Congress of the United States

Washington, DC 20515

February 29, 2024

President Joseph Biden
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear President Biden, Secretary Becerra, and Administrator Brooks-LaSure:

We write with grave concern that corporate health insurers offering Medicare Advantage (MA) plans are harming vulnerable patients across the country and endangering the solvency of the Medicare Trust Funds. We appreciate that the Biden Administration shares this concern and applaud your recent actions to protect patients and the Medicare program. In particular, we welcome the updates to the risk adjustment model that the Centers for Medicare and Medicaid Services (CMS) made in the 2024 Medicare Advantage Rate Notice and the actions you have taken to remove the obstacles to care that many MA beneficiaries face. We urge you to consider continued efforts to address remaining issues with the program by making it easier for beneficiaries to receive care, ensuring funds that are incorrectly going to MA companies are redirected to patients and providers, and modernizing the benefits in traditional Medicare (TM).

Supporters of MA claim the program reduces costs. Unfortunately, the MA program has never saved the government money.[1] In fact, spending per beneficiary is growing faster in MA than in TM, and the Medicare Payment Advisory Commission (MedPAC) estimates that CMS pays MA plans 6 percent more per enrollee than what it would cost to cover the same enrollee in TM.[2] Despite these higher costs, the data demonstrates that MA often provides worse coverage than TM. For example, a recent study found that people in MA are significantly more likely to die in the month following surgery for stomach, pancreatic, or liver cancer compared to people in TM.[3] Other recent data has shown that the bottom 5 percent of MA plans are responsible for 10,000 preventable deaths every year.[4]

MA Insurers Make Misleading Claims

In light of this troubling trend of higher costs and poorer care, we believe it is essential that older adults, people with disabilities, and lawmakers and administrators regulating MA, recognize misinformation disseminated by private insurers. For example, a report by CMS showed that contrary to insurer claims, MA plans drive health inequities: Black, Native American or Alaska Native, and Hispanic MA enrollees have lower clinical quality scores for 39 percent, 64 percent, and 31 percent, respectively, of all clinical care scores measured compared to the national average, despite outside

studies showing they are healthier prior to enrolling in MA.[5,6] Studies also show that, while the number of Black, Asian, and Hispanic enrollees in MA has grown over the last several years, those communities continue to be offered and enrolled in plans with lower quality ratings than those of White MA enrollees.[7]

In the past, private insurance companies have stated that they will be forced to cut benefits if the government stops the overpayments these companies have collected for decades, which we believe the data demonstrates is a false narrative. Following efforts to reduce MA overpayments in the Affordable Care Act, there were no decreases in access to care or increases in costs for MA beneficiaries.[8] We believe that curbing overpayments would, however, rein in excessive profit margins made on the backs of taxpayers, which have allowed private MA insurers to more than double their profit margins per enrollee.[9] Furthermore, we understand that when beneficiaries realize the disadvantages of MA and wish to switch to TM they often struggle to enroll, and frequently do not qualify for supplemental plans like Medigap.[10] Without Medigap, beneficiaries may be expected to pay up to 20% of their cost of care, without a cap, making TM more expensive and effectively trapping beneficiaries in MA plans that do not serve them. Thus, we believe that the false promises of MA plans hurt beneficiaries even as they seek to leave their MA plan.

Reforms are Needed to Improve Patient Health

To curb insurer practices in MA that we consider dangerous and to improve the health of older adults and people with disabilities, and guarantee Medicare's solvency, we urge CMS to consider the following actions:

1. Ensure that insurance companies do not prevent older adults and people with disabilities from getting care by putting up obstacles, including onerous prior authorizations, Artificial Intelligence (AI) algorithms, or limited networks;
2. Strengthen provider encounter and patient data collection and transparency to improve public understanding of the effects of insurer-run MA plans on patients and the Medicare program;
3. Rein in overpayments to insurers in MA by adjusting benchmarks to compensate for favorable selection and cracking down on deceptive tactics by private insurance companies, including upcoding; and
4. Strengthen Medicare for everyone through administrative action, such as by lowering Medicare premiums, and support legislative efforts to expand Medicare benefits, cap out-of-pocket (OOP) costs in TM, and adjust the physician fee schedule to account for increases in provider costs.

1. Ensure that insurance companies do not prevent older adults and people with disabilities from getting care by putting up obstacles, including onerous prior authorizations, Artificial Intelligence (AI) algorithms, or limited networks.

