 2024: Enrollment Update and Key Trends, KFF (Aug. 8, 2024), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/ [https://perma.cc/8XMS-8URP].

9. Lokken Amended Complaint, supra note 1, at 2.

10. Casey Ross & Bob Herman, Denied by AI: How Medicare Advantage Plans Use Algorithms to Cut Off Care for Seniors in Need, STAT (Mar. 13, 2023), https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/ (on file with the *Columbia Law Review*) [hereinafter Ross & Herman, Denied by AI].

11. Letter from Rep. Judy Chu et al. to Chiquita Brooks-LaSure, Adm'r, Ctrs. for Medicare & Medicaid Servs. 1 (June 25, 2024), https://chu.house.gov/sites/evo-subsites/chu.house.gov/files/evo-media-document/Final%20Chu-Nadler-Warren%20Letter%20to%20CMS%20to%20Increase%20Oversight%20of%20AI%20in%20Medicare%20Advantage%20Coverage%20Decisions%2006.25.2024.pdf [https://perma.cc/WTX8-BEEW].

12. See Majority Staff of S. Permanent Subcomm. on Investigations, 118th Cong., Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care 4, 47–52 (2024), https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf (on file with the *Columbia Law Review*).

2023 to address some of the concerns about AI-produced medical necessity determinations,[13] some claim the rule is not enough.[14]

This Note explores the current state of coverage determinations in Medicare Advantage. It views insurers' use of AI—and the harmful effects that accompany such use—as the latest development in a Medicare Advantage program that has been plagued for decades with inaccuracy and opacity. To combat this problem, CMS should enhance information sharing about denials while also increasing meaningful access to the appeals process for individual beneficiaries. Not only will such mechanisms improve access to care, but they will also reflect an important return of power and autonomy to beneficiaries, enabling the individuals most affected by determinations to take control of their own coverage and care.

The Note proceeds in three Parts. Part I explores the concept of medical necessity in Medicare, asking what it is and who decides it. Part II outlines the problems present in the coverage determination process today, noting the high rates of inaccuracy and opacity in determinations. It also summarizes CMS's most recent attempt to combat these problems, concluding that more is needed. Part III charts a path forward, presenting two important accountability mechanisms that CMS can enact to enhance insurer accountability.

I. MEDICAL NECESSITY: WHAT IS IT AND WHO DECIDES?

Since its inception, Medicare has only covered services that are "*reasonable and necessary* for the diagnosis or treatment of illness or injury."[15] This provision remains today as a broad standard under which involved actors—most notably third-party insurers—make coverage determinations in individual beneficiaries' cases. Often referred to as "medical necessity"—a term this Note will adopt—this requirement can, and often does, serve as the sole reason to deny coverage to a Medicare beneficiary, as demonstrated by Clemens's case.[16] This Part outlines the medical necessity provision. Section I.A asks *what* medical necessity is, demonstrating how this statutory provision operates as a flexible standard applied to individual cases, rather than a rigid, uniform rule. Section I.B

13. See infra section II.B.

14. See, e.g., Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 51–52 ("CMS has not provided sufficiently specific guidance on separating the use of predictive technologies from patient determinations regarding post-acute care."); Jennifer D. Oliva, Regulating Healthcare Coverage Algorithms, 100 Ind. L.J. 1861, 1878 (2025) ("While CMS was well-intentioned in issuing this rule, the agency left numerous unanswered questions on the table insofar as insurer implementation and use of [utilization management] algorithms are concerned.").

15. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862(a)(1), 79 Stat. 286, 325 (codified as amended at 42 U.S.C. § 1395y(a)(1)(A) (2018)) (emphasis added).

16. See Lokken Amended Complaint, supra note 1, at 25 (noting that the reason provided for the denial of care was that "rehab care was not medically necessary").

explores *who* makes determinations of medical necessity in Medicare today, discussing the integral role of Medicare Advantage insurers. Section I.C outlines the regulatory tools the government retains over determinations.

A. *An Intentionally Broad Standard*

Created by the Social Security Amendments of 1965,[17] Medicare has long served a foundational role in this country's healthcare system, providing coverage to tens of millions of Americans every year.[18] While the program's benefits are extensive, it has always excluded—by statute—services that are not medically necessary.[19] The statute currently reads: "[N]o payment may be made under [Medicare] for any expenses incurred for items or services . . . not reasonable and necessary for the diagnosis or treatment of illness or injury . . . ."[20] The inclusion of a medical necessity requirement in the statute is largely uncontroversial,[21] merely assuring beneficiaries do not receive unnecessary or harmful care.[22] Similar provisions appear across various health insurance plans both domestically and abroad.[23]

Medicare's medical necessity provision operates as a broad and ambiguous standard rather than a precise rule. Outside the original governing language, neither Congress nor HHS and its subsidiary agencies

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17. Social Security Amendments §§ 100–411, 1801–1875.

18. See Freed et al., supra note 8 (noting that in 2024, over sixty million individuals were enrolled in Medicare).

19. Social Security Amendments § 1862(a)(1).

20. 42 U.S.C. § 1395y(a)(1)(A); see also id. § 1395y(a)(1)(B)–(E) (repeating the "reasonable and necessary" requirement for various types of services).

21. See Janet L. Dolgin, Unhealthy Determinations: Controlling "Medical Necessity", 22 Va. J. Soc. Pol'y & L. 435, 483 (2015) ("The notion of medical necessity, in the abstract, is unproblematic.").

22. See T. Christian Miller, Patrick Rucker & David Armstrong, "Not Medically Necessary": Inside the Company Helping America's Biggest Health Insurers Deny Coverage for Care, ProPublica (Oct. 23, 2024), https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations [https://perma.cc/5W4Q-Y8CX] (noting that utilization management processes "serve to guard against doctors who recommend unnecessary and even potentially harmful treatments"); see also Dolgin, supra note 21, at 438 ("Validation of the notion of medical necessity and development of methods for implementing the notion would seem basic to any healthcare system that is anxious both to provide adequate care and contain costs." (citing Edward B. Hirshfeld & Gail H. Thomason, Medical Necessity Determinations: The Need for a New Legal Structure, 6 Health Matrix 3, 19–20 (1996))).

23. See, e.g., Cathy Charles, Jonathan Lomas, Mita Giacomini, Vandna Bhatia & Victoria A. Vincent, Medical Necessity in Canadian Health Policy: Four Meanings and . . . a Funeral?, 75 Milbank Q. 365, 365 (1997) ("[T]he concept of medical necessity has been a cornerstone of Canadian federal legislation regarding publicly funded health service coverage."); Mark A. Hall & Gerard F. Anderson, Health Insurers' Assessment of Medical Necessity, 140 U. Pa. L. Rev. 1637, 1645–47 (1992) (discussing the contractual provisions that govern medical necessity in private domestic insurance plans); id. at 1647 n.30 ("The Medicaid statute has been construed similarly to require states to cover all 'medically necessary services.'").

have passed or promulgated any legally binding definitions or interpretations of this provision.[24] Medical necessity has thus taken on a "multiplicity of meanings," with different interest groups promoting "varying views of the term's meaning" over time.[25] Even in its consumer-facing handbook, CMS largely parrots the statute, defining as medically necessary any service "needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet[s] accepted standards of medicine."[26] Such a definition leads to "heterogeneous interpretations."[27]

While many criticize this amorphous definition as contributing to a Medicare program that is "inconsistent" and "unprincipled" in what it covers,[28] some caution against further defining medical necessity.[29] The practice of medicine itself produces caution: Medicine is neither one-size-fits-all nor stagnant. The medical field today widely recognizes that quality care consists not of a standardized list of approved treatments but instead "must be tailored or 'personalized' to [an] individual's unique biochemical, physiological, environmental exposure, and behavioral profile."[30] This required individualization on the patient side is coupled with "rapidly evolving medical knowledge" and a changing technological landscape on the provider side.[31] With so many changing variables from person to person and day to day, no singular definition can cover with precision what it means for a service or treatment to be medically necessary for each and every beneficiary.[32] It is in such situations that broad

24. See Timothy P. Blanchard, "Medical Necessity" Denials as a Medicare Part B Cost-Containment Strategy: Two Wrongs Don't Make It Right or Rational, 34 St. Louis U. L.J. 939, 975 (1990) ("[T]he statute gives no guidance regarding the interpretation of this broad criterion."); John V. Jacobi, Tara Adams Ragone & Kate Greenwood, Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform, 120 Penn. St. L. Rev. 109, 129 (2015) ("There is no straight-forward, generally accepted definition of medical necessity.").

25. William M. Sage, Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance, 53 Duke L.J. 597, 601, 603 (2003).

26. See Ctrs. for Medicare & Medicaid Servs., HHS, Medicare & You 2026: The Official U.S. Government Medicare Handbook 120 (2025), https://www.medicare.gov/publications/10050-medicare-and-you.pdf [https://perma.cc/VP39-3DUX].

27. See Dolgin, supra note 21, at 438.

28. See, e.g., Sage, supra note 25, at 601 ("[D]ecisions involving medical necessity are frequently characterized by inconsistent administration, poor communication, distrust and . . . relatively unprincipled, results-oriented judicial resolution.").

29. See id. at 604 ("This counsels against mandating intricate, but supposedly less ambiguous, definitions of medical necessity, as some commentators have suggested.").

30. Laura H. Goetz & Nicholas J. Schork, Personalized Medicine: Motivation, Challenges, and Progress, 109 Fertility & Sterility 952, 952 (2018).

31. Amy B. Monahan & Daniel Schwarcz, Rules of Medical Necessity, 107 Iowa L. Rev. 423, 427 (2022); see also id. at 432 ("Standards of treatment for medical care are constantly advancing, technology is changing, clinical evidence is expanding, and individual patients often have unique presentations.").

32. See id. at 432 ("The range of possible medical treatments and clinical presentations was thought to be too vast and likely to evolve to specify in the terms of a contract.");

standards—which can adjust and account for changing circumstances—typically dominate over hard-and-fast rules.[33] Indeed, scholars have found that in the private insurance sphere, where more precise definitions of medical necessity have started to emerge,[34] there have been detrimental effects on access to care, particularly due to the rules' lack of individualization and inflexibility.[35] Given that good medicine requires providing "the right care for the right patient for the right problem at the right time,"[36] medical necessity must allow for the same type of person-, situation-, and time-specific determinations rather than rigidly following objective criteria.

Medical necessity—as it exists in Medicare—therefore remains a broad and somewhat ambiguous standard that all services must meet to be covered. This ambiguity is often thought inevitable[37] and even helpful. It enables decisionmakers to account for both an individual's particular circumstances and evolving industry knowledge to ensure the program covers services that are necessary for a particular beneficiary at a particular time.[38]

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see also Dolgin, supra note 21, at 448 ("[T]here could be no hard and fast rules within medicine about how best to care for patients."); Sage, supra note 25, at 649 ("Too many different actors with varying perspectives and incentives are involved in creating, implementing, and policing medical necessity for the term to develop a unitary meaning that can be applied consistently when insurance arrangements are entered into, when treatment is proposed, and when disputes are resolved.").

33. See Monahan & Schwarcz, supra note 31, at 437 ("Rules typically prevent individualized determinations, and they may become outdated . . . . [This] means that some medically beneficial care will be denied to individuals who do not conform to broader trends." (footnote omitted)); see also id. at 430 ("[T]he specificity of rules often leaves them inflexible, both to unique circumstances and to technological or other societal changes." (footnote omitted) (citing Derek E. Bambauer, Rules, Standards, and Geeks, 5 Brook. J. Corp. Fin. & Com. L. 49, 52 (2010))).

34. See id. at 427 (noting that over the past two decades, private insurers have "increased their reliance on rules rather than standards").

35. See id. at 482 ("The rulification of medical necessity raises the real possibility that individuals with health insurance will have no effective legal recourse when they are denied coverage for critical care . . . on the basis of an insurer-drafted rule that . . . does not account for the individual's unique presentation.").

36. Ian Coulter, Patricia Herman, Gery Ryan, Lara Hilton, Ron D. Hays & Members of the CERC Team, The Challenge of Determining Appropriate Care in the Era of Patient-Centered Care and Rising Health Care Costs, 24 J. Health Servs. Rsch. & Pol'y 201, 201 (2019).

37. See, e.g., Sage, supra note 25, at 604 ("[A]mbiguity in the interpretation of medical necessity is inevitable . . . .").

38. Medicare also has certain bright-line rules, mainly in the form of national and local coverage determinations. These determinations *categorically* prohibit or require coverage for certain medical services. See Susan Bartlett Foote & Robert J. Town, Implementing Evidence-Based Medicine Through Medicare Coverage Decisions, 26 Health Affs. 1634, 1636 (2007) ("The resulting LCDs and NCDs . . . can grant, limit, or exclude items or services from Medicare."). These rules are binding on all parties making coverage determinations. Ctrs. for Medicare & Medicaid Servs., HHS, Report to Congress Fiscal Year 2023: Medicare National Coverage Determinations 2 (2024), https://www.cms.gov/files/

B. *The Origins and Expansion of Insurer Power*

Because medical necessity operates as a broad standard, it is important to know *who* is applying this standard.[39] Over fifty years ago, a New York court tasked with resolving a medical necessity dispute asked this very question, stating: "The words 'necessary for proper treatment' call into play the exercise of judgment. 'Proper' in whose eyes? The patient's, the treating physician's, the hospital's, an [insurance] administrator's, or a court's looking back on the events sometime afterwards?"[40] As Clemens's story illuminates, Medicare Advantage insurers hold great power over these determinations in Medicare today.

Medicare has always relied on third-party insurers to administer coverage determinations and manage payments to doctors.[41] The original

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document/2023-report-congress.pdf [https://perma.cc/SZ57-BME9]. These categorical rules, however, are then always followed by a second, individualized determination to see if the service is necessary for the specific beneficiary at the particular time they are requesting it. See Eleanor D. Kinney, The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint, 1 Admin. L.J. 1, 13–14 (1987) (explaining that coverage determinations require two steps, the second of which asks "whether the benefit was either necessary and reasonable *in a specific instance*" (emphasis added)). It is this second, individualized determination that this Note is primarily concerned with.

