

To: **ALL INTERESTED PARTIES**

From: Arnold Ventures

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## **THE EVIDENCE IS CLEAR: WE MUST DO MORE TO REDUCE MASSIVE OVERPAYMENTS TO MEDICARE ADVANTAGE PLANS**

Medicare Advantage (MA) plans have become an increasingly popular choice for seniors, but despite promising better care at lower costs, many big insurance companies have been systematically overcharging enrollees and taxpayers billions of dollars annually. This fraud and abuse of the system has been recognized through multiple [federal lawsuits](#), [audits](#), [investigations](#), and [expert](#) analyses.

Recent reforms from the Centers for Medicare & Medicaid Services (CMS) represent only a first step to reduce overcharges. The evidence of egregious upcoding practices and the billions of dollars in overpayments from coding and other sources suggest Congress and the administration need to do much more to hold insurance companies accountable, rein in waste and abuse, and protect Medicare enrollees and taxpayers.

### **THE REAL COST OF ABUSIVE INSURANCE BILLING PRACTICES**

[Overpayments](#) to MA plans exceed [\\$80 billion a year](#), driven in large part by plans' abusive billing practices. MedPAC estimates that coding alone will cost taxpayers [\\$50 billion in 2024](#). This abuse is widespread. Many insurance companies intentionally make enrollees appear sicker and inflate their payments by aggressively coding the number and severity of diagnoses. [Audits](#) have found that insurers are using diagnostic codes that in some cases have little or no connection to patients' health conditions and needs – or to the care patients actually receive. Every additional unwarranted code drives higher payments and profits for plans without helping patients.

Overpayments to MA plans from upcoding are projected to cost taxpayers and beneficiaries more than [\\$600 billion over the next 8 years](#), with total overpayments from all sources being even larger. Overpayments threaten Medicare's financial health and solvency while also increasing premiums for all beneficiaries across Medicare. In 2024, Part B premiums will be about [\\$13 billion higher](#) because of MA overpayments. Seniors and taxpayers should not have to foot the bill for insurance companies who are making billions of dollars while engaging in abusive behavior.

### **CMS' PAYMENT REFORMS ARE A NECESSARY STEP TO REDUCE INDUSTRY OVERCHARGES**

CMS is already making progress in reining in waste and abuse from MA plans, but larger scale reforms are needed to protect and strengthen the Medicare program. CMS' risk adjustment changes from last year represent more than [\\$7 billion in net savings](#) to the Medicare Trust Fund this year and are anticipated to result in more than [\\$9 billion in net savings](#) in 2025. To build on this progress, CMS should increase the coding intensity adjustment to fully account for plans' upcoding. It should also limit the use of information from health risk assessments and chart reviews, which account for approximately half of the coding overpayments to plans. Congress and the administration need to do

much more to hold insurance companies accountable to beneficiaries and taxpayers. Now is the time to go further to address overpayments – not to pull back.

### **THE MA MARKET IS THRIVING – INSURERS DO NOT NEED A BIGGER INCREASE IN PAYMENTS**

The MA market is robust and profitable for insurers. Over the past decade, growth has [outpaced expectations](#). Profit margins from MA plans average [\\$1,730 per enrollee](#), at least double the margins reported by insurers in other health care markets. While Americans are returning to pre-pandemic levels of health care consumption, plans [are over-exaggerating](#) the need for higher payments to account for increased utilization despite continued massive overpayments.

Next year MA plans are set to receive an estimated payment [increase of 3.7% - or \\$16 billion](#). Past experience and the robust MA market suggest insurers have ample headroom to make adjustments and remain profitable without needing to reduce benefits. Last year, MA plans claimed they would have to cut benefits and increase premiums and cost-sharing even though they received a [3.32% payment increase](#). Despite their overheated rhetoric, the MA market remained stable from 2023 to 2024. Enrollment continues to [increase](#), Medicare enrollees have access to a [similar number of plans](#), [extra benefits](#) remain widely available, and the share of plans with [no additional monthly premium](#) remains the same.

### **GREATER OVERSIGHT AND ACCOUNTABILITY IS ESSENTIAL TO PROMOTE HEALTH EQUITY AND PROTECT HIGH-NEED ENROLLEES**

There are concerning disparities in MA plan offerings for communities of color. In counties with the highest Black populations, MA plan quality ratings often [fall below the national average](#). Additionally, [studies](#) show it is more common for people of color and high-need enrollees to switch out of MA compared with [non-high-need enrollees](#). A recent [report](#) found that beneficiaries in the last year of life disenrolled from MA to traditional Medicare at more than twice the rate of all other MA enrollees. All of this ultimately raises questions of quality and access to care for the highest-need patients.

Disparities also appear to exist in prior authorizations, with the most vulnerable seniors at the highest risk of denials. A [recent analysis](#) found that prior authorization requests are denied at double the rate for MA contracts with only dual-eligible special needs plans (D-SNP) – despite fewer prior authorization requests. In 2021, firms with contracts containing only D-SNPs received nearly 670,000 prior authorization requests, 12% of which were denied. The denial rate for all MA plans was 6%. At the same time, MA plans are reaping large [profits](#) from them. D-SNPs have some of the highest [profit margins](#) among all MA plans.

### **BOTTOM LINE: CUTTING WASTE AND FRAUD IS NOT A BENEFIT CUT**

The MA market continues to be robust, offers generous benefits, and delivers large profits to insurers. Even with the proposed payment increases, experience and evidence suggest there is considerable room for MA plans to reduce costs and still earn significant profits without cutting benefits for seniors. Threats by insurance companies to cut benefits is a choice they are making to put profits ahead of affordable, quality health care for seniors.