We applaud CMS's recent actions on insurer tactics that we believe limit care and aim to increase their profits in MA. Specifically, we appreciate CMS prohibiting insurers from imposing additional clinical criteria for prior authorization approvals outside of current Medicare policies and streamlining the prior authorization process.[11,12] If enforced properly, these actions could decrease the roughly 260,000

medical prior authorizations and 1.5 million payment requests that are improperly denied by MA insurers each year.[13,14,15] We believe these reforms to be even more vital as the number of prior authorizations in MA continues to increase: 97 percent of medical practices recently reported that their patients experienced a delay or denial of medically necessary care as a result of prior authorization requirements imposed by private insurers.[16] Further, 86 percent of physicians have reported that despite insurer claims that prior authorization is intended to contain costs, such tactics actually lead to higher health care utilization and waste.[17] For example, insurers may require extra diagnostic tests to "confirm" the diagnosis a medical provider has already made.[18] Cracking down on prior authorization could reduce physician and hospital overhead and physician burnout while saving taxpayer dollars. We urge you to consider strong enforcement of these regulations and meaningfully penalize plans that do not comply.

We also encourage CMS to scrutinize private insurance companies that use AI to make coverage decisions and erect barriers to care. Some medical providers have said that these algorithms misapply Medicare coverage criteria, resulting in inappropriate denials of care.[19] Indeed, there are many harrowing reports of patients with MA coverage who were denied care for stroke recovery, forced into dangerously premature discharges from their hospital stays, and more – all because an arbitrary AI algorithm told the insurance company that the care should be denied.[20] We urge you to consider developing new regulations to ensure that these algorithms abide by Medicare coverage requirements and to consider enforcing existing statutory requirements compelling insurers to disclose the methodology behind algorithms used for coverage decisions to CMS and medical providers. More broadly, CMS could also consider establishing a centralized claims processing system to ensure consistent application of Medicare benefits and monitor insurers' compliance with Medicare coverage guidelines.

Sadly, it appears MA insurers also use restricted networks to create additional obstacles to care for beneficiaries. Researchers found that patients enrolled in MA who had lung, esophagus, stomach, pancreas, colon, or rectal cancer were five times less likely to receive cancer care at a National Cancer Institute-designated cancer center, three times less likely to receive care at a teaching hospital, and almost half as likely to receive care at a Commission on Cancer accredited hospital because the insurer running their plan excluded those top-tier hospitals from the network.[21] Mortality has also been shown to be significantly higher for MA beneficiaries with stomach, pancreas, and liver cancers than comparable beneficiaries in TM.[22] We find that, even when MA enrollees try to find in-network providers, they must rely on plan directories that often contain numerous errors or list providers who are unreachable or unavailable. These "ghost" networks make it even more difficult for a beneficiary to find care.[23] We hope that CMS will define a sufficient network, as required by statute, as one that includes any provider who accepts Medicare's approved rate for services covered under Medicare.[24] At the very least, we request that CMS consider requiring insurers to offer the same network for all MA plans in a region and to ensure the top 100 cancer centers in the United States are included in plan networks to fix the dearth of top-rated, in-network cancer care for MA enrollees.

2. Strengthen provider encounter and patient data collection and transparency to improve understanding of the effects of MA on patients and the Medicare program.

We believe CMS data collection practices in MA to be flawed, making it difficult for policymakers and regulators to oversee the program and legislate potential reforms adequately. While researchers have access to some data samples and aggregated data, without full data transparency, we see it as impossible to answer many important questions about MA and its impact on older adults and people with disabilities.[25] We support the November 2023 proposal from CMS to require a health equity analysis of prior authorization use and the January 2024 final rule requiring insurers to provide a specific denial reason.[26] We further urge CMS to consider strengthening provider encounter and patient data collection and transparency as part of the agency's efforts to improve MA data transparency announced in December 2023.[27] CMS could consider creating a centralized data processing system to achieve the goals of increased transparency.

These changes could allow CMS to analyze and publicly share many important data points that researchers can use to answer important questions about the MA program. For example, this data could be used to evaluate the characteristics of patients whose prior authorization requests are approved or denied, ensuring care is not impeded for specific sub-groups. It could also allow researchers to calculate MA enrollees' average out-of-pocket (OOP) spending. More MA beneficiaries report having trouble paying medical bills or getting care due to cost than TM beneficiaries, and Black beneficiaries are more likely to report cost-related problems if they are enrolled in MA versus TM.[28,29,30] Additionally, examining OOP costs for supplemental benefits, such as vision, dental and hearing benefits could shed light on the value those benefits offer to MA beneficiaries.