It is not always easy, however, to parse out whether an insurer's denial is based on medical necessity or a separate requirement. For example, an insurer may state that it is denying coverage because it is missing information. But that may mean that it does not have the information to determine if the service is medically necessary, and thus, the denial really is related to the medical necessity provision. The reasons can bleed into one another, and the medical necessity provision often plays a role.

39. See Dolgin, supra note 21, at 438 ("Individual determinations about healthcare coverage reflect the particular decision-maker . . . .").

40. Mount Sinai Hosp. v. Zorek, 271 N.Y.S.2d 1012, 1016 (Civ. Ct. 1966). Given that the events of this case happened before the creation of Medicare, the case involves a private insurer's medical necessity provision. Id. at 1014. Nevertheless, the question remains relevant.

41. See Dolgin, supra note 21, at 453 ("[T]he legislation authorized insurance companies to render coverage determinations and to administer Medicare payments." (citing Sylvia A. Law & Barry Ensminger, Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism), 61 N.Y.U. L. Rev. 1, 12–13, 12 n.67 (1986))). While repeating the long history of how third-party insurers came to be integral to Medicare is beyond the scope of this Note, a few points merit mention. For years, many doctors and hospitals opposed government-funded national health insurance. See Kinney, supra note 38, at 6 (noting the "formidable ideological opposition [to Medicare], particularly from the medical profession, because of the fear of government control of medical practices"); David Orentlicher, Rights to Healthcare in the United States: Inherently Unstable, 38 Am. J.L. & Med. 326, 328 (2012) (noting that during the Cold War, the AMA "waved the flag of socialism to mobilize public opposition" to Medicare). As early as 1920, the AMA passed a resolution "declar[ing] its opposition to . . . any scheme embodying a system of compulsory contributory insurance against illness . . . provided, controlled or regulated by any State or the Federal Government." House of Delegates, AMA, Proceedings of the New Orleans Session: Minutes of the Seventy-First Annual Session of the American Medical Association, Held at New Orleans, April 26–30, 1920, at 37 (1920).

In the 1960s, the government and medical profession finally struck a compromise: Instead of the government managing every aspect of the program, third-party insurers

statute instructed the Secretary to enter into contracts with insurers, delegating to them a number of tasks, including making payments to treating physicians, ensuring physician and hospital compliance with various sections of the program, and protecting "against unnecessary utilization of services."[42] The delegation was expansive.[43] As Wilbur Cohen, one of the chief architects of Medicare, told President Lyndon B. Johnson at the time, the insurers "would have to do all the policing" of the program,[44] which inevitably included determining whether services met the statutory medical necessity requirement.[45]

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would perform day-to-day functions like processing claims. See Dolgin, supra note 21, at 453 (noting that Congress added insurance companies as part of an effort "to placate physicians and hospital groups"); Hall & Anderson, supra note 23, at 1663 n.93 ("[T]he federal government was forced to adopt the same insurance system provided in the private sector in order to avoid a boycott by the hospital industry and the medical profession."). Doctors and hospitals believed these intermediaries would "serve as a buffer" between themselves and the federal government and "make Medicare more palatable to the medical profession." Sylvia A. Law, Blue Cross: What Went Wrong? 38 (2d ed. 1976); see also Kinney, supra note 38, at 9 ("[T]he hospital industry lobbied for the arrangement as it allowed the hospitals to deal with familiar Blue Cross plans and insurance companies rather than with the federal government."). Indeed, by the time of passage, there had been a "long-standing alliance between the insurance industry and organized medicine." Herman Miles Somers & Anne Ramsay Somers, Doctors, Patients, and Health Insurance: The Organization and Financing of Medical Care 415 (1961).

Despite this historical alliance between the medical profession and insurers, a change in payment models left the parties in opposition. See infra notes 59–63 and accompanying text. Noting this history, one scholar bluntly stated his opinion on the role doctors and hospitals played in creating the system that exists today:

> However one may view the use of private insurance companies to process Medicare claims, the medical profession has no ground to complain about it now. Certainly neither the law nor the policymakers can have sympathy for the medical profession, which fought to put [insurers] in power at the inception of the Medicare program, now that their accomplice appears to have turned . . . against them. . . . Be that as it may, physicians . . . nevertheless have valid complaints regarding carrier claims processing and review activities.

Blanchard, supra note 24, at 942 n.13. For a more detailed account of the politics surrounding this scheme and the passage of Medicare, see generally Judith M. Feder, Medicare: The Politics of Federal Hospital Insurance (1977); Law, supra; Ronald L. Numbers, Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912–1920 (1978).

42. See Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 1816, 1842, 79 Stat. 286, 297–99, 309–12 (codified as amended at 42 U.S.C. §§ 1395h, 1395u (2018)).

43. See Kinney, supra note 38, at 9 ("Congress delegated extraordinary adjudicative powers to these private organizations with respect to resolving appeals over coverage and payment issues arising under Part A and Part B of the Medicare program.").

44. Nicholas Bagley, Bedside Bureaucrats: Why Medicare Reform Hasn't Worked, 101 Geo. L.J. 519, 527–28 (2013) (internal quotation marks omitted) (quoting Larry DeWitt, The Medicare Program as a Capstone to the Great Society—Recent Revelations in the LBJ White House Tapes (May 2003) (unpublished manuscript)).

45. See Blanchard, supra note 24, at 957–58 (noting the third parties used screens "to identify claims that may not be medically necessary").

At the time, however, the insurers largely deferred to treating physicians regarding medical necessity determinations.[46] The insurers did not have financial motives of their own—unlike insurers today, which operate on a risk-based model[47]—so they served as mere fiscal intermediaries.[48] The insurers themselves identified as solely "fiduciary institutions" that would have "no interference in the provision of care."[49] Additionally, the statutory framework retained important roles for both treating physicians and the government. Treating physicians served their role on the front end of the process. For Medicare to reimburse any claim, a physician certification had to accompany the claim, stating that the services "were medically required."[50] Thus, kickstarting the entire process, physicians made their own judgment about medical necessity and certified it in writing. Without a certification, no reimbursement would be made.[51] The government, on the other hand, served as a back-end check on the entire process, providing a robust appeals process for beneficiaries who disagreed with the insurer's ultimate determination.[52]

This original statutory framework remains largely untouched. Today, treating physicians attest that care is medically necessary when they seek payment; third-party insurers then "police" claims to ensure full compliance with the statute, including making their own judgment as to medical necessity; and the government provides an appeals process if there are major disagreements. What has changed, however, are the internal motives and processes driving third-party insurers as they go about determinations. This has come with the rise of the risk-based, capitated payment system and Medicare Advantage.

In the years following Medicare's enactment, healthcare costs skyrocketed[53] while societal confidence in physicians plummeted.[54] Studies

46. See Law, supra note 41, at 121 ("In the early years of the Medicare program there was no effort to overrule the determinations of physicians and utilization review committees that care was medically necessary."); Hall & Anderson, supra note 23, at 1644 ("[P]rivate insurers were initially very deferential to both hospitals and physicians.").

47. See infra notes 60–63 and accompanying text.

48. See Somers & Somers, supra note 41, at 414–15 (describing how insurers at the time were "highly reluctant . . . to assume any such responsibility" over costs and care).

49. Id. at 415 (internal quotation marks omitted) (quoting Joseph F. Follman, Jr., Commercial Insurance Views Financing of Hospital and Medical Care, 58 J. Mich. St. Med. Soc'y 971, 973 (1959)).

50. Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 1814(a)(2), 1835(a)(2), 79 Stat. 286, 294–95, 303–04 (codified as amended at 42 U.S.C. §§ 1395f(a)(2), 1395n(a)(2) (2018)).

51. See id.

52. See id. § 1869 (noting that "[a]ny individual dissatisfied with any determination" was entitled to a hearing). More detail about the appeals process is in section I.C.

53. See Dolgin, supra note 21, at 452 (noting that national spending on healthcare rose from $39 billion to $119 billion in the decade following Medicare's enactment).

54. See Hui Zheng, Losing Confidence in Medicine in an Era of Medical Expansion?, 52 Soc. Sci. Rsch. 701, 701 (2015) ("[T]he percentage of Americans reporting little confidence in medicine has doubled from 4.5% in 1974 to 9.8% in 1994 . . . ."). For a more

led to a "growing awareness of errors in medical judgement and of the widespread variation in the prevalence of procedures" performed by different physicians.[55] Particularly notable was the public realization that physicians had—and were acting on—financial incentives to order more services than were necessary.[56] Because Medicare reimbursed physicians for each service provided, physicians earned more income the more services they ordered.[57] This new data and subsequent realization led to backlash across the country in the 1970s, eventually resulting in congressional hearings in which individuals testified to their experiences of feeling like doctors were treating them as "raw material for the production of profits."[58]

The findings and resulting public sentiment led insurance companies—as the police of the Medicare program—to more greatly scrutinize coverage.[59] To encourage Medicare insurers to internalize the role of ensuring treatments were medically necessary, Congress changed the way such insurers were paid, creating a risk-based payment model that made insurers' financial motives diametrically opposed to those of physicians.[60] This consisted of implementing a capitated payment system, which sets a prospective payment to an insurer per beneficiary it serves, regardless of how many services the insurer covers for that beneficiary.[61] If the insurer

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detailed account of this trend, see generally Mark Schlesinger, A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession, 80 Milbank Q. 185 (2002) (outlining the public's loss of faith and confidence in the medical profession during this time).

55. Schlesinger, supra note 54, at 193.

56. See Hall & Anderson, supra note 23, at 1667 ("[A]mple data suggests that physician financial incentives are . . . a significant determinant of treatment behavior."); see also Adnan Varol, M.D., P.C., v. Blue Cross & Blue Shield of Mich., 708 F. Supp. 826, 833 (E.D. Mich. 1989) (noting that doctors were admitting that pay, not medical judgment, drove some of their medical decisions).

57. See Pamela H. Bucy, Health Care Reform and Fraud by Health Care Providers, 38 Vill. L. Rev. 1003, 1012 (1993) ("Because the fee for service system rewards for volume of services rendered, there is strong incentive for the fraudulent provider to perform and bill for unnecessary services."); Kinney, supra note 38, at 19 ("[S]ince hospitals could be assured of payment for all the reasonable costs of covered services, they were rewarded for providing more services at higher cost. Physicians also had comparable incentives . . . .").

58. See Medicare and Medicaid Frauds: Hearing Before the Subcomm. on Long-Term Care of the S. Spec. Comm. on Aging: Part 5, 94th Cong. 544 (1976) (statement of Patricia G. Oriol, Chief Clerk, Senate Comm. on Aging); see also id. at 542 (statement of Patricia G. Oriol, Chief Clerk, Senate Comm. on Aging) ("[D]octors . . . were completely frank about their determination to make as many dollars as possible for as little care as possible.").

59. See Hall & Anderson, supra note 23, at 1652 ("These studies encouraged insurers to begin reviewing the appropriateness of medical procedures more closely . . . .").

60. See id. at 1682 (noting that the system created a situation in which there is "a treating physician with an incentive for ordering too much treatment, and a reviewing physician [from the insurance company] with an incentive to pay for too little").

61. Yash M. Patel & Stuart Guterman, Commonwealth Fund, The Evolution of Private Plans in Medicare 2 (2017), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_dec_patel_evolution_private_p

approves no services in any given month, the entire month's payment is profit. If, on the other hand, the insurer covers a great number of expensive services in a month, it loses money (as again, the insurer receives the same rate regardless). The capitated system—a reflection of a classic risk-based model used frequently in insurance and elsewhere—left third-party Medicare insurers with an inherent financial motive to closely monitor the care doctors were ordering.[62] And, just as Congress had hoped, the insurers started to police coverage and medical necessity with more rigor.[63]

Alongside the implementation of the capitated payment system came the rapid expansion of Medicare Advantage.[64] Medicare Advantage serves as an "alternative to 'traditional' or 'original' Medicare" in which purely private insurers contract with the government to provide a host of services to enrollees for a capitated payment.[65] These services extend far beyond claims processing, instead coordinating many aspects of a beneficiary's care. For example, Medicare Advantage insurers can create their own utilization management policies, limit coverage to certain networks, charge additional premiums, offer supplemental and bundled services, and exercise a host of other controls.[66] These plans also often use prior authorization—a process that requires beneficiaries to obtain a determination of medical necessity before receiving the service rather

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lans_medicare_managed_care_ib.pdf [https://perma.cc/S2QP-WWVY] ("The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a capitated payment system with prospectively set payment rates per enrollee . . . .").

62. See Off. of Inspector Gen., HHS, OEI-09-16-00410, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials 1 (2018) [hereinafter Off. of Inspector Gen., Medicare Advantage Appeal Outcomes], https://oig.hhs.gov/documents/evaluation/3140/OEI-09-16-00410-Complete%20Report.pdf [https://perma.cc/6VC7-4QLN] ("A central concern about the capitated payment model . . . is the potential incentive for insurers to inappropriately deny access to services and payment in an attempt to increase their profits."); Dolgin, supra note 21, at 445 ("The fewer claims that an insurance company pays, the greater the company's profits." (citing Hall & Anderson, supra note 23, at 1668)); see also Law, supra note 41, at 108 ("There is no economic incentive for [an insurer under a capitated system] to provide a prolonged and intensive course of life-saving treatment. Incentives for economy can also be incentives for no care or inferior care.").

63. See Hall & Anderson, supra note 23, at 1653 ("Suddenly, from all directions, physicians experienced much greater scrutiny of their treatment decisions than ever before.").

64. Medicare Advantage has gone by different names throughout the years, including Medicare+Choice and Medicare Part C. Christina Ramsay, Gretchen Jacobson, Steven Findlay & Aimee Cicchiello, Medicare Advantage: A Policy Primer, Commonwealth Fund (Jan. 31, 2024), https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer (on file with the *Columbia Law Review*). For purposes of consistency and clarity, this Note will exclusively use the term Medicare Advantage.

