



266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

March 31, 2026

VIA ELECTRONIC SUBMISSION

Mr. Matthew Wendel
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
7500 Security Blvd
Baltimore, MD 21244

Re: AI Tools for Medicare Experience Modernization - Request for Information

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **AI Tools for Medicare Experience Modernization - Request for Information**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

Based on this experience, we know beneficiary decisions about how to access Medicare coverage, including through Original Medicare (OM) or Medicare Advantage (MA), are high stakes and highly personal.

Among the most frequent calls to Medicare Rights' Helpline are from or on behalf of people trying to navigate enrollment and plan selection.ⁱ For many, the complicated MA and Part D plan landscapes, as well as Medicare's complex enrollment rules and timelines, lead to confusion and overwhelm. While CMS has resources to help, they often fall short of empowering active and informed choices. When suboptimal enrollments result, the consequences can be serious and include delays in care, higher out-of-pocket costs, and barriers to preferred providers.ⁱⁱ

In the RFI, CMS indicates interest in exploring how AI could be used to update the current system. Specifically, to "provide personalized plan recommendations, conversational AI support, predictive analytics, accessible decision support tools, and call center automation to help Medicare beneficiaries make informed plan choices and maximize their coverage." While we appreciate the focus on an improved beneficiary experience, we have significant questions and concerns about how this vision would be operationalized, as well as with the agency's larger effort to inject AI into Medicare.ⁱⁱⁱ

Although we agree that CMS tool modernizations are needed, we urge caution with swift AI uptake in this space. While AI has potential in some areas, it is not infallible or always safe. AI tools can replicate^{iv} or amplify biases,^v give unethical, harmful, or life-threatening advice,^{vi} fail to grapple with complex medical decision-making and triage,^{vii} and raise questions of “accountability, transparency, permission and privacy.”^{viii} Further, plan websites and provider directories are often riddled with errors, which may increase AI access to and dissemination of misinformation.

Our concerns about AI are rooted in experience. To date, where AI has been used in Medicare, there has been minimal transparency and no accountability. MA plans’ use of AI or algorithmic-driven software to make coverage decisions has created significant barriers to care,^{ix} which are now being replicated in OM through the WISeR model.^x These issues demonstrate that AI is not ready to be used in an unmonitored way, or in situations where its results cannot be fact checked, reliably duplicated, or clearly explained.^{xi}

We also note several other readiness barriers—the evolving state of AI science, the lack of AI regulation and oversight, flagging public trust in its safety,^{xii} concerns about data breaches and privacy,^{xiii} and the lack of evidence that AI tools are capable of capturing the nuance of coverage decisions—which likewise reveal it is too soon to give AI vendors access to millions of Medicare beneficiaries and their personal information.

The RFI also raises questions about the role of MA plans in an AI-reliant enrollment system. Given the incredible profits in MA,^{xiv} the program’s history with favorable selection and beneficiary steering,^{xv} documented examples of bias toward MA in administrative tools and communications,^{xvi} and discussions both past and present around automatic MA enrollment,^{xvii} there is the potential that this technology could be exploited to benefit plans at enrollee expense. Such misuse could include pushing people into MA or towards certain plans, misrepresenting plans’ networks and benefits, and otherwise de-centering beneficiary needs and preferences in ways that put their health, well-being, and financial security at risk.

With so much at stake, we appreciate that CMS recognizes the need for safeguards. For example, we agree with the agency’s list of “Prohibited Affiliations, including insurance carriers or health plans that offer Medicare products, insurance producing agencies or brokerages that earn commissions from Medicare plan sales, field Marketing Organizations (FMOs) or agencies of any kind whose business model relies on insurance sales commissions, and any entity with a financial incentive to steer beneficiaries toward specific plans or carriers.”

Looking ahead, we urge the agency to build upon these consumer protections. AI may eventually become reliable and safe enough to provide the type of decision support CMS appears to envision, but it is not there yet. Even in such a future, sturdy guardrails would still be needed. In our view, at a minimum such tools would have to:

- Use vetted and consumer-tested scripts to ensure fairness and comprehensibility
- Be neutral between OM and MA
- Explain the repercussions and importance of the choice between OM and MA, including explanations of utilization management and networks
- Explain the existence of, eligibility for, and links to application materials for financial assistance programs and Medigap plans

- Reveal all factors considered when making an enrollment recommendation
- Be demonstrably free of demographic and other biases, with robust testing and fully funded research in place to uncover issues as they arise
- Ensure the safety and security of beneficiary data
- Be unlinked from any financial ties to plans or health systems, including private equity stakes, with full transparency about ownership and other clientele
- Allow beneficiaries to rate considerations on their importance (e.g. preferred providers, supplemental benefits) and use those rankings when making plan suggestions
- Provide for Special Enrollment Periods (SEPs) for plan choices based on AI suggestions
- Include robust feedback and complaint mechanisms for beneficiaries and other users
- Be immediately withdrawn if evidence of bias, steering, data breaches, or other serious issues emerge

In addition to our concerns about AI specifically, we urge CMS to proceed with extreme caution when considering any changes that could disrupt access to assistance pathways that are working well for beneficiaries, such as the live, in-person, one-on-one help available through State Health Insurance Assistance Programs (SHIPs) and 1-800-Medicare. In our experience, these resources are both highly valued and widely preferred among beneficiaries.