CMS could also collect data to better understand why MA beneficiaries disenroll from MA Beneficiaries in poor health are more likely than healthy beneficiaries to switch from MA to TM, and MA enrollees are more than twice as likely to switch to TM in their last year of life.[31,32] MA enrollees who are people of color, live in rural areas, are dually eligible for Medicare and Medicaid, and have experienced functional impairment are also all more likely to switch to TM.[33] Complete disenrollment data could reveal the magnitude and drivers of demographic shifts from MA to TM, such as out-pocket costs and denial rates.

3. Rein in overpayments to insurers in MA by adjusting benchmarks to compensate for favorable selection and cracking down on deceptive tactics by private insurance companies, including upcoding.

Leading government watchdogs, including MedPAC, the Committee for a Responsible Federal Budget, the Congressional Budget Office, and the Government Accountability Office have documented that insurance companies overcharge the government for the MA plans they run by an estimated **$81-$156 billion per year**.[34] Data indicates that companies obtain these extra taxpayer dollars through 1) upcoding, a process of adding diagnosis codes to a patient's medical record to make them appear sicker, 2) favorable selection, in which insurers recruit healthier enrollees who require less care, 3) quality bonus payments, which are based on flawed metrics that have failed to improve plan quality, and 4) inflated benchmarks due to "induced utilization" from supplemental coverage. [35]

We applaud the changes CMS finalized in the 2024 Medicare Advantage Rate Notice to cut down on insurers' misuse of medical codes to increase payments.[36] However, we urge you to consider fully implementing the remaining changes to the MA risk adjustment model in 2025 rather than phasing them in through 2026.[37] We also urge CMS to consider increasing the coding intensity adjustment to further correct for upcoding by insurance companies. Researchers estimate that the proper coding

intensity adjustment is over 15 percent; however, CMS has never increased the coding intensity factor above the statutory minimum adjustment of 5.9 percent.[38] We further propose adopting the Demographic Estimate of Coding Intensity (DECI) model over the existing risk adjustment model. The DECI model estimates that, after correcting for demographics, MA beneficiaries are no sicker than FFS beneficiaries despite their inflated risk scores; rather, MA enrollees are healthier than TM beneficiaries.[39] This model could be most effective in a targeted manner to crack down on the bad actor plans that participate in intense risk score gaming without hurting plans that do not participate in risk score gaming.

In addition, we support restricting the use of chart reviews and health risk assessments, allocating more agency resources to risk adjustment data validation audits, and raising the standard for quality bonus payments. CMS could institute a "favorable selection factor" into the benchmark calculation, which would eliminate overpayments that occur due to MA's much healthier and lower-cost population. Together, these steps could save taxpayers over $100 billion per year.[40]

4. Improve the overall Medicare program through administrative action, such as lowering Medicare premiums, and support legislative efforts to expand Medicare benefits, cap OOP costs in TM, and adjust the physician fee schedule to account for increases in provider costs.

We are grateful that the Biden Administration shares our goal of improving Medicare to ensure it provides comprehensive and affordable care for beneficiaries today and in the future, and we support CMS making necessary changes to the program to realize this shared vision. Nearly all of the following actions could be paid for solely by stopping overpayments to insurance companies in MA. Doing so would also directly decrease Medicare Part B premiums by as much as $260 billion over the next decade by reducing the actuarial rate that CMS uses to set premiums.[41,42]

Additionally, we urge the Biden Administration to continue supporting efforts to improve Medicare, building on President Biden's push to strengthen Medicare through the Build Back Better Act. Specifically, we support using the savings from MA payment reforms to expand Medicare benefits to cover comprehensive dental, vision, and hearing care. These savings could also be used to apply the Medicare Economic Index to the Physician Fee Schedule, which could ensure that payments to physicians account for rising costs and in turn allow more physicians to treat older adults and people with disabilities on Medicare.[43] Finally, we strongly support legislative efforts to establish an OOP cap in TM, which would level the playing field between TM and MA and give more people the financial flexibility to choose TM.

We applaud your attention to issues in MA and the steps you have taken to protect beneficiaries. We support building on this progress by ending delays and denials of care by insurance companies running MA plans, strengthening transparency efforts, reining in overpayments to insurance companies, and supporting efforts to lower costs and expand benefits in TM. We look forward to continuing to work together towards our shared vision for a comprehensive, sustainable Medicare program that serves patients' needs, not insurers' profits.