65. See id.

66. See id; see also Hannah Ruth Leibson, Hidden in Plain Sight: Two Models of Medicare Privatization, 33 U. Fla. J.L. & Pub. Pol'y 81, 110 (2022) ("Medicare Advantage providers become responsible for the entire administration of the plan." (citing Travis Broome & Farzad Mostashari, Spurring Provider Entry Into Medicare Advantage, Health Affs. Forefront (July 6, 2017), https://www.healthaffairs.org/content/forefront/spurring-provider-entry-into-medicare-advantage (on file with the *Columbia Law Review*))).

than seeking approval after the fact—which is generally not allowed in traditional Medicare.[67]

Essentially, Medicare Advantage results in a "greater delegation" of powers to third-party, private insurers.[68] Indeed, Medicare Advantage is often referred to as the "privatization" of Medicare,[69] and accordingly, it has drawn participation from the nation's most prominent private insurers, which now operate Medicare Advantage plans alongside their private plans.[70] While these insurers are still subject to the Medicare statute, and therefore, under law, their enrollees still "have the same rights and protections [they] would have under Original Medicare,"[71] Medicare Advantage insurers exercise powers far greater than insurers did at the inception of Medicare. This is what proponents of Medicare Advantage intended. They claimed that delegating powers en masse to private insurers could lead to better coordination and increased efficiency.[72] These Medicare Advantage plans are now the norm in Medicare,[73] and any inquiry into coverage determinations in Medicare inevitably requires consideration of these plans' unique blend of expanded powers and inherent financial interests.[74]

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67. See Off. of Inspector Gen., HHS, OEI-09-18-00260, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care 4 (2022), https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf [https://perma.cc/EBH3-ZQSF] [hereinafter Off. of Inspector Gen., Medicare Advantage Denials Raise Concerns].

68. See Leibson, supra note 66, at 108 (stating that in Medicare Advantage, "the private contractor moves from passenger to driver" and has "greater delegation" and "amassed power").

69. See, e.g., id. at 107.

70. Six of the seven top Medicare Advantage insurers by enrollment currently also offer commercial plans. Freed et al., supra note 8. The seventh insurer, Humana, also offered commercial plans until 2023, when it decided to shift its focus to solely government-funded insurance programs. Press Release, Humana, Humana to Exit Employer Group Commercial Medical Products Business (Feb. 23, 2023), https://news.humana.com/press-room/press-releases/2023/humana-to-exit-employer-group-commercial-medical-products [https://perma.cc/VA4N-K6CB].

71. Ctrs. for Medicare & Medicaid Servs., HHS, Understanding Medicare Advantage Plans 5 (2024), https://www.medicare.gov/publications/12026-understanding-medicare-advantage-plans.pdf [https://perma.cc/63C2-LECJ].

72. See Patel & Guterman, supra note 61, at 2 ("Proponents argued that the efficiencies of HMOs could reduce government expenditures, improve quality, and provide additional benefits beyond those offered by traditional Medicare."). Unfortunately, these claims appear to have been incorrect. It is widely accepted that Medicare Advantage costs the government more money while delivering poorer health outcomes. See, e.g., Leibson, supra note 66, at 110 ("This hands-off, highly-privatized model has given rise to several negative externalities over the past years."); Ramsay et al., supra note 64 ("Medicare Advantage costs the government more than traditional Medicare for covering the same beneficiary.").

73. See Freed et al., supra note 8 ("In 2024, 32.8 million people are enrolled in a Medicare Advantage plan, accounting for more than half, or 54 percent, of the eligible Medicare population . . . .").

74. Due to the prominence of Medicare Advantage and its insurers' unique financial incentives, this Note focuses its remaining inquiry on medical necessity determinations in Medicare Advantage. It bears noting, however, that the Trump Administration has

C. *The Government's Regulatory Tools*

While Medicare Advantage insurers hold vast power over determinations today, the government retains multiple mechanisms of control. The federal Medicare statute still governs, and it entrusts the HHS Secretary with the power to create rules and regulations as necessary.[75] Currently, federal law sets certain requirements for how Medicare Advantage insurers must make medical necessity and coverage determinations. Among other things, it demands insurers have a standardized procedure for making determinations, provides specific time frames in which insurers must make determinations, and requires that insurers share certain information with beneficiaries.[76] Most recently, CMS promulgated a rule mandating Medicare Advantage insurers rely on their internal physicians, rather than any automated system, when making adverse medical necessity determinations. The rule also limits the types of data and criteria that insurers can use when making determinations.[77] These "modest rules" direct Medicare Advantage insurers on how they must approach determinations.[78]

Additionally, federal law mandates an appeals process that enables beneficiaries to appeal an insurer's determination when the beneficiary believes the insurer to be incorrect. This appeals process has five stages. A beneficiary's first step is to ask the Medicare Advantage insurer for a

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announced plans to start rewarding contractors that cut costs and use AI in traditional Medicare. See Press Release, Ctrs. for Medicare & Medicaid Servs., HHS, CMS Launches New Model to Target Wasteful, Inappropriate Services in Original Medicare (June 27, 2025), https://www.cms.gov/newsroom/press-releases/cms-launches-new-model-target-wasteful-inappropriate-services-original-medicare [https://perma.cc/XC25-ML7D] (announcing a model that will utilize "enhanced technologies, including artificial intelligence" and pay contractors "based on their ability to reduce unnecessary or non-covered services"); see also Suzanne Blake, Medicare Will Start Using AI to Help Make Coverage Decisions Next Year, Newsweek (Aug. 8, 2025), https://www.newsweek.com/medicare-will-start-using-ai-help-make-coverage-decisions-next-year-2111093 [https://perma.cc/R5T7-GLPF] (reporting on an "AI test pilot" in traditional Medicare that will result in contractors having "incentive[s] to deny coverage"). This proposal—which makes traditional Medicare operate more like Medicare Advantage—is concerning, given the poor outcomes Medicare Advantage delivers to beneficiaries. See Blake, supra ("For many Americans, the term 'Medicare Advantage' has left them asking what the real advantage was, as plans haven't worked out in some parts of the country as efficiently as originally promised." (internal quotation marks omitted) (quoting Alex Beene, Fin. Literacy Instructor, Univ. of Tenn. at Martin)); see also infra section II.A. While this Note focuses on Medicare Advantage, the same concerns noted here may arise in traditional Medicare, should the Trump Administration go through with this proposal.

75. See 42 U.S.C. §§ 1395–1395lll (2018) (including various delegations to HHS and its subsidiary agencies to effectively manage the Medicare program).

76. See id. § 1395w-22(g); 42 C.F.R. §§ 422.101, 422.560–422.634 (2024).

77. This rule is outlined in detail in section II.B.

78. Letter from Sen. Ron Wyden, Rep. Frank Pallone, Jr. & Rep. Richard E. Neal to Chiquita Brooks-LaSure, Adm'r, Ctrs. for Medicare & Medicaid Servs. 1–2 (Oct. 29, 2024), https://www.finance.senate.gov/imo/media/doc/102924_wyden_neal_pallone_letter_to_cms_about_ma.pdf [https://perma.cc/7D86-2ZZE].

reconsideration.[79] While such a process is completely internal to the insurance plan, federal law demands that any reconsideration involve a physician at the insurance company "*other than [the] physician involved in the initial determination*."[80]

If the insurer stands by its original determination, still refusing to cover the service, the decision is automatically forwarded to an Independent Review Entity (IRE) to start the second step of the appeals process.[81] The insurer must send the determination—along with all information that led to the determination, including the patient's case file and the insurer's utilization management tools—to the IRE for an external review.[82] The IRE, which has its own doctors and healthcare professionals, is retained by CMS and "independently review[s] and assess[es] the medical necessity of the items and services pertaining to [the beneficiary's] case."[83] The IRE then makes its own determination, which is binding on both the insurer and the beneficiary.[84]

If the IRE upholds the insurer's denial, the beneficiary can once again appeal the decision.[85] The final three steps of the appeals process involve various government actors, and a beneficiary must follow them in sequential order. The beneficiary can first appeal to an administrative law judge (ALJ) from the Office of Medicare Hearings and Appeals (OMHA) for a hearing.[86] After the ALJ renders a decision, that decision can be appealed to the Medicare Appeals Council,[87] which is made up of multiple

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79. 42 U.S.C. § 1395w-22(g)(2); Appeals in Medicare Health Plans, Medicare.gov, https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/medicare-health-plans [https://perma.cc/K4JJ-RBWH] (last visited Sep. 12, 2025) ("If you disagree with the initial decision from your plan, you or your representative can ask for a reconsideration.").

80. 42 U.S.C. § 1395w-22(g)(2)(B) (emphasis added).

81. Id. § 1395w-22(g)(4).

82. See Ctrs. for Medicare & Medicaid Servs., HHS, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance ¶¶ 50.12.1–50.12.4, 60.1–60.7 (2024), https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf [https://perma.cc/4B6L-KYHF] [hereinafter Ctrs. for Medicare & Medicaid Servs., Parts C & D] (outlining plan responsibilities regarding case files to be sent to the IRE).

83. Level 2 Appeals: Medicare Advantage (Part C), HHS, https://www.hhs.gov/about/agencies/omha/the-appeals-process/level-2/part-c/index.html [https://perma.cc/4L69-VR4K] (last updated Jan. 9, 2020).

84. Ctrs. for Medicare & Medicaid Servs., Parts C & D, supra note 82, ¶ 60.7.

85. 42 U.S.C. § 1395w-22(g)(5).

86. See Ctrs. for Medicare & Medicaid Servs., Parts C & D, supra note 82, ¶ 70.1 ("Any party to the reconsideration, except the [Medicare Advantage] plan, has a right to a hearing." (emphasis omitted)). These appeals, however, are only available for denials of services that cost $180 or more. Appeals in Medicare Health Plans, supra note 79.

87. 42 C.F.R. § 422.608 (2024).

ALJs.[88] If that decision still is not accepted, the final step is an appeal to a federal district court, invoking classic judicial review.[89]

Federal law thus creates a robust appeals process for beneficiaries denied coverage that involves various actors: multiple doctors from the insurance plan, independent doctor reviewers from the IRE, a host of ALJs in OMHA and the Medicare Appeals Council, and Article III judges. This appeals process combines with laws that set out general procedures as to how Medicare Advantage insurers must make determinations to comprise the government's main regulatory tools regarding medical necessity determinations. Therefore, while Medicare Advantage insurers hold vast power in applying this necessarily broad statutory standard to an individual beneficiary's case—a power that has been enhanced over time—the government retains the power to check these insurers should they stray away from their statutory duties.

II. THE CURRENT STATE OF DETERMINATIONS IN MEDICARE ADVANTAGE

Unfortunately, Medicare Advantage insurers have seemingly strayed from their duties. This Part outlines the current state of coverage determinations. Section II.A demonstrates that Medicare Advantage insurers are using AI to incorrectly and opaquely deny coverage, often based on a lack of medical necessity, and sometimes obstructing access to the appeals system in the process. Section II.B outlines recent reforms that the government has enacted to curb improper denials. Section II.C then notes the shortfalls of the reforms.

A. *Automated Denials on the Rise*

While the precise ways that Medicare Advantage insurers use AI today remain varied and unclear,[90] the technology is playing an increasing role in medical necessity and coverage determinations, as demonstrated by

88. See Who Are the Board Members & Judges?, HHS, https://www.hhs.gov/about/agencies/dab/about-dab/who-are-the-board-members-and-judges/index.html [https://perma.cc/DJ9H-JBPE] (last updated Dec. 5, 2025) (listing out the members of the Medicare Appeals Council and their qualifications).

89. 42 C.F.R. § 422.612. Appeals to a federal court, however, are only available for services that meet a certain amount in controversy. Appeals in Medicare Health Plans, supra note 79. In 2024, that amount was $1,840. Id.

90. See Nat'l Ass'n of Ins. Comm'rs, Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management 7–10 (2024), https://healthlaw.org/wp-content/uploads/2024/11/20241111_Role-of-AI-in-UM_508_FINAL-v2.pdf [https://perma.cc/9ZHZ-VYU8] (exploring three separate ways health insurers may use AI in determinations); Ross & Herman, Denied by AI, supra note 10 ("[T]he precise role the algorithms play in these decisions has remained opaque."); Letter from Rep. Judy Chu et al. to Chiquita Brooks-LaSure, supra note 11, at 2 ("[W]e do not know what inputs are used for the algorithms and AI tools currently being used . . . .").

multiple investigations.[91] While the use of AI in decisionmaking is not always inherently harmful,[92] it is concerning in this context, as evidence shows that AI usage may be correlated with increasing denials, inaccuracy, and discrimination.[93] In recent years, Medicare Advantage insurers have seen a slight uptick in denials, from 5.7% in 2019 to 6.4% in 2023.[94] The trend is more stark for costly services, such as post-acute rehabilitation services, an area in which UnitedHealthcare's denial rate increased from 10.9% in 2020 to 16.3% in 2021 to 22.7% in 2022.[95] Humana's denial rate for similar services saw a comparable increase, growing by 54% between

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91. See, e.g., Kevin De Liban, TechTonic Just., Inescapable AI: The Ways AI Decides How Low-Income People Work, Live, Learn, and Survive 10 (2024), https://static1.squarespace.com/static/65a1d3be4690143890f61cec/t/673c7170a0d09777066c6e50/1732014450563/ttj-inescapable-ai.pdf [https://perma.cc/WE65-RB39] ("About 16.5 million low-income people are exposed to AI-related decision-making through the prior authorization processes used in Medicare Advantage programs. As a result, people are denied medically necessary treatments and medicines." (emphasis omitted)); Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 11 ("[T]here is evidence that AI is already widely used today [in medical necessity determinations] . . . ."); id. ("Today, one of the most common uses of AI in health insurance is for utilization management." (emphasis omitted)); Ross & Herman, Denied by AI, supra note 10 ("Elevance, Cigna, and CVS Health, which owns insurance giant Aetna, have all purchased [AI tools] in recent years. One of the biggest and most controversial companies behind these models, NaviHealth, is now owned by UnitedHealth Group."); id. ("STAT's investigation revealed these tools are becoming increasingly influential in decisions about patient care and coverage.").

