Resolution Concerning the Medicare Advantage Program

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Submitted: October 24, 2022

Whereas, the Medicare Payment Advisory Commission has found that the Center for Medicare and Medicaid Services (CMS) has been overpaying the Medicare Advantage insurers and thereby depleting the Medicare Trust Fund every year since at least 2004 with excessive “benchmark payments” to Medicare Advantage plans,¹ such that Medicare spending would have been $321 less per MA enrollee had those enrollees remained in traditional Medicare,² and

Whereas, CMS has taken no remedial action while the Medicare Advantage companies are rampantly abusing the diagnostic coding system used to predicate monthly capitated payments, adding further to Medicare Advantage overpayments,³ ⁴ ⁵ and

Whereas, CMS has exempted Medicare Advantage insurers from having to pay for hospice care, resulting in simultaneous double payments from the Medicare Trust Fund to both the MA plan and the hospice provider, so long as MA patients are enrolled in a hospice program, and

Whereas, some of the MA overpayments allow for enhanced benefits (lower premiums, dental, optical, and hearing aid subsidies) in most zip codes, thereby luring additional Medicare enrollees to sign on to a MA plan, the overpayments have also resulted in lavish profits for the Medicare Advantage insurers⁶ ⁷ and a flurry of deceptive media advertising, and

Whereas, the Medicare Advantage plans continue to impose tremendous cost and administrative burden on physicians and other health care providers, requiring time consuming pre-authorization procedures and appeals of MA plan denials of payment for care already provided, with over 30% of MA enrollees experiencing at least one payment denial annually,⁸ and

Whereas, the Office of the Inspector General of the Department of Health and Human Services found that 13% of preauthorization denials and 18% of denials of payment were inappropriate,⁹

³ Livingston, S; Insurers profit from Medicare Advantage’s incentive to add coding that boosts reimbursement. Modern Healthcare Sept 1, 2018
⁷ Publication of United Health Group, July 16, 2022.
denying or truncating post-hospitalization rehabilitation care, \textsuperscript{10} inpatient care, imaging, and many other services; therefore be it:

RESOLVED that the Vermont Medical Society will advocate to the Center for Medicare and Medicaid Services to discontinue overpayments to Medicare Advantage plans and to use those funds to improve traditional Medicare and bolster the Medicare Trust Fund; and be it further

RESOLVED that the Vermont Medical Society will advocate to Vermont’s Congressional delegation to improve the benefit package in traditional Medicare - by reducing deductibles and copays, and capping annual out-of-pocket spending - and by adding dental, hearing, and vision coverage; and be it further

RESOLVED that the Vermont Medical Society will advocate to the Center for Medicare and Medicaid Services to improve and stabilize physician payment, including an increase in reimbursement for mental health and primary care services within the traditional Medicare program.

\textsuperscript{10} Medicare Advantage plans telling rehab patients to go home early. Kaiser Health News reprint of Long Beach Press-Telegram expose, October 17, 2022