Thank you for the opportunity to provide feedback. We look forward to continued dialogue, and to working together to ensure all people with Medicare have access to the decision-making tools, coverage, and care they need. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

ⁱ Medicare Rights Center, “Medicare Trends and Recommendations: An Analysis of Call Data from the Medicare Rights Center’s National Helpline” (January 13, 2025), <https://www.medicarerights.org/policy-documents/2023-medicare-trends-and-recommendations>.

ⁱⁱ Medicare Rights Center, “Medicare Advantage Proliferation: Too Much of a Complicated Thing” (July 23, 2025), <https://www.medicarerights.org/policy-documents/medicare-sustainability-ma-proliferation>.

ⁱⁱⁱ See, e.g., CMS, “Artificial Intelligence at CMS” <https://ai.cms.gov/>.

^{iv} Ziad Obermeyer, “Dissecting racial bias in an algorithm used to manage the health of populations” (October 25, 2019), <https://www.science.org/doi/10.1126/science.aax2342>; Jerlyn QH Ho, et al., “Gender biases within Artificial Intelligence and ChatGPT: Evidence, Sources of Biases and Solutions” (May 2025), <https://www.sciencedirect.com/science/article/pii/S2949882125000295>.

^v Melissa Hall, et al., “A Systematic Study of Bias Amplification” (October 19, 2022), <https://arxiv.org/pdf/2201.11706>.

^{vi} Annika M Schoene & Cansu Canca, “For Argument’s Sake, Show Me How to Harm Myself: Jailbreaking LLMs in Suicide and Self-Harm Contexts” (July 8, 2025), <https://arxiv.org/pdf/2507.02990>.

^{vii} Ashwin Ramaswamy, et al., “ChatGPT Health performance in a structured test of triage recommendations” (February 23, 2026), <https://www.nature.com/articles/s41591-026-04297-7>.

^{viii} Thomas Davenport & Ravi Kalakota, “The potential for artificial intelligence in healthcare” (June 2019), <https://www.sciencedirect.com/science/article/pii/S2514664524010592?via%3Dihub>.

^{ix} See, e.g., STAT News, “Denied by AI” (2023), <https://www.statnews.com/denied-by-ai-unitedhealth-investigative-series/>.

^x See, e.g., Rebecca Adams, “Intelligence Report - Exclusive: Medicare’s AI experiment leads to delayed care for some seniors” (March 17, 2026), <https://wpintelligence.washingtonpost.com/topics/2026/03/18/exclusive-medicares-ai-experiment-leads-delayed-care-some-seniors/>.

^{xi} Thomas Davenport & Ravi Kalakota, “The potential for artificial intelligence in healthcare” (June 2019),

<https://www.sciencedirect.com/science/article/pii/S2514664524010592?via%3Dihub>.

^{xii} Oni Blackstock, “The AI push in health care is deepening medicine’s trust crisis” (March 23, 2026), <https://www.statnews.com/2026/03/23/ai-use-distrust-american-medicine/>.

^{xiii} Pieter Arntz, “AI chat app leak exposes 300 million messages tied to 25 million users” (February 9, 2026), <https://www.malwarebytes.com/blog/news/2026/02/ai-chat-app-leak-exposes-300-million-messages-tied-to-25-million-users>; Markus Kasanmascheff, “Meta AI Agent Goes Rogue, Exposes Data in Severe Data Breach” (March 20, 2026), <https://winbuzzer.com/2026/03/20/meta-ai-agent-rogue-data-breach-sev1-xcxwbn/>; Cybernews Team, “Analysis of AI tools: 84% breached, 51% facing credential theft” (May 8, 2025), <https://cybernews.com/security/ai-tools-data-breaches-workplace-security-risks/>.

^{xiv} Jared Ortaliza, *et al.*, “Health Insurer Financial Performance in 2024” (February 23, 2026), <https://www.kff.org/medicare/health-insurer-financial-performance/>.

^{xv} US Dept of Justice, “The United States Files False Claims Act Complaint Against Three National Health Insurance Companies and Three Brokers Alleging Unlawful Kickbacks and Discrimination Against Disabled Americans” (May 1, 2025), <https://www.justice.gov/opa/pr/united-states-files-false-claims-act-complaint-against-three-national-health-insurance>.

^{xvi} See, *e.g.*, Center for Medicare Advocacy, “Special Report: Medicare & You 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage” (Sept. 20, 2021), <https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf> (including the Addendum cataloguing such bias); also see *CMA Alert* “Medicare & You 2021 – An Assessment of Bias in Favor of Medicare Advantage” (Sept. 18, 2020), <https://medicareadvocacy.org/medicare-you-2021-an-assessment-of-bias-in-favor-of-medicare-advantage/>.

^{xvii} Mehmet Oz & George Halvorson, “Medicare Advantage For All Can Save Our Health-Care System” (June 11, 2020), <https://www.forbes.com/sites/steveforbes/2020/06/11/medicare-advantage-for-all-can-save-our-health-care-system/>; Khaleda Rahman, “What Dr. Oz Has Said About Changing Medicare” (November 21, 2024), <https://www.newsweek.com/what-dr-oz-has-said-about-changing-medicare-1989533>.