92. The entire point of the medical necessity determination process is to ensure access to necessary care and prevent unnecessary care. To the extent AI can do that, many agree it should be welcomed. As one consumer advocate says: "In an ideal world, AI would increase efficiency without posing any additional harms to patients or their access to care." Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 12 (emphasis omitted) (internal quotation marks omitted) (quoting a consumer advocate). Whether AI will ever be able to do this, given the personalization and complexity required for medical decisions, has not yet been determined. See supra notes 31–36 and accompanying text. While this Note does not take an opinion on the future capabilities of AI, current models do not seem to have the ability to make these decisions accurately. See infra notes 93, 110–123 and accompanying text.

93. See Brandon Novick, Denying Coverage With AI: CMS's New Medicare Model, Ctr. for Econ. & Pol'y Rsch. (July 8, 2025), https://cepr.net/publications/denying-coverage-with-ai-cmss-new-medicare-model/ (on file with the *Columbia Law Review*) (reporting that use of AI in coverage determinations has "not proven to be reliable" and "has difficulty getting facts correct"); see also infra notes 110–123.

94. Jeannie Fuglesten Biniek, Nolan Sroczynski, Meredith Freed & Tricia Neuman, Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023, KFF (Jan. 28, 2025), https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/ [https://perma.cc/EVW2-AA2L] [hereinafter Fuglesten Biniek et al., Medicare Advantage Insurers]. A separate study found a similar trend, finding that denials had increased by 15% between 2015 and 2022. Suhas Gondi, Kushal T. Kadakia & Thomas C. Tsai, Coverage Denials in Medicare Advantage—Balancing Access and Efficiency, JAMA Health F., Mar. 1, 2024, at 1, 1, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2815743 (on file with the *Columbia Law Review*).

95. Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 4.

2020 and 2022.[96] Physicians across practice areas report this trend: In a 2024 survey, 75% reported that denials have "[i]ncreased somewhat or significantly" over the last five years.[97]

This increasing rate of denials has tracked with the increasing usage of AI in the determination process. In its October 2024 report, the Senate Permanent Subcommittee on Investigations noted that UnitedHealthcare's denial rate was increasing at the very same time the prominent insurer "was implementing multiple initiatives to automate the process."[98] A more direct correlation was found in UnitedHealthcare's internal meeting minutes, in which the company approved a new automated model after noting it produced "an increase in adverse determination rate."[99] The producers of the models and processes market them explicitly as tools that can increase denial rates: Salespeople for Cigna's EviCore, for example, "have boasted of a 15% increase in denials."[100] Denials, many of them lacking accuracy and transparency, are on the rise.

1. *Determinations Are Frequently Inaccurate.* — Medicare Advantage insurers regularly invoke Medicare's medical necessity provision to incorrectly deny necessary services.[101] HHS started investigating the accuracy of denials after CMS's audits of plans found "widespread and persistent

96. Id. at 6. The correlation with costly services is not shocking given the financial incentives Medicare Advantage insurers have under the capitated payment model. The Senate Permanent Subcommittee on Investigations concluded that Medicare Advantage insurers "target" such costly services for medical necessity denials, knowing the impact it has on their bottom line. Id. at 19. In such circumstances, the Senate Permanent Subcommittee on Investigations concluded, Medicare Advantage insurers were "substituting judgment about medical necessity with a calculation about financial gain." Id. at 7.

97. AMA, 2024 AMA Prior Authorization Physician Survey (2025), https://www.ama-assn.org/system/files/prior-authorization-survey.pdf [https://perma.cc/6FDP-VQAG].

98. Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 4.

99. See id. at 5 (internal quotation marks omitted) (quoting UnitedHealthcare's internal meeting minutes).

100. See Miller et al., supra note 22.

101. One caveat to the figures presented in this Note is that not all denials are based on a lack of medical necessity. Other reasons appear on denial notices: the service is experimental, the service does not meet coverage criteria, the provider is out of network, the request has missing information, and so on. These reasons, however, are often overlapping. In many ways, a denial based on a lack of information might be saying: "We do not have the data to determine whether this is medically necessary." A denial based on coverage criteria might be saying: "Our coverage criteria, which were created to determine if something is medically necessary, have not been met." So, the reasons often bleed into one another, with medical necessity frequently playing a role, albeit sometimes a step removed. Further, data categorizing these denials is not readily accessible or digestible—yet another demonstration of the opacity that exists in this system. See infra section II.A.2. The numbers that appear in this Note encompass more than outright medical necessity denials. But this does not affect this Note's conclusions about inaccuracy and opacity.

problems related to inappropriate denials of services."[102] HHS's investigation confirmed as much to be true, reporting that in a study of over twelve thousand denials, "an estimated 13 percent met Medicare coverage rules" meaning "these services likely would have been approved . . . under original Medicare."[103] Among post-service payment denials, the error rate was even higher, with 18% of denials being incorrect.[104] The report explicitly noted that Medicare Advantage insurers were denying services that neutral physician reviewers determined were medically necessary.[105]

Medicare Advantage insurers admit to the high rate of inaccuracy, albeit indirectly. As mandated by law, plans must reconsider their original determinations as the first step of a beneficiary's appeal.[106] In doing so, Medicare Advantage plans overturned their own decisions at a staggering rate of 80% or higher in every year between 2019 and 2023, deciding upon review that a service should indeed be covered despite their first determination that it should not be.[107] Government reviewers went on to overturn even more determinations at later stages in the appeals process.[108] When plans are forced to defend their original determinations, they find them to be inaccurate in the majority of cases.[109]

Medicare Advantage insurers' use of AI in the determination process has only exacerbated inaccuracy.[110] Beneficiary advocates express this concern, stating that they believe AI is "simply lead[ing] to a faster cadence of incorrect . . . decisions that could result in delayed or denied care."[111] The Center for Medicare Advocacy (CMA), a national nonprofit

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102. Off. of Inspector Gen., Medicare Advantage Denials Raise Concerns, supra note 67, at 2 (citing Off. of Inspector Gen., Medicare Advantage Appeal Outcomes, supra note 62).

103. Id. at 9.

104. Id. at 12.

105. See id. at 10, 32, 36–38, 40–41 (noting various cases in which physician reviewers found care medically necessary despite a denial from the Medicare Advantage plan).

106. See supra notes 79–80 and accompanying text.

107. Fuglesten Biniek et al., Medicare Advantage Insurers, supra note 94.

108. See Off. of Inspector Gen., Medicare Advantage Appeal Outcomes, supra note 62, at 9 ("Independent reviewers overturned additional denials in favor of beneficiaries and providers at four levels of appeal[.]").

109. Two things are worth noting about this data. First, the appeals likely suffer from a self-selection bias as to which determinations get appealed. One can imagine that claims with more merit are more likely to be appealed, thus skewing this data as appeals disproportionately reflect more meritorious claims. Second, it is also possible that the insurer was not provided all the relevant information upon the first consideration and, therefore, the changed determination does not reflect an insurer's changed position but rather new or changed information. Both factors would tend to inflate the rates of reversal. Nevertheless, such reversal rates are so high that it remains concerning.

110. Because Medicare Advantage insurers remain opaque about the precise role AI is playing in determinations, it is not possible to find direct causation. This is part of the opacity that exists. See infra section II.A.2. This Note, therefore, primarily relies on correlations that have been documented.

111. Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 13.

that closely follows Medicare trends, agrees this is happening, stating that it sees cases in which AI tools appear overly restrictive and deny beneficiaries access to necessary care.[112] Multiple lawsuits allege the same, claiming that certain AI models have inaccuracy rates as high as 90%, yet remain in use.[113] Some of this may be due to the algorithms' inability to account for individual characteristics or special circumstances, which is necessary for medical necessity determinations.[114] As CMA Codirector David Lipschutz has reported, the algorithms in Medicare Advantage often operate as "a hard-and-fast rule . . . . There's no deviation from [their outputs], no accounting for changes in condition, no accounting for situations in which a person could use more care."[115]

The distributional effects of this inaccuracy are also concerning, as AI has been found to exacerbate discrimination, particularly against individuals from protected classes.[116] This bias has been documented across AI tools in various domains,[117] including in the healthcare industry. For example, one algorithm that relied on insurance data "fail[ed] to account for a collective nearly 50,000 chronic conditions experienced by black patients" and thus did not recommend those patients for extra health services, often instead recommending white patients who were not as sick.[118] Additionally, "physicians overestimate pain tolerance of patients

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112. Ctr. for Medicare Advoc., The Role of AI-Powered Decision-Making Technology in Medicare Coverage Determinations 9 (2022), https://medicareadvocacy.org/wp-content/uploads/2022/01/AI-Tools-In-Medicare.pdf [https://perma.cc/QA3D-5DU8].

113. Lokken Amended Complaint, supra note 1, at 2; see also Barrows Complaint, supra note 8, at 13 ("Upon information and belief, over 90 percent of patient claim denials are reversed . . . [which] demonstrates the blatant inaccuracy of the nH Predict AI Model . . . ."). Again, this number is likely inflated due to the concerns addressed above in note 109.

114. See supra notes 32–36 and accompanying text.

115. Ross & Herman, Denied by AI, supra note 10 (internal quotation marks omitted) (quoting David Lipschutz, Codirector, CMA). Given that individualized decisionmaking is a key basis for the broad medical necessity standard, a tool that is unable to deviate from hardline rules will inevitably fail to correctly employ the standard.

116. See Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 13–14 (noting that when AI is used in coverage determinations, there are "potential risks for discrimination against consumers, particularly patients from protected classes"). The potential for increased discrimination when AI is involved is well documented, prompting former President Joe Biden to issue an executive order to combat such discrimination. See Exec. Order No. 14,110, 3 C.F.R. 657, 658 (2024) ("From hiring to housing to healthcare, we have seen what happens when AI use deepens discrimination and bias, rather than improving quality of life."). President Donald Trump, however, revoked this order when he took office. See Exec. Order No. 14,148, 90 Fed. Reg. 8237, 8240 (Jan. 20, 2025).

117. See, e.g., Talia B. Gillis, The Input Fallacy, 106 Minn. L. Rev. 1175, 1176 n.5 (2022) (listing various sources that discuss the bias in algorithmic decisionmaking); Margot E. Kaminski & Jennifer M. Urban, The Right to Contest AI, 121 Colum. L. Rev. 1957, 1969–71 (2021) (discussing instances of biased AI in healthcare, employment, and lending).

118. See Shraddha Chakradhar, Widely Used Algorithm for Follow-Up Care in Hospitals Is Racially Biased, Study Finds, STAT (Oct. 24, 2019), https://www.statnews.com/2019/10/24/widely-used-algorithm-hospitals-racial-bias/ (on file with the *Columbia Law*

of color, leading to systemic undertreatment";[119] low-income individuals can be excluded from receiving necessary treatments due to a lack of insurance coverage;[120] and "women and minorities are frequently excluded from medical research."[121] Given that inequities pervade the United States healthcare system and available datasets, there is serious concern that "[t]he introduction of AI-informed decision making . . . will continue to exacerbate many of these inequities."[122] As Medicare Advantage insurers increasingly use AI, more beneficiaries—particularly the most vulnerable—may receive denials stating care is "not medically necessary," when in fact their situation requires care. These inaccurate denials have devastating health and financial consequences for beneficiaries and their families.[123]

2. *Determinations Are Opaque*. — Compounding the inaccuracy of determinations is the opacity that accompanies them, both in what led to the determinations and in how a beneficiary can challenge them. A CMS audit found that nearly half of all Medicare Advantage insurers are "sending incorrect or incomplete denial letters, which may inhibit beneficiaries' and providers' ability to appeal."[124] Treating physicians report a similar phenomenon, stating that often "their attempts to get explanations [about denials] are met with blank stares and refusals to share more information."[125] An internal memorandum provided to employees of naviHealth—a subsidiary of UnitedHealth Group that created and uses an algorithm to make coverage decisions[126]—makes clear

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Review); see also Sharon Begley, Discovery of Racial Bias in Health Care AI Wins *STAT* Madness 'Editors' Pick', STAT (Apr. 6, 2020), https://www.statnews.com/2020/04/06/stat-madness-editors-pick-racial-bias-in-health-care-ai/ (on file with the *Columbia Law Review*) ("The artificial intelligence software . . . routinely let healthier white patients into the programs ahead of black patients who were sicker and needed them more.").

119. Sahar Takshi, Unexpected Inequality: Disparate-Impact From Artificial Intelligence in Healthcare Decisions, 34 J.L. & Health 215, 242 (2021).

120. Id. at 218 n.7.

121. Id. at 222.

122. Id. at 218, 222.

123. See, e.g., Lokken Amended Complaint, supra note 1, at 18–35 (outlining claims about the drastic consequences the plaintiffs faced due to care denials); see also Casey Ross & Bob Herman, UnitedHealth Pushed Employees to Follow an Algorithm to Cut Off Medicare Patients' Rehab Care, STAT (Nov. 14, 2023), https://www.statnews.com/2023/11/14/unitedhealth-algorithm-medicare-advantage-investigation/ (on file with the *Columbia Law Review*) [hereinafter Ross & Herman, UnitedHealth] (sharing how, after a denial for a continued stay in a nursing home, a family was forced to pay out of pocket for a private caregiver to care for their mother).

