Dear Chairman Pallone, Ranking Member McMorris Rodgers, Subcommittee Chairwoman DeGette, and Subcommittee Ranking Member Griffith:

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work in the health care sector is driven by a recognition that the system costs too much and fails to adequately care for the people it seeks to serve. We prioritize five objectives to make health care more affordable and accessible: lower excessive prescription drug prices; lower excessive commercial sector prices; ensure Medicare’s financial sustainability; improve provider payment to incentivize the delivery of high-quality and efficient care; and improve care for people with complex health needs.

To that end, we appreciate the committee’s efforts to improve oversight of the Medicare Advantage program, and we support continued efforts to implement policies that hold Medicare Advantage plans accountable for delivering value to beneficiaries and taxpayers.

Private Medicare Advantage plans play an important role in providing Medicare coverage and are projected to enroll over half of Medicare beneficiaries by 2023. We support Medicare Advantage as an option for beneficiaries. Medicare Advantage plans have the potential to provide care less expensively than fee-for-service Medicare and to coordinate and organize the delivery system to improve care.

However, the growth of the Medicare Advantage program has come at a high cost. There is considerable evidence that Medicare Advantage plans are overpaid relative to traditional Medicare. Despite Medicare Advantage plans’ potential to deliver less costly care, Medicare Advantage has never generated savings for the Medicare program.1 While we support Medicare Advantage, we do not support overpayments. And beneficiaries and taxpayers cannot afford them, especially with the Medicare Hospital Insurance Trust Fund facing insolvency within the next six years. Nearly 45 percent of Medicare Advantage funding comes from the Hospital Insurance Trust Fund.

An important driver of overpayments to Medicare Advantage plans is plans’ ability to increase their payments by aggressively coding beneficiary diagnoses and making beneficiaries appear less healthy than similar beneficiaries enrolled in traditional Medicare. The Medicare Payment Advisory Commission found that Medicare Advantage plans’ risk scores were about 9.5 percent higher than risk scores for similar beneficiaries enrolled in traditional Medicare in 2020. This resulted in $12 billion in excess payments to Medicare Advantage plans in 2020, even after

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accounting for the coding intensity adjustment the Centers for Medicare and Medicaid Services (CMS) makes.\textsuperscript{1} Other estimates suggest that plans’ risk scores and overpayments could be even higher, including estimates that risk scores were 20 percent higher than in traditional Medicare in 2019 and that Medicare overpaid plans by more than $106 billion from 2010 to 2019.\textsuperscript{2, 3} This problem is getting worse. Risk scores are increasing by about 1.5 percent each year, resulting in larger and larger overpayments over time.\textsuperscript{1}

“Upcoding” by Medicare Advantage plans inflates their payments and raises serious program integrity concerns. Because of the payment incentives to aggressively code beneficiary diagnoses, plans use a range of approaches to increase risk scores. Reports by the Office of the Inspector General have highlighted the use of two tactics – chart reviews and health risk assessments – that plans use to identify beneficiary diagnoses. Medicare Advantage plans generated more than $9 billion in risk-adjusted payments in 2017 from diagnoses that were only reported on chart reviews and health risk assessments and for which there were no other records of services or treatment associated with the diagnosis.\textsuperscript{4}

While all Medicare Advantage plans face financial incentives to intensively code beneficiary diagnoses, in some cases, these incentives lead plans to engage in abusive and even fraudulent practices. The Department of Justice has said that investigating and litigating fraud under the False Claims Act in the Medicare Advantage program is a priority. They have settled multiple False Claims Act suits against Medicare Advantage plans, and are currently pursuing additional suits against several more insurers. For instance, Kaiser Foundation Health Plan of Washington agreed to pay more than $6 million and two Florida plans agreed to pay more than $16 million to settle allegations that they submitted invalid or unsupported diagnosis codes to CMS to inflate their reimbursements.\textsuperscript{5, 6}

Congress can address upcoding by increasing the coding intensity adjustment to fully account for differences in coding between Medicare Advantage and traditional Medicare, and by making other improvements to risk adjustment such as excluding diagnoses that are only reported on health risk assessments.

Congress should also improve oversight and accountability of Medicare Advantage to ensure plans are delivering on their promise of providing high-value care to enrollees. A large and

\begin{itemize}
\item \textsuperscript{5} Department of Justice. \textit{Medicare Advantage Provider to Pay $6.3 Million to Settle False Claims Act Allegations}. November 16, 2020.
\item \textsuperscript{6} Schulte, Fred. \textit{Medicare Advantage Insurer Settles Whistleblower Suit for $32 Million}. NPR. May 31, 2017.
\end{itemize}
growing share of Medicare beneficiaries are enrolled in Medicare Advantage plans. Yet we have surprisingly little transparency and data on the benefits and care provided to Medicare Advantage enrollees and their value, including the impact on health outcomes. And although we are paying more for Medicare Advantage, the existing evidence does not suggest that Medicare Advantage plans consistently outperform traditional Medicare, contrary to the managed care industry’s claims.

Patient satisfaction scores are similarly high across both Medicare Advantage and traditional Medicare. Patient satisfaction scores are similarly high across both Medicare Advantage and traditional Medicare.7,8 Medicare Advantage plans deliver higher quality care based on certain metrics (for example, greater use of preventive care services and fewer hospital admissions) but not on others. Most studies suggest Medicare Advantage plans do not perform better on outcomes such as readmission rates, mortality, and racial/ethnic disparities.7

The Medicare Payment Advisory Commission has said that the current state of quality reporting in Medicare Advantage does not allow for an accurate description of the quality of care in Medicare Advantage or how it compares to the care provided in traditional Medicare.7 Yet, Medicare Advantage plans received more than $11 billion in taxpayer-funded quality bonus payments in 2021.9 In addition to taking other steps to increase transparency and oversight of Medicare Advantage, Congress should consider reforms to the flawed quality bonus program which has further increased Medicare Advantage plan payments without generating improvements in quality.

We appreciate the committee’s commitment to increasing oversight of Medicare Advantage plans and to improving the Medicare program. Please reach out to Mark Miller (mmiller@arnoldventures.org) or Erica Socker (esocker@arnoldventures.org) with any questions.

Sincerely,

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