Sincerely,

Pramila Jayapal
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Member of Congress

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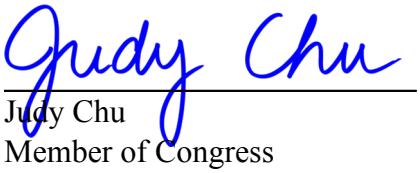

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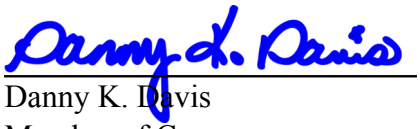

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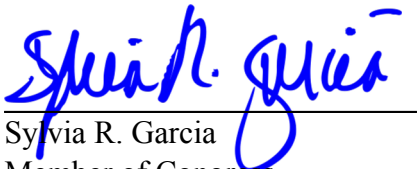

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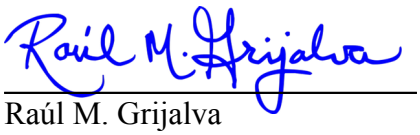

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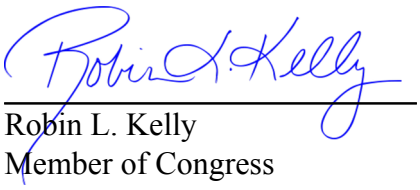

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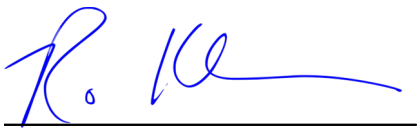

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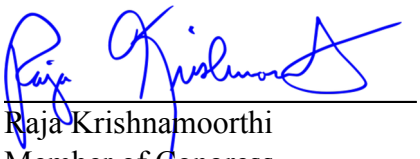

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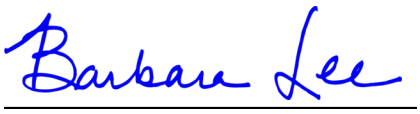

Barbara Lee
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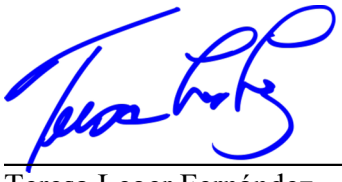

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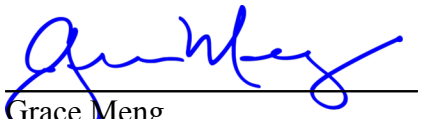

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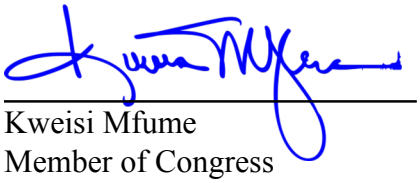

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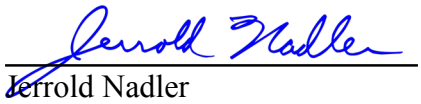

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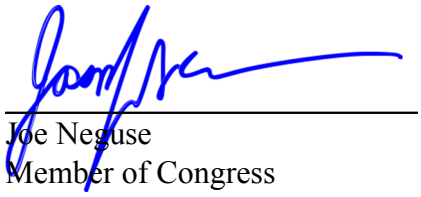

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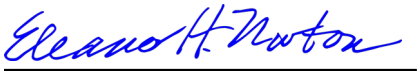

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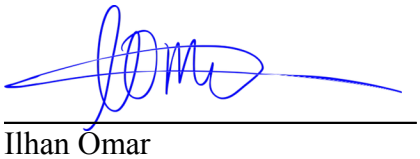

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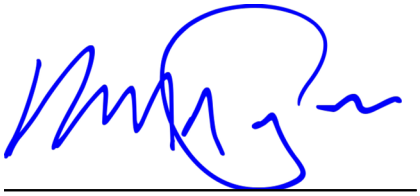

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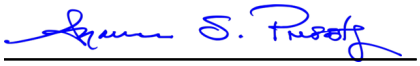

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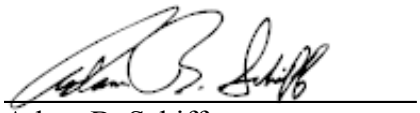

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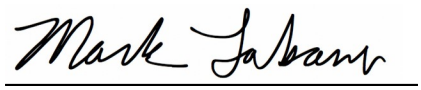

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