124. Off. of Inspector Gen., Medicare Advantage Appeal Outcomes, supra note 62, at 12.

125. Ross & Herman, Denied by AI, supra note 10.

126. After receiving significant backlash due to reports on its use in care denials, naviHealth has since rebranded. Bob Herman & Casey Ross, UnitedHealth Discontinues a Controversial Brand Amid Scrutiny of Algorithmic Care Denials, STAT (Oct. 23, 2023), https://www.statnews.com/2023/10/23/unitedhealth-optum-navihealth-rebranding-

that this lack of information is intentional in some cases, stating, "IMPORTANT: Do NOT guide providers or give providers answers to the questions" about their requests for care.[127]

Once again, AI has exacerbated this concern, further preventing beneficiaries from understanding or challenging decisions. Beneficiaries are "neither aware of the algorithms, nor able to question their calculations."[128] There remains a lack of disclosure as to how plans are using AI in determination processes and applications of the medical necessity provision.[129] This opacity carries over into how AI is deployed in beneficiaries' individual cases. One legal aid attorney reports that "[the algorithm's report] is never communicated with clients,"[130] and, even if requested, plans often refuse to disclose such information on the basis that the AI relies on "proprietary datasets."[131] This makes it "even more difficult for consumers and providers to get detailed information about why a request was denied and what criteria and data were used,"[132] information that is often necessary to mount a successful appeal.[133]

Such opacity has limited beneficiaries' ability to access the appeals process, which is how they can get incorrect determinations reversed.[134] While Medicare Advantage insurers denied 3.2 million prior authorization requests in 2023, beneficiaries appealed only 11.7% of these denials.[135] Over 2.5 million denials, therefore, never received a second look and never had a chance for reversal. A 2023 survey conducted by KFF—a leading healthcare policy nonprofit—reports that a lack of information and transparency may be contributing to this low rate, finding that 35% of Medicare beneficiaries were uncertain whether they had appeals rights and an additional 7% believed that they had no appeals rights.[136] Even

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algorithm/ (on file with the *Columbia Law Review*). It still, however, exists under the UnitedHealth Group umbrella. Id.

127. Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 28 (internal quotation marks omitted) (quoting instructions from naviHealth to its employees).

128. Ross & Herman, Denied by AI, supra note 10; see also Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 18 ("AI is an impenetrable 'black box,' obscuring the chain of command and making it nearly impossible for consumers to push back on decisions regarding their own care.").

129. See supra note 90 and accompanying text.

130. Ross & Herman, Denied by AI, supra note 10 (alteration in original) (internal quotation marks omitted) (quoting Christine Huberty, Att'y).

131. See Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 14.

132. Id.

133. This outcome has been documented across appeals systems for various public benefits. One report concludes that "AI makes it harder for individuals harmed to contest decisions," specifically in the realm of "administrative hearings." De Liban, supra note 91, at 16 (emphasis omitted).

134. See supra notes 107–109 and accompanying text.

135. Fuglesten Biniek et al., Medicare Advantage Insurers, supra note 94.

136. Karen Pollitz, Kaye Pestaina, Alex Montero, Lunna Lopes, Isabelle Valdes, Ashley Kirzinger & Mollyann Brodie, KFF Survey of Consumer Experiences With Health Insurance,

when enrollees knew of their rights, they did not know how to invoke them, with 61% reporting that they did not know which government agency, if any, they could contact for help regarding their health insurance coverage.[137] Even treating physicians, who should be experts in the field, reported appealing a very small number of adverse decisions, citing mistrust in the appeals system and a lack of time or resources.[138]

The current state of coverage determinations in Medicare Advantage is not one of applying a broad statutory standard through robust inquiry into beneficiaries' individual circumstances. Instead, determinations look more like what Clemens alleges in her complaint: the rapid issuance of an automated, opaque, and inaccurate denial that is difficult to appeal.[139] Armed with AI technologies that enable an "increased volume and speed" of denials,[140] Medicare Advantage insurers are leaving many beneficiaries without access to the care their doctors certified was medically necessary. This not only results in "[c]ostly implications for patients" but also strains the country's healthcare system overall.[141]

B. *CMS Increases Procedural Requirements*

The state of incorrect, opaque determinations prompted CMS to take action.[142] On April 5, 2023, CMS promulgated a final rule that, among other things, aimed to "help ensure [Medicare Advantage] enrollees have consistent access to medically necessary care, without unreasonable

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KFF (June 15, 2023), https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/ [https://perma.cc/LA6W-D8DS].

137. Id.

138. See AMA, supra note 97; see also Gondi et al., supra note 94, at 1 ("[A]ppealing denials contributes to clinician workload and burnout.").

139. See Lokken Amended Complaint, supra note 1, at 24–25.

140. Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 13 (emphasis omitted).

141. See Michael J. Alkire, Unnecessary Insurance Claim Denials Compromise Patient Care and Provider Bottom Lines, STAT (May 1, 2024), https://www.statnews.com/2024/05/01/insurance-claim-denials-compromise-patient-care-provider-bottom-lines/ (on file with the *Columbia Law Review*) ("Refusing or delaying legitimate medical claims has a significant impact on providers and patients. Problematic payer practices strain hospital resources, deplete cash reserves and hinder medically necessary care.").

142. This section will focus on the rule CMS promulgated in 2023, which directly addresses both medical necessity and AI and remains in legal effect. CMS promulgated another rule in April 2025. Medicare and Medicaid Programs 2026 Policy and Technical Changes, 90 Fed. Reg. 15,792 (Apr. 15, 2025) (to be codified at 42 C.F.R. pts. 417, 422, 423, 460). But the 2025 rule does not have direct relevance to this Note's inquiry. Interestingly, the proposed rule predating the 2025 final rule addressed AI, including a section titled "Ensuring Equitable Access to Medicare Advantage (MA) Services—Guardrails for Artificial Intelligence." Proposed Medicare and Medicaid Programs 2026 Policy and Technical Changes, 89 Fed. Reg. 99,340, 99,396–98 (proposed Dec. 10, 2024). The final rule—adopted after the change in administration—dropped this section. Medicare and Medicaid Programs 2026 Policy and Technical Changes, 90 Fed. Reg. at 15,795. The most relevant AI and medical necessity provisions, therefore, are in the 2023 rule.

barriers or interruptions."[143] The rule codified two relevant provisions relating to how Medicare Advantage insurers must make such decisions.

First, the rule clarified the factors that insurers can use when making "medical necessity determinations."[144] The rule both prohibits insurers from using any internal coverage criteria that are not supported by clinical guidelines or not "publicly accessible"[145] and mandates that every decision account for "[t]he enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes."[146] In describing the latter half of this provision, the rule's accompanying explanation emphasizes the individualized nature of a decision, noting plans "must ensure that they are making medical necessity determinations based on the circumstances of the specific individual . . . *as opposed to using an algorithm or software* that doesn't account for an individual's circumstances."[147]

After receiving questions about this new provision, particularly whether it "mean[s] that [Medicare Advantage] organizations cannot use algorithms or artificial intelligence to make coverage decisions," CMS released further guidance in February 2024.[148] The guidance explicitly addressed how both the "publicly accessible" criteria requirement and the individualization requirement applied to the use of AI. As to the public accessibility requirement, CMS stated: "[P]redictive algorithms or software tools cannot apply other internal coverage criteria that have not been explicitly made public and adopted in compliance with the evidentiary standard in § 422.101(b)(6)."[149] This was a further elaboration on the rule, which stated that such tools' "proprietary nature does not absolve [Medicare Advantage] plans from their responsibilities under this final rule."[150] To the contrary, "[t]he [Medicare Advantage] plan must make the evidence that supports the internal criteria used by (or used in developing) these tools publicly available, along with the internal coverage policies themselves."[151] As to the individualization requirement, CMS responded:

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143. Medicare Program 2024 Policy and Technical Changes, 88 Fed. Reg. 22,120, 22,122 (Apr. 12, 2023) (codified at 42 C.F.R. pt. 422).

144. 42 C.F.R. § 422.101(c)(1) (2024).

145. Id. § 422.101(b)(6).

146. Id. § 422.101(c)(1)(i)(C).

147. Medicare Program 2024 Policy and Technical Changes, 88 Fed. Reg. at 22,195 (emphasis added).

148. See Memorandum from Ctrs. for Medicare & Medicaid Servs. to All Medicare Advantage Orgs. & Medicare-Medicaid Plans (Feb. 6, 2024), https://calhospital.org/wp-content/uploads/2024/02/HPMS-Memo-FAQ-on-CC-and-UM-020624.pdf [https://perma.cc/4F74-GEWX] [hereinafter Ctrs. for Medicare & Medicaid Servs., Feb. 6 Memo].

149. Id. at 3.

150. Medicare Program 2024 Policy and Technical Changes, 88 Fed. Reg. at 22,195.

151. Id.

> An algorithm or software tool can be used to assist [Medicare Advantage] plans in making coverage determinations, but it is the responsibility of the [Medicare Advantage] organization to ensure that the algorithm or artificial intelligence complies with all applicable rules for how coverage determinations by [Medicare Advantage] organizations are made. For example, compliance is required with all of the rules at § 422.101(c) for making a determination of medical necessity, including that the [Medicare Advantage] organization base the decision on the individual patient's circumstances, so an algorithm that determines coverage based on a larger data set instead of the individual patient's medical history, the physician's recommendations, or clinical notes would not be compliant with § 422.101(c).[152]

Both requirements have had implications for how insurers make medical necessity determinations, including the role AI is allowed to play.

The second relevant provision in the rule addresses *who* must make determinations of medical necessity. The rule requires that any "partially or fully adverse medical necessity . . . decision . . . be reviewed by a physician or other appropriate health care professional" before the insurer finalizes it.[153] CMS copied this provision from the requirement already present for medical necessity determinations at the reconsideration stage[154] and now requires the same expert input for the first determination. The provision, therefore, prohibits a plan from using only AI to issue any denial based on medical necessity. CMS stated that it would utilize a "combination of routine and focused audits in 2024" to monitor compliance with these new requirements to "make sure that [Medicare Advantage] beneficiaries get the care they need."[155]

These CMS regulations are a welcome first step to combatting Medicare Advantage insurers' current misuse of AI and the medical necessity provision to deny beneficiaries access to care. The regulations require more transparency through disclosure of criteria and data; demand individualization, which is a key underpinning of any quality medical necessity determination; and provide a human check prior to any denial that could impede a beneficiary's access to care. Each of these changes, if enforced well, could alleviate some of the concerns that surround improper denials today.

C. *Accountability Remains Missing*

Although the CMS regulations are helpful, they fall short in fully protecting beneficiaries from inaccurate AI-generated denials. This is

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152. Ctrs. for Medicare & Medicaid Servs., Feb. 6 Memo, supra note 148, at 2.

153. 42 C.F.R § 422.566(d) (2024).

154. See Medicare Program 2024 Policy and Technical Changes, 88 Fed. Reg. at 22,217 ("This is the same standard of review with respect to expertise that applies to physician review of reconsiderations at § 422.590(h)(2).").

155. Ctrs. for Medicare & Medicaid Servs., Feb. 6 Memo, supra note 148, at 14.

largely because the regulations fail to enact a sufficient accountability method for incorrect determinations, both individually and at large. Of course, by implementing the new requirements, CMS hopes to prevent these inaccurate determinations before they happen. But this strategy rests on two questionable assumptions.

1. *An Overemphasis on Front-End Procedure.* — First, in focusing solely on front-end[156] rules, CMS conflates improved internal procedures with improved outcomes. These two items are related and often go hand in hand. They are not, however, the same. In the context of medical necessity, the goal is an outcome: Beneficiaries obtain coverage for medically necessary services but do not receive coverage for unnecessary or harmful services. The statutory language focuses solely on an outcome, stating covered services must be "reasonable and necessary," without establishing any mandated procedure to determine this.[157] Similarly, in practice, beneficiaries care about the outcome—whether they receive coverage for necessary services—rather than whatever procedure led to that outcome. Both in law and fact, the outcome is what is important, and any procedural requirements are likely only as good as their ability to produce correct outcomes.[158]

Unfortunately, CMS has not provided ample evidence that its new procedural requirements will lead to better outcomes. And preliminary evidence indicates otherwise. Take, for example, CMS's new requirement that a human healthcare professional must review any adverse medical necessity determination before issuance.[159] Nearly all plans claim to already comply with this requirement. For example, UnitedHealthcare claims that its AI decisionmaking model already requires human review for any case that results in a denial.[160] Cigna and Humana both claim to follow similar models.[161] Yet these are the very Medicare Advantage plans

156. This Note uses the term *front-end* to describe anything that happens before the insurer issues a determination. The procedural requirements that an insurer must meet before issuing any determination, including items like what information can be used and who can be involved, fall into this category. The term *back-end* refers to anything that happens after an insurer makes a determination, including the recourse beneficiaries have to challenge such determinations. This includes items like notice requirements and the appeals process.

157. See 42 U.S.C. § 1395y(a)(1)(A) (2018).

158. This may seem like an obvious point. But there are many situations in which a procedure is itself an ultimate good. In elections, for example, the fair and democratic process is in and of itself a good, often more important than any specific outcome. This is not the case for medical necessity determinations. But see infra note 189 and accompanying text.

159. 42 C.F.R. § 422.566(d) (2024).

160. See Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 23 ("[T]hese documents and public statements from UnitedHealthcare indicate that final denials of prior authorization requests could come only from human reviewers . . . .").

161. See id. at 46 (describing Humana's "preference to 'put humans in the loop for purposes of decision-making'" (quoting Humana, Ethical Usage of Augmented Intelligence Standard (2022))); Miller et al., supra note 22 (discussing a Cigna model that the company

facing class action suits that allege their models are producing inaccurate denials.[162] The lawsuits allege that the human review may be happening, but the plans essentially demand that human reviewers adhere to the algorithm's result, threatening "possible termination" if reviewers deviate in their recommendations.[163] Medicare Advantage insurers have thus checked the box on the procedural requirement, but there is no evidence that determinations have gotten more accurate, which is the true goal.

The same goes for the other enacted requirements. CMS itself wrote, "[M]any [Medicare Advantage] organizations may already be interpreting our current rules in a way that aligns with what we proposed."[164] Yet CMS promulgated this rule because beneficiaries are not receiving the necessary care to which they are entitled.[165] If Medicare Advantage insurers are already following these requirements but outcomes remain poor, the newly codified procedural requirements alone will not suffice. Again, in medical necessity determinations, the procedure is often only as important as its ability to lead to proper outcomes. CMS has provided no evidence that the new requirements can do as much.[166]

2. *A Lack of Enforcement Mechanisms.* — Even if the new requirements could lead to better outcomes, CMS fails to create mechanisms that will enable either CMS or beneficiaries to hold Medicare Advantage insurers accountable for these requirements, both on an individual and plan-wide basis. On the individual level, the rule does not provide an enhanced remedy or recourse for individuals improperly denied medically necessary care. Instead, the only enforcement methods it mentions are in the aggregate, noting CMS continues to conduct plan-wide audits, issue warning letters, require corrective action plans, and pursue civil penalties and sanctions when it finds insurers are failing to comply with the new

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says "never automate[s] medical necessity denials" (internal quotation marks omitted) (quoting an Aetna spokesperson)).

162. See, e.g., Kisting-Leung Third Amended Complaint, supra note 8, at 1; Barrows Complaint, supra note 8, at 1; Lokken Amended Complaint, supra note 1, at 2.

163. E.g., Ross & Herman, UnitedHealth, supra note 123; see also Barrows Complaint, supra note 8, at 3–4 (noting that "Humana intentionally limits its employees' discretion to deviate from the nH Predict AI Model").

164. Medicare Program 2024 Policy and Technical Changes, 88 Fed. Reg. 22,120, 22,190 (Apr. 12, 2023) (codified at 42 C.F.R. pt. 422).

165. See Proposed Medicare Program 2024 Policy and Technical Changes, 87 Fed. Reg. 79,452, 79,498 (proposed Dec. 27, 2022) (noting that "CMS has received feedback from various stakeholders" that Medicare Advantage plans' current techniques "create a barrier to patients accessing medically necessary care").

166. This is true for a more zoomed-out historical look as well. Over the years, CMS has "exercised greater control over contractors, as evidenced by increasing procedural requirements." Susan Bartlett Foote, The Impact of the Medicare Modernization Act's Contractor Reform on Fee-for-Service Medicare, 1 St. Louis U. J. Health L. & Pol'y 67, 70 (2007). Yet outcomes today are as poor as ever. See supra section II.A. It thus does not appear that proceduralizing medical necessity determinations on the front end alone suffices to obtain better outcomes. It certainly may help, but it has not proven enough to solve the issue at hand.

rule.[167] But audits do little to provide a remedy for individuals suffering without the care they need. One can wonder how much comfort someone like Clemens would find in the idea that, while nothing will change in her individual case, CMS may issue a warning letter or fine her insurer at the end of the year. Individual beneficiaries and their families are the parties most harmed by inaccurate denials. A proper rule would place beneficiaries at the center of any remedy.[168]

Of course, CMS may point to the existing appeals process[169] as the proper mechanism for individual remedies. CMS, however, has noted that Medicare Advantage plans often withhold appropriate data or appeals directions from beneficiaries, hampering beneficiaries' ability to appeal.[170] Physicians have reported the same.[171] While the appeals process is an important tool for beneficiaries,[172] it only works if beneficiaries have the data and information needed to properly access it. They currently do not, and the rule does little to change this.[173] And, even if beneficiaries appeal their determinations, they must first exhaust the internal reconsideration stage, which can result in serious delays in care.[174] The new rule thus continues to leave beneficiaries without a proper remedy in their individual cases.

Even on a plan-wide basis, CMS has not introduced a mechanism that will lead to true accountability for improper decisions or procedure. As noted, the mechanism CMS uses is the same one it has used for years:

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167. See Ctrs. for Medicare & Medicaid Servs., Feb. 6 Memo, supra note 148, at 14.

168. See infra note 189 and accompanying text.

169. See section I.C for a discussion of what this process entails.

170. See supra section II.A.2.

171. See supra notes 125, 127 and accompanying text; see also AMA, supra note 97 (noting that 67% of physicians do not appeal because they "do not believe the appeal will be successful," while 55% report having "insufficient . . . resources/time").

172. As discussed above, data show that when beneficiaries do invoke this right, they are highly successful, with Medicare Advantage plans reversing their determinations at rates above 80%. See Fuglesten Biniek et al., Medicare Advantage Insurers, supra note 94.

173. The new rule requires Medicare Advantage insurers to make public the criteria on which they base their decisions. 42 C.F.R § 422.101(b)(6)(ii) (2024). This, however, only requires that plans disclose their general coverage criteria or formulas at large. See id. § 422.101(b)(6)(ii)(A). It does not require plans to disclose how exactly criteria interacted with a specific beneficiary's situation. See id. Beneficiaries will likely still lack the information they need to challenge these determinations. Additionally, while CMS has for years required Medicare Advantage insurers to "[s]tate the specific reasons for the denial" in adverse determinations, id. § 422.568(e), broad language with references to regulatory codes has generally sufficed to meet this "specific reasons" standard. See Letter from Rep. Judy Chu et al. to Chiquita Brooks-LaSure, supra note 11, at 2 (asking for more specific language on denial letters). Given how broad and ambiguous medical necessity is, see supra section I.A, this does not give beneficiaries or their doctors enough information. Insurers are failing to meet even these basic requirements. See supra note 124 and accompanying text.

174. See supra notes 79–80 and accompanying text; see also Fuglesten Biniek et al., Medicare Advantage Insurers, supra note 94 (reporting that despite high reversal rates at the reconsideration stage, "patients potentially faced delays in obtaining services").

conducting audits to detect violations and then issuing sanctions when violations are discovered.[175] By all means, audits and sanctions are necessary. But they do not suffice to produce proper outcomes when it comes to Medicare Advantage insurers. In HHS's 2018 report, the Department noted that CMS was conducting audits and pursuing civil penalties against insurers in violation of the rules, particularly against those Medicare Advantage insurers issuing incorrect denials.[176] Nevertheless, HHS concluded that CMS "continue[d] to see the same types of violations in its audits of different [plans] every year."[177] Seven years later, the same problem persists, despite CMS engaging in audits and enforcement actions the entire time.[178] CMS provides no explanation for why or how its traditional means will result in better outcomes this time around.

To the contrary, early data show that insurer behavior is the same. In June 2024—six months after the new rule went into effect—a group of federal legislators wrote to CMS, reporting: "Plans continue to use AI tools to erroneously deny care and contradict provider assessment findings."[179] In October 2024, separate legislators wrote to CMS, stating that "plans are not following even the modest rules CMS has put into place."[180] Reports are not only coming out of Congress but from journalists and experts as well.[181] Casey Ross, a cowriter on the *STAT* exposé, reported in December 2024 that he had not "seen any evidence . . . that [insurers are] planning to pull back on the use of the algorithms or change the way they do it or welcome any additional oversight."[182] It seems Medicare Advantage insurers continue to see little, if any, threat in CMS's current enforcement methods.[183]

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175. See Ctrs. for Medicare & Medicaid Servs., Feb. 6 Memo, supra note 148, at 14 (outlining CMS's plan to conduct audits and issue "enforcement actions" for non-compliance).

176. See Off. of Inspector Gen., Medicare Advantage Appeal Outcomes, supra note 62, at 1.

177. Id.

178. See, e.g., Medicare Parts C & D Oversight & Enf't Grp., Ctrs. for Medicare & Medicaid Servs., 2023 Part C and Part D Program Audit and Enforcement Report 3–4, 8 (2024), https://www.cms.gov/files/document/2023-program-audit-enforcement-report.pdf [https://perma.cc/B2A8-XURR].

179. Letter from Rep. Judy Chu et al. to Chiquita Brooks-LaSure, supra note 11, at 1.

180. Letter from Sen. Ron Wyden et al. to Chiquita Brooks-LaSure, supra note 78, at 1–2.

181. See, e.g., Outlook 2024: AI Risks Start to Come Into Focus; Eyes Are on MA Rule, Telehealth Audits, Rep. on Medicare Compliance, Jan. 15, 2024, at 1, 5 https://www.pyapc.com/wp-content/uploads/2024/01/rmc-jan-15.pdf [https://perma.cc/AQ5A-LL63] ("Experts are skeptical [Medicare Advantage] plans will abide by the new rule . . . .").

182. Willis Ryder Arnold & Meghna Chakrabarti, How Insurance Companies Use AI to Deny Claims, WBUR (Dec. 18, 2024), https://www.wbur.org/onpoint/2024/12/18/unitedhealth-ai-insurance-claims-healthcare [https://perma.cc/27MJ-JCS5] (quoting Casey Ross, Reporter, STAT).

183. Unfortunately, when it comes to Medicare Advantage, this sentiment extends beyond coverage denials, with insurers seeming to thwart a wide array of laws and regulations.

Scholars and policymakers alike share skepticism that traditional enforcement methods can bring about the change in Medicare Advantage that is necessary. One scholar wrote: "[A]udits should not be confused with oversight. . . . [B]ecause of their random nature, audits are likely to only identify some instances of fraud and abuse."[184] Additionally, individuals have noted that CMS's small budget has at times made it "ill-equipped in the matchup with moneyed insurers."[185] Such comments—combined with data that reveal outcomes remain subpar despite enforcement efforts—demonstrate that while CMS audits and subsequent sanctions are important, they alone will not suffice to bring about the change needed.

The new rule, therefore, fails to create a system in which access to necessary care will significantly improve, despite that being the rule's stated goal.[186] Its focus on front-end procedure, rather than improved outcomes, and its failure to create new enforcement mechanisms, both at the individual and plan level, inhibit its effectiveness. The rule is a welcome first step to combatting Medicare Advantage insurers' improper coverage determinations, but more is needed to ensure beneficiaries can access the medically necessary care to which they are entitled.[187]

See, e.g., Christopher Weaver & Anna Wilde Mathews, UnitedHealth Group Is Under Criminal Investigation for Possible Medicare Fraud, Wall St. J., https://www.wsj.com/us-news/unitedhealth-medicare-fraud-investigation-df80667f (on file with the *Columbia Law Review*) (last updated May 15, 2025) (discussing a criminal investigation into "the company's Medicare Advantage business practices"); Press Release, DOJ, Cigna Group to Pay $172 Million to Resolve False Claims Act Allegations (Sep. 30, 2023), https://www.justice.gov/archives/opa/pr/cigna-group-pay-172-million-resolve-false-claims-act-allegations [https://perma.cc/38SR-J8MV] (discussing a settlement secured after the government alleged Cigna submitted "inaccurate and untruthful diagnosis codes for its Medicare Advantage Plan enrollees in order to increase its payments from Medicare"). Given just how persistent and widespread the problems with Medicare Advantage are, even some Republicans have supported greater regulation, calling for "bipartisan support for a crackdown." See Anna Wilde Mathews & Christopher Weaver, Dr. Oz Criticizes Some Medicare Advantage Business Practices, Wall St. J., https://www.wsj.com/politics/policy/dr-oz-criticizes-some-medicare-advantage-business-practices-45c98a2a?mod=article_inline (on file with the *Columbia Law Review*) (last updated Mar. 14, 2025).

184. Leibson, supra note 66, at 113–14.

185. Brendan Williams, United We Fall? The Change Healthcare Cyberattack and the Danger of a Too-Big-to-Fail Health Insurer, 101 Denv. L. Rev. Forum 1, 12 (2024), https://www.denverlawrev.org/_files/ugd/9d4c2a_8d0706ff6fd44fdc81d276f972c571e7.pdf [https://perma.cc/5CHW-5X35].

186. See supra note 143 and accompanying text.

187. It merits acknowledging that Medicare beneficiaries have "earned their eligibility" to participate in the program by paying into Social Security during their working years. Orentlicher, supra note 41, at 329; see also Oliva, supra note 14, at 1876 (noting that Medicare Advantage beneficiaries "spent their entire working lives paying taxes to earn Medicare benefits in retirement"). When Medicare Advantage insurers illegally deny coverage of medically necessary care, they are typically denying care to individuals who have spent years paying into the system.

III. OBTAINING BETTER OUTCOMES THROUGH BENEFICIARY EMPOWERMENT

This Part explores how CMS can improve its current regime to better combat Medicare Advantage insurers' issuance of inaccurate and opaque coverage denials.[188] CMS should do two things. First, CMS should diligently track, disclose, and create penalties for inaccurate denials arising from each individual Medicare Advantage plan. Such efforts will hold insurers accountable for whether they cover necessary care, shifting the focus from front-end procedure to outcomes. Second, CMS should strengthen the current appeals process through increased education and transparency. These two efforts—and the strategies set forth in this Part to implement them—will not only reduce the frequency of inaccurate denials but also serve as an important shift in how Medicare Advantage is administered more generally, returning power to the beneficiaries who are most affected. Medical necessity determinations intimately affect beneficiaries' lives, and beneficiaries—rather than their insurers, their doctors, or a government agency—should have more say in determinations.[189]

Notably, these efforts are not directed only at insurers' use of AI in determinations, which, as described above, appears to play an increasing role in the inaccuracy and opacity in the process. These efforts will combat improper use of AI, but they take aim at all coverage determinations. This broadened scope is important for two reasons. First, problems with the medical necessity determination process have existed in Medicare Advantage for years.[190] Even before insurers integrated AI into their processes, these insurers made inaccurate and opaque determinations.[191]

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188. This Note's proposals do not mean CMS should cease its current audits or enforcement methods—which remain important—but they merely urge CMS to fill the gaps that remain.

189. This is not a new sentiment. In 1976, Professor Sylvia A. Law, writing on national health insurance and the lack of consumer input, stated the following:

> A structure that gives people, individually and collectively, an opportunity to participate in making decisions about the health services they receive is [a] better structure even if the same substantive result can be achieved more cheaply and efficiently through professional, technical, or bureaucratic decision making. In fact, of course, a system in which decisions about the allocation and manner of delivery of health services was democratized would not produce the same substantive results as professional, technical, or bureaucratic decision making. The results of the decisions now being made by professional and bureaucratic processes are, by any standard, unsatisfactory.

Law, supra note 41, at 149.

190. See id. at 116–17 (describing insurers' use of medical necessity denials in the 1970s as "an administrative and human disaster"); Blanchard, supra note 24, at 944 (writing in 1990 on "claims processing delays and inappropriate claims denials").

191. See Off. of Inspector Gen., Medicare Advantage Appeal Outcomes, supra note 62, at 10–11 (noting that, in every year between 2012 and 2016, violations for "insufficient denial letters" and "inappropriate denials" were common).

While the insurers' use of AI is a concerning new development exacerbating these issues,[192] the issues speak to a deeper concern of Medicare Advantage insurers and their medical necessity determinations going unchecked more generally. This Note thus presents a solution that encompasses AI usage but does not limit its remedies to the latest technology or strategy insurers are using.

Second, when it comes to medical necessity determinations, outcomes—in the form of grants or denials of coverage—are likely more important to beneficiaries than the internal procedures used to arrive at those outcomes.[193] Focusing efforts solely on regulating the AI used in the determinations process risks overemphasizing procedural requirements that may not lead to better outcomes.[194] Recognizing this, this Note presents solutions that combat the underlying issues in Medicare Advantage's coverage determination process that AI is currently exacerbating. Section III.A proposes new data collection and disclosure requirements focused on determination outcomes. Then, section III.B focuses on important enhancements to the current appeals process, a proven method that enables beneficiaries to obtain better outcomes in individual cases. While these two mechanisms admittedly will not prevent every inaccurate determination, they will lead to positive changes for beneficiaries.

A. *Increased Data Collection and Disclosure*

Collecting and disclosing information about each Medicare Advantage plan's denial rates and practices is an important first step toward accountability.[195] The entire concept of Medicare Advantage is built on the idea that beneficiaries get "to choose from among a broad[]

192. See supra section II.A.

193. See Julie Carter & Rachel Gershon, Clearer Choices: Why Medicare Advantage Enrollees Need Better Information on Supplemental Benefits, Health Affs. Forefront (June 13, 2025), https://www.healthaffairs.org/content/forefront/clearer-choices-why-medicare-advantage-enrollees-need-better-information-supplemental (on file with the *Columbia Law Review*) (noting that beneficiaries choose or change plans based on what coverage they believe they will receive); see also Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 12 (reporting a consumer advocate's statement that, in an ideal world, AI could play a role in coverage determinations if it did not have any harmful effects on access to care). But see supra note 189 and accompanying text.

194. See supra sections II.B–.C.

195. This is not a novel suggestion, but it remains important. For years, advocates and policymakers have asked for increased transparency in Medicare Advantage. See, e.g., Gondi et al., supra note 94, at 2 ("Given the lack of available data to describe [Medicare Advantage] claim denials, increasing transparency is a critical first step."); Letter from Rep. Judy Chu et al. to Chiquita Brooks-LaSure, supra note 11, at 1–2 (noting that "more detailed information about denials is warranted" to "protect access to care" and "improve clarity"); Letter from Just. in Aging to Chiquita Brooks-LaSure, Adm'r, Ctrs. for Medicare & Medicaid Servs. 5 (May 29, 2024), https://justiceinaging.org/wp-content/uploads/2024/05/JIA-Medicare-Advantage-Data-RFI-response.pdf [https://perma.cc/XKZ6-UNJ6] ("We ask that CMS release data that gives a fuller picture of service requests that are delayed or denied.").

array of private health plans" to determine which plan can best serve them and their care needs.[196] Currently, however, neither the government nor insurers provide beneficiaries with the information necessary to determine which plan will reliably cover the services that they need.[197] As medical necessity determinations are a key component controlling which care beneficiaries have access to, it only makes sense for beneficiaries to have access to information about how each plan invokes and applies the medical necessity provision.[198]

A successful transparency regime will involve two parts: collection and presentation. First, CMS should increase its collection and analysis of data on coverage denials from Medicare Advantage plans. CMS currently collects data on denials, including the number of requests for services, the number of those requests resulting in denials, and the number of denials overturned at the internal reconsideration stage.[199] Significant gaps, however, remain in the data. CMS does not require Medicare Advantage insurers to report why they deny certain services,[200] which types of services

196. See Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 8; see also Thomas G. McGuire, Joseph P. Newhouse & Anna D. Sinaiko, An Economic History of Medicare Part C, 89 Milbank Q. 289, 290 (2011) ("[T]he [Medicare Advantage] program has pursued two stated goals. The first is to expand Medicare beneficiaries' choices to include private plans with coordinated care and more comprehensive benefits . . . .").

197. See Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy 359 (2024), https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-3.pdf [https://perma.cc/XPN7-MZE9] ("[B]eneficiaries lack meaningful quality information when choosing among [Medicare Advantage] plans."); Lindsey Copeland, Medicare Advantage Plan Data Remains Inadequate, Medicare Rts. Ctr.: Medicare Watch (May 18, 2023), https://www.medicarerights.org/medicare-watch/2023/05/18/medicare-advantage-plan-data-remains-inadequate [https://perma.cc/P5FB-YBD4] ("Significant gaps in data about Medicare Advantage (MA) plan processes and enrollee experiences make it impossible for . . . beneficiaries to make informed coverage choices."); cf. Carter & Gershon, supra note 193 (advocating for better information sharing about plans' supplemental benefits with Medicare Advantage beneficiaries).

198. See Gondi et al., supra note 94, at 2 ("CMS should go farther by requiring that plans disclose both how often services are denied and why they were denied. Denial rates provide a more helpful signal of health care access across plans than do dense coverage criteria, and disclosure would help beneficiaries choose from among [Medicare Advantage] plans . . . ."); see also Medicare Payment Advisory Comm'n, supra note 197, at 362 ("To make informed choices about enrolling in [a Medicare Advantage] plan, beneficiaries need good information about the quality and access to care provided by [Medicare Advantage] plans in their local market.").

199. Ctrs. for Medicare & Medicaid Servs. & Ctr. for Medicare Drug Benefit & C&D Data Grp., Medicare Part C Reporting Requirements 6–8 (2025), https://www.cms.gov/files/document/cy-2025-part-c-reporting-requirements.pdf [https://perma.cc/6TMN-4K9U].

200. See Jeannie Fuglesten Biniek, Meredith Freed & Tricia Neuman, Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency, KFF (Apr. 10, 2024), https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/ [https://perma.cc/8WRF-NNKM] [hereinafter Fuglesten Biniek et al., Gaps in Medicare Advantage Data] ("Medicare Advantage insurers do not report the reasons for prior authorization denials to CMS." (emphasis omitted)).

they are denying,[201] or how or why an appeal resulted in a reversal.[202] CMS also does not require that insurers break this data down by plan but instead only requires that they do so at the contract level.[203] As a single insurer can have many plans under one contract—plans that serve different populations—this data does not enable CMS or beneficiaries to understand what is happening within each plan.[204] These data gaps make it "substantially more difficult [for CMS] to assess whether Medicare Advantage insurers are complying with" laws[205] and for beneficiaries to know if a plan is best for them.[206]

The increased collection of data, of course, should be coupled with thoughtful presentation. In fact, CMS's main objection to requiring Medicare Advantage plans to increase their reporting is due to "data overload, patient understanding, and usability of the data," including that a "patient might not be able to relate to the data and would not refer to the reports as intended."[207] CMS, however, can choose how to best present the data to beneficiaries. CMS already distills and presents significant amounts of information about different plans and their benefits with its Plan Finder tool, a tool that enables patients to compare plans' costs and supplemental benefits.[208] CMS could present basic information about denial rates, denial reasoning, and reversals for the most prominent

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201. See Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 47 ("Notably, these requirements do not require Medicare Advantage insurers to break down their prior authorization data by service category."); Fuglesten Biniek et al., Gaps in Medicare Advantage Data, supra note 200 ("Medicare Advantage insurers are not required to report prior authorization requests, denials, and appeals by type of service . . . .").

202. See Janet P. Sutton, More Medicare Advantage Beneficiaries Are Filing Appeals for Denied Services or Treatments, Commonwealth Fund: Blog (Oct. 8, 2024), https://www.commonwealthfund.org/blog/2024/more-medicare-advantage-beneficiaries-are-filing-appeals-denied-services-or-treatments (on file with the *Columbia Law Review*) ("There are limited publicly available data on trends in beneficiary appeals to [Medicare Advantage] plans . . . .").

203. See Fuglesten Biniek et al., Gaps in Medicare Advantage Data, supra note 200 ("[T]he aggregate-level data that CMS is requiring Medicare Advantage plans to post on their websites will only be available at the contract, rather than plan level.").

204. See id. ("Contracts can include multiple types of Medicare Advantage plans . . . . [B]y aggregating data in this way, it is not possible to assess variations in prior authorization practices across plans within a contract, including across plans that serve different populations.").

205. Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 48.

206. See Robert A. Bitonte & Michelle Gutierrez Harris, Transparency in Payors' Medical Necessity Denials, 40 J. Legal Med. 2, 2 (Supp. 2020) (arguing that, without data, beneficiaries are forced to enroll in a plan "blindly").

207. See Advancing Interoperability and Improving Prior Authorization Processes, 89 Fed. Reg. 8758, 8890 (Feb. 8, 2024) (to be codified at 42 C.F.R. pt. 156).

208. See Press Release, Ctrs. for Medicare & Medicaid Servs., Medicare Plan Finder Gets an Upgrade for the First Time in a Decade (Aug. 27, 2019), https://www.cms.gov/newsroom/press-releases/medicare-plan-finder-gets-upgrade-first-time-decade [https://perma.cc/27KZ-JJUL] ("The new Plan Finder walks users through the Medicare Advantage and Part D enrollment process from start to finish and allows people to view and compare many of the supplemental benefits that Medicare Advantage plans offer.").

service categories in a similar, digestible fashion. Or CMS could outsource this work. There are many nonprofits and other stakeholders that have the technical expertise necessary to distill data and the intimate knowledge of beneficiaries' capabilities to access and understand data. For example, New York Legal Assistance Group (NYLAG)—a nonprofit legal services organization in New York—has distilled and published similar information regarding Medicaid Managed Long-Term Care through its Data Transparency Project.[209] The project gathered selected data from government reports and turned it into interactive visuals for consumers and advocates to use when thinking about choosing a plan.[210] KFF also regularly tracks, distills, and publishes such data for the public.[211] Working with organizations like these—or at the very least making the data available to these organizations for their use—could also assuage CMS's concerns.

Data sharing can lead to better outcomes in three ways. First, data can alert CMS to potential violations and drive enforcement efforts. The data may reveal oddities or inconsistencies for certain plans or even alert CMS to contracts it should not renew.[212] Second, consumers can use the data when choosing which plan to enroll in, avoiding plans that have high denial rates in service categories important to them.[213] Current data show that plans vary significantly in how often and for which services they deny

209. NYLAG, New York State Managed Long-Term Care Data Transparency Project (2022), https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf [https://perma.cc/79Z6-YTAF].

210. Id. at 1. The interactive visuals live on NYLAG's website and enable users to isolate data for certain plans, on certain issues, or from certain regions of the state. MLTC Data Transparency Project, NYLAG, https://nylag.org/mltcdatatransparency/ [https://perma.cc/Y4DZ-HTHH] (last visited Sep. 11, 2025).

211. See, e.g., Nancy Ochieng, Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico & Tricia Neuman, Medicare Advantage in 2025: Enrollment Update and Key Trends, KFF (July 28, 2025), https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/ [https://perma.cc/7AK6-8PNG]; Nancy Ochieng, Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico & Tricia Neuman, Medicare Advantage in 2025: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization, KFF (July 28, 2025), https://www.kff.org/medicare/medicare-advantage-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/ [https://perma.cc/QSR4-CF8L].

212. See Letter from the Am. Hosp. Ass'n to Chiquita Brooks-LaSure, Adm'r, Ctrs. for Medicare & Medicaid Servs. 2 (May 29, 2024), https://www.aha.org/system/files/media/file/2024/05/AHA-RFI-Response-to-CMS-on-Medicare-Advantage-Data-and-Oversight.pdf [https://perma.cc/EU84-EBCE] ("We believe data collection and reporting on plan performance metrics that are meaningful indicators of patient access are a critical component of an effective enforcement strategy and strongly support CMS efforts to require [Medicare Advantage] plans to submit additional information necessary to conduct appropriate oversight." (emphasis omitted)).

213. See Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 47 (noting that data transparency would enable "the seniors weighing various plans, or deciding between Medicare Advantage and traditional Medicare[] to see whether certain kinds of care are being singled out for denials").

coverage.[214] Data also show denial and appeal trends in Medicare Advantage differ from those in traditional Medicare.[215] Providing beneficiaries with this data—in a comprehensible way—will enable them to have a meaningful choice of whether to enroll in a Medicare Advantage plan or remain in traditional Medicare.[216] When some beneficiaries learn of a certain insurer's policies around denials, they change their enrollment decisions.[217] As plans are paid per enrollee, insurers will suffer the consequences if they continue to erroneously deny care compared to other plans or traditional Medicare.

Finally, even before CMS and beneficiaries start using this data to make decisions, Medicare Advantage insurers may start to change their behavior. According to a phenomenon known across various fields as the sentinel effect, "perceived oversight" often leads to "improved behavior."[218] Research has shown this to be true in the healthcare industry, with perceived oversight leading to increased compliance, reduced fraud, and lower financial reporting aggressiveness.[219] Medicare Advantage insurers do not appear immune from this effect. Internal documents reveal that if insurers know their decisions are likely to be appealed and reviewed by other entities, they change their behavior. One internal UnitedHealthcare email noted that the insurer had formed a working group to "identify cases which may result in an appeal" and find ways to correct the determination before it got to that stage.[220] If Medicare Advantage insurers know that both CMS and millions of beneficiaries have access to data on their medical necessity denials, the sentinel effect will hopefully drive them to self-correct even outside of beneficiaries and CMS holding them accountable. While information sharing may not solve all the woes in Medicare Advantage, it can start to combat erroneous coverage denials by revealing which plans may be misapplying the medical necessity

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214. See id. at 19 ("The data provided by the companies show that . . . the rate of denial was substantially higher for some companies."); see also Fuglesten Biniek et al., Medicare Advantage Insurers, supra note 94 (noting denial rates for different insurers).

215. See Fuglesten Biniek et al., Medicare Advantage Insurers, supra note 94; see also Alkire, supra note 141 (reporting that Medicare Advantage insurers denied 20.1% of post-acute care requests, while original Medicare denied only 3.0%). But see supra note 74 (noting that a recent Trump Administration proposal could result in similar concerns about inaccuracy and lack of transparency in traditional Medicare).

216. See Letter from Sen. Ron Wyden et al. to Chiquita Brooks-LaSure, supra note 78, at 1 ("People with Medicare should be able to benefit from an array of plan choices that they can easily comprehend . . . .").

217. See Ross & Herman, Denied by AI, supra note 10 (telling the story of an individual who refused to enroll with a UnitedHealth Medicare Advantage plan after experiencing the insurer's medical necessity denials).

218. Jared Koreff, Sean W.G. Robb & Gregory M. Trompeter, The Sentinel Effect and Financial Reporting Aggressiveness in the Healthcare Industry, 34 Acct. Horizons 131, 132 (2020).

219. See id. at 131–32.

220. Majority Staff of S. Permanent Subcomm. on Investigations, supra note 12, at 28 (internal quotation marks omitted) (quoting Dir. of Clinical Value, UnitedHealthcare).

standard at high rates, enabling beneficiaries to avoid those plans and CMS to engage in enforcement efforts.

B. *Enhanced Disclosure and Education for Appeals*

While the increased transparency efforts described in this Part serve an important role in combatting erroneous denials at the plan-wide level—and hopefully create a program with fewer incorrect denials—such efforts are unlikely to help an individual beneficiary who is actively facing a denial that they believe is wrong. Alongside transparency efforts aimed at increasing choice for beneficiaries, therefore, it is important for CMS to ensure individual beneficiaries have adequate access to the appeals process,[221] a process that Congress mandates by statute.[222] There is significant evidence that when beneficiaries access the appeals process, it works. As discussed above, "[f]rom 2019 through 2023, more than eight in ten (81.7%) denied prior authorization requests that were appealed were overturned."[223] These high rates have been steady throughout the years, with the rate between 2014 and 2016 being only slightly lower at 75%.[224] Most of these reversals happen at the first two stages, after which the number of appeals greatly diminishes.[225] Many beneficiaries, however, never access this process, with appeal rates, particularly for denied prior authorization requests, sitting at just 11.7%.[226] Ensuring beneficiaries can access this process, particularly the first two steps, is important for combatting erroneous denials. This Note puts forth two efforts that CMS can make to maintain and improve access.

1. *Partner for Outreach and Education Efforts.* — CMS should partner with organizations to improve beneficiaries' knowledge of the appeals process. Beneficiaries currently are not invoking their appeals rights, appealing less than 12% of adverse determinations.[227] Many beneficiaries report that they did not know they had the right to appeal.[228] When someone does not know their rights, they cannot successfully invoke them.[229] Because

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221. See supra section I.C.

222. 42 U.S.C. § 1395w-22(g)(4)–(5) (2018).

223. Fuglesten Biniek et al., Medicare Advantage Insurers, supra note 94.

224. Off. of Inspector Gen., Medicare Advantage Appeal Outcomes, supra note 62, at 7.

225. See id. at 7–9, 27 (reporting that of the 863,000 appeals in Medicare Advantage between 2014 and 2016, less than five thousand moved beyond the IRE stage). Throughout this Part, this Note intends to focus on increasing access to the first two steps of this appeals process. They alone are typically quite successful. See id. (showing that over 99.8% of reversals were made in either the first or second stage). They also both have decently tight time frames, enabling care to be delivered in a timely manner. See Appeals in Medicare Health Plans, supra note 79.

226. See supra notes 134–138 and accompanying text.

227. See supra note 135 and accompanying text.

228. See supra notes 136–137 and accompanying text.

229. See Catrina Denvir, Nigel J. Balmer & Pascoe Pleasence, When Legal Rights Are Not a Reality: Do Individuals Know Their Rights and How Can We Tell?, 35 J. Soc. Welfare & Fam. L. 139, 140 (2013) (noting that "without such knowledge, individuals will more often

of this, Know Your Rights campaigns have proliferated among the nation's top legal services and civil rights organizations over the years.[230] Beyond the practical aspects, some also argue that knowing one's rights is an important meta-right, based in multiple theories of morality.[231]

Such knowledge, however, has little effect if not accompanied by direction in how to properly invoke the rights in practice.[232] Reports show Medicare beneficiaries also struggle in this aspect, with 61% reporting not knowing how to invoke their rights.[233] News reports also note how difficult this is for experts in the field, calling the appeals process "an impossible labyrinth" at times.[234] Outreach by CMS must not only focus on rights in the abstract[235] but must provide practical guidance on how beneficiaries can invoke their rights with their particular plans in the context of improper medical necessity determinations.

To successfully do this—and thus improve access to the appeals process and independent review—CMS should prioritize the involvement of community-based groups that regularly engage in the appeals process.[236] Grantmaking to such groups for both beneficiary education and

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fail to vindicate their rights . . . [and] fail to take steps to protect themselves"); Olivia Newman, The Right to Know Your Rights, 49 Polity 464, 464 (2017) ("[M]any individuals fail to declare their rights because they do not know or fully understand what their rights entail.").

230. See, e.g., Know Your Rights, ACLU, https://www.aclu.org/know-your-rights [https://perma.cc/U5BL-GA5U] (last visited Sep. 12, 2025); Know Your Rights, NAACP, https://naacp.org/find-resources/know-your-rights [https://perma.cc/ZE7J-D5FS] (last visited Sep. 12, 2025); Know Your Rights, NYCLU, https://www.nyclu.org/resources/know-your-rights?types=right&issues=&dates=&searchTerm=&pageNumber=1 [https://perma.cc/KLD9-7ENJ] (last visited Sep. 12, 2025).

231. See Newman, supra note 229, at 470–79 (exploring the basis for the right to know one's rights in deontological, consequentialist, and social contract theories).

232. See Charles Elsesser, Community Lawyering—The Role of Lawyers in the Social Justice Movement, 14 Loy. J. Pub. Int. L. 375, 393 (2013) ("The 'know your rights' events by lawyers are often dry recitations of the law. Many lawyers, in giving these presentations, fail to mention the practical difficulties in implementing these rights, leaving the individuals with a false sense of individual power.").

233. See Pollitz et al., supra note 136 (noting that 61% of Medicare beneficiaries do not know who to call when they face coverage issues).

234. See Cheryl Clark, I Set Out to Create a Simple Map for How to Appeal Your Insurance Denial. Instead, I Found a Mind-Boggling Labyrinth., ProPublica (Aug. 31, 2023), https://www.propublica.org/article/how-to-appeal-insurance-denials-too-complicated (on file with the *Columbia Law Review*).

235. See Brandi M. Lupo, Legal Rights, Real-World Consequences: The Ethics of Know Your Rights Efforts and Towards Improved Community Legal Education, 17 Nw. J. Hum. Rts. 1, 19 (2019) ("[W]hen rights are discussed in universal, general terms, they can easily 'operate in and as an ahistorical, acultural, acontextual idiom . . . .'" (quoting Wendy Brown, States of Injury: Power and Freedom in Late Modernity 97 (1995))).

236. There are multiple groups that do this important work. The Medicare Rights Center runs a national hotline, providing assistance with appeals. Counseling & Advocacy, Medicare Rts. Ctr., https://www.medicarerights.org/counseling-and-advocacy [https://perma.cc/2C58-9JHN] (last visited Sep. 12, 2025). NYLAG, discussed above, does similar work in New York City. Healthcare Access, NYLAG, https://nylag.org/healthcare-access/ [https://perma.cc/2XBF-6NTN] (last visited Sep. 12, 2025).

consultation with CMS about improved notices prioritizes the sharing of practical, real-world knowledge by leveraging the experience and expertise these groups have in engaging with the process.[237] Also, given that Medicare inherently serves a vulnerable population,[238] outsourcing to community groups helps ensure those in charge of these efforts have the cultural competency and built trust to adequately engage and communicate with beneficiaries.[239] By utilizing these groups' expertise on the appeals process and their long-time relationships with beneficiaries and other vulnerable communities, CMS can empower beneficiaries and their advocates to access this all-important process.

2. *Require Specificity in Denial Letters.* — Along with generally improving access to the appeals process, CMS should ensure such access is meaningful. Beneficiaries are facing increasingly opaque denials, exacerbated by the use of AI technologies.[240] Even under the 2023 rule, there is no requirement for denials to include person-specific data or reference the particular criteria used in the case at hand in a thorough manner.[241] This lack of information prevents individuals from knowing whether an appeal is warranted or not.[242] As two scholars have queried: "[W]ithout knowing the basis for the denial, how can one show it was flawed?"[243]

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237. See Peter Frumkin, Service Contracting With Nonprofit and For-Profit Providers: On Preserving a Mixed Organizational Ecology, *in* Market-Based Governance: Supply Side, Demand Side, Upside, and Downside 66, 79 (John D. Donahue & Joseph S. Nye Jr. eds., 2002) (noting that, when outsourcing, "looking at an organization's track record in achieving meaningful client outcomes" enables the government to "focus resources on organizations that have proved they can deliver quality results in their chosen field").

238. The only individuals eligible for Medicare are people aged sixty-five or older, people with disabilities, people with end-stage renal disease, and people with ALS. Who's Eligible for Medicare?, HHS, https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html [https://perma.cc/BL7T-94RY] (last updated Dec. 8, 2022). This vulnerability is compounded in Medicare Advantage, where a disproportionate number of beneficiaries are people of color and an increasing number are low income. Freed et al., supra note 8.

239. See Michael G. Wilson, John N. Lavis & Adrian Guta, Community-Based Organizations in the Health Sector: A Scoping Review, Health Rsch. Pol'y & Sys., Nov. 2012, at 1, 1 ("[C]ommunity-based organizations are well positioned to deliver such services 'because they understand their local communities and are connected to the groups they serve.'" (quoting Kata Chillag, Kelly Bartholow, Janna Cordeiro, Sue Swanson, Jocelyn Patterson, Selby Stebbins, Carol Woodside & Francisco Sy, Factors Affecting the Delivery of HIV/AIDS Prevention Programs by Community-Based Organizations, 14 AIDS Educ. & Prevention (Supplement) 27, 27 (2002))).

240. See supra section II.A.2.

241. See supra note 173 and accompanying text.

242. See Nat'l Ass'n of Ins. Comm'rs, supra note 90, at 30 ("Patients and providers need to be given a rationale for every denial, so that they can determine whether or not to appeal the decision . . . .").

243. Michelle M. Mello & Sherri Rose, Denial—Artificial Intelligence Tools and Health Insurance Coverage Decisions, JAMA Health F., Mar. 7, 2024, at 1, 1, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2816204 [https://perma.cc/7EBZ-SW83].

CMS should require Medicare Advantage insurers to provide reasoning that is person- and situation-specific in denial letters. This is merely a reflection of what determinations under the medical necessity standard are: individualized determinations that ask whether care is necessary for a given beneficiary at a given time.[244] Further, CMS already requires Medicare Advantage insurers to engage in individualized decisionmaking when applying the medical necessity provision,[245] and it is not clear why these individualized results cannot be shared with the party most affected. This disclosure will give beneficiaries the information they need to know exactly why the insurer found the care unnecessary in their specific case, providing them with critical information needed to launch an appeal should they believe the reasoning is incorrect.[246]

CONCLUSION

Medicare's medical necessity standard has been around since the program's inception and is an important provision to protect both beneficiaries and taxpayers. Today, however, Medicare Advantage insurers are commonly misusing this provision and their statutory privileges to deny care that is necessary. The introduction of AI into determinations has only exacerbated such misuse, resulting in a process that is increasingly inaccurate and opaque. To combat this, CMS should stay focused on outcomes rather than getting bogged down in the precise internal procedures of individual insurers and their AI programs. The goal remains the same: ensuring beneficiaries have access to necessary care while preventing coverage of unnecessary care, regardless of the means used to determine these outcomes. CMS can do this by collecting better data, improving disclosure to beneficiaries, and ensuring proper access to the appeals process. Doing so will not only lead to better outcomes, but it will also provide information and power to the party most affected by determinations: beneficiaries in need of care.[247]

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244. See supra section I.A.

245. See supra notes 146–147 and accompanying text.

246. Others have noted the importance of adding these details to denial letters. See, e.g., Letter from Rep. Judy Chu et al. to Chiquita Brooks-LaSure, supra note 11, at 2 ("We also recommend that denial notices should include person-specific details for why a service is denied . . . .").

247. This Note regrettably did not have the space to share more stories from individual beneficiaries that would show how devastating the effects of incorrect coverage denials can be. Medicare serves some of the country's most vulnerable residents in their greatest times of need, and every incorrect denial can lead to a beneficiary going without the medical care they desperately need. From crippling debt to the progression of a debilitating illness to death, the effects are severe and intimate. As policymakers, scholars, and lawyers look for solutions, stories and real-world effects must remain a key part of the inquiry. To read some of these stories and hear directly from beneficiaries and their families about their experiences, see Miller et al., supra note 22 (sharing the story of Little John Cupp); Ross & Herman, Denied by AI, supra note 10 (sharing the story of Dolores Millam); see also Lokken Amended Complaint, supra note 1, at 18–35 (outlining the experiences of various plaintiffs who have been denied coverage).